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

**CASE NO. 05-23037-CIV-JORDAN/BANDSTRA**

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

**Plaintiffs,**

**vs.**

**LIZ DUDEK, et. al.,**

**Defendants.**
_____/

# PLAINTIFFS' CORRECTED[1] PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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[1] Attached as Exhibit A is a redline version of the document, showing the corrections which have been made. The changes consist of corrections of typographical errors and record citationss.

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This is a class and representative action seeking declaratory and injunctive relief to require Florida officials responsible for the state's Medicaid program to operate that program so as to provide children the medical and dental care to which they are entitled under federal law.

## PROCEDURAL HISTORY OF THE ACTION

This action was initiated in 2005 on behalf of the Florida Pediatric Society, the Florida Association of Pediatric Dentists, and a number of individual children on the Medicaid program through their parents or legal guardians. The complaint alleges violations of the Federal Medicaid statutory requirement that children receive medical and dental services known as the Early Periodic Screening Diagnosis and Treatment ("EPSDT") ("EPSDT Requirements"), and to do so with reasonable promptness as required under 42 U.S.C. § 1396a(a)(8) and (a)(10) (Count I) ("Reasonable Promptness"); violations of the Federal statutory requirement that rates for reimbursing medical and dental providers be set, *inter alia*, so as to secure access to care for children that is equal to that of other children in the same geographical area as required under 42 U.S.C. § 1396a(30)(A) (Count II) ("Equal Access"); violations of the federal Medicaid requirements regarding HMOs (Count III) under 42 U.S.C. § 1396u-2(b)(5); and violations of the Federal statutory requirements that the states conduct outreach programs to inform individuals determined to be eligible for Medicaid of the availability of services

and to insure such patients requesting those services are able to receive them. (Count IV) ("Outreach") 42 U.S.C. § 1396a(a)(43).

On January 11, 2007, I denied Defendants' motion to dismiss as to three of the four Counts. D.E. 40. Defendants argued that the Medicaid Act did not provide privately enforceable rights permitting such actions to be enforced under 42 USC § 1983. I found that such enforceable rights existed with respect to all but Count III, but dismissed Count III regarding HMO reporting requirements. On April 24, 2007, I denied Defendants' motion to reconsider. D.E. 58.

Prior to the completion of discovery, I permitted two of the defendants, the Secretaries of the Department of Health and the Department of Children and Families, to file motions for summary judgment on the grounds that the asserted claims did not relate to those officials' statutory authority. Following briefing and argument, I largely denied these motions on March 19, 2009. D.E. 541.

Following extensive discovery, the issue of class certification was referred to the U.S. Magistrate Judge for a report and recommendation. On July 30, 2008 the Magistrate Judge recommended that intervention by certain additional plaintiffs be permitted. I affirmed that ruling with respect to K.V., S.C., K.S., and S.B. but not all of the intervening plaintiffs. D.E. 268. The Magistrate Judge, following briefing and argument, found the requirements of Rule 23 satisfied in an extensive report and recommendation. D.E. 613. Following further briefing and argument,

I overruled objections and certified a class for declaratory and injunctive relief consisting of all Florida children eligible for EPSDT services under the Medicaid Act. D.E. 671. As part of that decision, I found that at least one named plaintiff had standing to advance each of the three remaining accounts with respect to each of the Defendants. *See* Class Certification Order. D.E. 671, p. 3-5. Defendants' request for interlocutory review by the Court of Appeals was denied on December 1, 2009.

Prior to trial, Defendants filed an additional motion for summary judgment arguing that there was no private right of action, that "medical assistance" as used in the Medicaid Act did not provide an enforceable right to recipients to receive timely access to care, and that none of the Plaintiffs had standing. Following briefing and argument, this motion was denied in an order entered September 30, 2009. D.E. 672.

The trial of this matter commenced on December 9, 2009, and proceeded for a total of 94 trial sessions throughout 2010, 2011, and January 2012.[2] Over this period, Plaintiffs called 32 live witnesses in their case-in-chief (and 14 witnesses testified during rebuttal). Defendants did not file a motion for involuntary

[2] I initially had limited the parties to 100 hours each for trial. Defendants objected to this as insufficient in light of the importance of the issues presented, and I subsequently removed the time limitation on the parties' presentation of evidence. 2/11/10 Final Tr. 1864:7-1865:22.

dismissal at the conclusion of Plaintiffs' case-in-chief.[3] Defendants presented live testimony from 19 witnesses in their case-in chief. Both parties presented additional testimony by deposition and numerous exhibits were received in evidence.

Following the close of the evidence, the parties submitted proposed findings of fact and conclusions of law and presented closing argument on March 26-27, 2012. These findings deal with liability and entitlement to declaratory relief, as with the agreement of all parties, I previously indicated that if liability is established, I will conduct an additional hearing on the issue of injunctive relief.

## SUMMARY OF PARTIES' POSITIONS ON ISSUES TRIED

Plaintiffs contend that the Florida Medicaid program has failed to provide Florida children with access to medical and dental care in accordance with the EPSDT Requirements, the Reasonable Promptness requirements, the Equal Access requirements, or the Outreach requirements under the Medicaid Act. Plaintiffs allege that a number of structural, financial, and administrative barriers result in

[3] At the conclusion of their case in chief, Plaintiffs requested a preliminary injunction on two of their issues – the conversion ratio used by Florida to set Medicaid reimbursement rates and the level of dental reimbursement. Without deciding the novel issue of whether a preliminary injunction was allowed under FED. R. CIV. P. 65(a)(1)(2), I ruled that it would not be appropriate to consider such a motion until Defendants had a full chance to present their own case in chief, and denied the motion without prejudice. D.E. 1007.

children not receiving the access to care Federal law has bestowed as an enforceable right, which they categorize into six areas:

First, Plaintiffs submit that Florida's Medicaid reimbursement structure is fundamentally inconsistent with the Federal Medicaid Act. Florida determines reimbursement by a "conversion ratio" with respect to the setting of reimbursement rates for most medical procedures so as to assure "budget neutrality," while failing to consider whether such rates are sufficient to meet federal requirements. Plaintiffs contend this is a *per se* structural violation of the guarantees of access to EPSDT services, to receive required care with reasonable promptness, and the right to equal access to care.

Second, Plaintiffs contend that Florida has violated the Medicaid Act by wrongly terminating thousands of young children from eligibility who in fact are entitled to "continuous eligibility." Moreover, when eligibility is restored, these children are often "switched" to a different primary provider than that which the parent initially selected. These issues allegedly affect tens of thousands of Medicaid children each year, who are thereby denied their rights to EPSDT services, as well as their right to receive such care with reasonable promptness.

Third, Plaintiffs argue that primary care to which they have entitlement under the EPSDT Requirements is not provided, as evidenced by the fact that hundreds of thousands of children do not receive any preventative health care

according to the official EPSDT reports submitted to the federal government. Moreover, the percentage of children receiving certain aspects of preventative health care, such as lead blood screens, is extremely low. Plaintiffs point to legislative budget requests that AHCA has submitted to the legislature calling for increases in reimbursement for child health checkups, for blood lead screening and for outreach, as needed to bring the program into compliance with federal law.

Fourth, Plaintiffs maintain that Medicaid children face long delays and unreasonable obstacles in receiving access to needed specialist care in many areas of the states, and for many important specialists. Such specialist care is also a federal right as part of the EPSDT Requirements under 42 U.S.C. § 1396d(r)(5), the reasonable promptness provisions, as well as under 42 U.S.C. § 1396a(a)(43) for children who request such services. Plaintiffs point to admissions made by high-level AHCA officials that Florida Medicaid recipients face a critical lack of access to specialist care, to surveys of area offices by AHCA reflecting acute shortage of specialists in many areas, and to the testimony of both primary care physicians and specialists with respect to the difficulties and delays in finding specialists to treat children on Medicaid.

Fifth, Plaintiffs contend that Florida fails to provide children with access to dental care, which is one of the EPSDT Requirements under the Medicaid Act, pointing to official government reports showing Florida the worst state in the

country with only 21% of children receiving any dental care. Plaintiffs point to low reimbursement rates for Florida dentists who accept Medicaid children as the principal reason for this failure, which results in many dentists refusing to treat Medicaid children.

Sixth, Plaintiffs contend that Florida has violated Section 43(a) of the Medicaid Act by utilizing an application form that is unnecessarily complex and eliminating the statewide outreach program designed to inform children determined to be eligible for Medicaid of their rights to services. It is estimated that over 250,000 Florida children are eligible for but not enrolled in the Medicaid program.

Defendants' position, notwithstanding public statements by AHCA administrators and legislative budget requests to the contrary, is that there are no systemic problems in the Florida Medicaid program. Defendants maintain that every child who needs care is able to be provided for and that Plaintiffs' position is based on overstated statistical and unreliable anecdotal information. Defendants claim that AHCA's prior legislative budget requests relating to these issues were exaggerated and unreliable; they similarly claim that state surveys of problems in accessing specialist care are not accurate. In addition, Defendants argue that the state now does a better job through managed care and other initiatives in making sure children receive access to care, that improvements have occurred – such as a

recent increase in dental reimbursement – and that to the extent children do not receive care; that may reflect a personal or family choice not to seek care.

Defendants also argue that the named Plaintiffs lack standing because they did not have a problem receiving needed care and face no reasonable prospect of a future denial of care. Defendants object to the certification of a class on multiple legal grounds. Finally, Defendants renew their argument that the Medicaid statute is not enforceable by recipients, and that the promise of "medical assistance" relates to the expediency with which providers receive reimbursement and does not constitute an assurance that recipients will in fact receive adequate access to care.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Court makes the following findings of fact, and conclusions of law:

### I. JURISDICTION AND PARTIES

1. This is a class action brought on behalf of all children under the age of 21 who now, or in the future, will reside in Florida, and who are or will be eligible for Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") services as part of the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act. Plaintiffs seek declaratory and injunctive relief to require Florida officials responsible for the Medicaid program to provide the plaintiff class with the rights of access to medical care required by federal law. D.E. 220-2.

2. This Court has jurisdiction under 28 U.S.C. § 1331, § 1343(a)(3) and §1343(a)(4), this being a civil action under 42 U.S.C. § 1983 for declaratory and injunctive relief for deprivation of rights secured by Title XIX of the Social Security Act, 42 U.S.C. §§1396 et seq.

3. Pursuant to Section 409.902, Florida Statutes (2008), the Agency for Health Care Administration ("AHCA") is designated as the "single State agency" authorized to make payments for covered medical goods and services under Title XIX of the Social Security Act, to the extent that such services are provided to eligible individuals by qualified Medicaid providers. Defendant Holly Dudek is sued in her official capacity as the Secretary of AHCA.

4. The Department of Children and Families ("DCF") has been delegated the responsibility for making Medicaid eligibility determinations under Florida law. FLA. STAT. §409.963. Defendant David Wilkins is sued in his official capacity as the Secretary of DCF.

5. The Department of Health ("DOH") has been delegated the responsibility to administer the Children's Medical Services ("CMS") program, which is responsible for ensuring that Medicaid children with special health care needs receive Medicaid services. FLA. STAT. §391.016, §391.026. "Children with special health care needs" means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and

who also require health care and related services of a type or amount beyond that which is generally required by children. FLA. STAT. § 391.021(2) (2009). Defendant Harry Frank Farmer, Jr. is sued in his official capacity as the Surgeon General, and head of DOH.

6. Plaintiffs allege that Florida Medicaid is not in compliance with various provisions of Title XIX of the Social Security Act, including its EPSDT Requirements, 42 U.S.C. § 1396d(r), 42 U.S.C. §1396a(a)(43)(b) and (c); the Reasonable Promptness provision, 42 U.S.C. § 1396a(a)(10). 42 U.S.C. §1396a(a)(8) and (a)(10); the Equal Access provision, 42 U.S.C. §1396a(a)(30)(A); and the Outreach provision, 42 U.S.C. § 1396a(a)(43).

7. The Plaintiff Class, which I certified in my Order of September 20, 2009, consists of all children under the age of 21 who now, or in the future will, reside in Florida and who are, or will be, eligible under Title XIX of the Social Security Act for Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") services. As set forth in its findings below, I reaffirm this as an appropriate class action seeking declaratory and injunctive relief pursuant to FED. R. CIV. P. 23.

8. The Plaintiff Class is represented by Individual Plaintiffs J.S., N.G., J.W., N.A., L.C., K.K., N.V., and S.B. Each Individual Plaintiff is a Medicaid-eligible child. I find, as discussed in detail below, that these Individual Plaintiffs

face a realistic and immediate danger of sustaining a violation of their legal rights as a result of Defendants' non-compliance with the Medicaid Act, and accordingly, have standing to bring each of these claims against each of these Defendants.

9. Two organizations also are plaintiffs. The Florida Pediatric Society ("FPS"), the Florida Chapter of the American Academy of Pediatricians, is an advocacy organization consisting of doctors, and its mission is to improve the health and welfare or infants, children, and young adults of Florida. The Florida Academy of Pediatric Dentistry ("FAPD") is an advocacy organization consisting of dentists, and its mission is to practice the art and science of pediatric dentistry and to promote optimal health care for infants, children, and persons with special health care needs. As discussed below, I find they also have standing to advance these claims.

## II. RELEVANT PRINCIPLES UNDER 42 U.S.C. § 1983

10. 42 U.S.C. § 1983, the Civil Rights Act, provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State…subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit or equity, or other proper proceeding for redress…

11. The Social Security Act in general, and Title XIX thereof (The Medicaid Act), is a "law" within the meaning of 42 U.S.C. § 1983 which creates a

right of action for people who, are deprived of a right secured by the Constitution and laws of the United States." *Neb. Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295 (8th Cir. 1985) (emphasis in original). Section 1983 provides a federal remedy for violations, not only of the U.S. Constitution, but also for federal statutes as well. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980); *31 Foster Children v. Bush*, 329 F. 3d 1255, 1268 (11th Cir. 2003); *see Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 508-23 (1990) (42 U.S.C. §1983 may be used to enforce section 13(A) of the Medicaid Act).

12. Civil rights litigation is a historically proven tool for bringing state institutions and programs into compliance with federal mandates. *See* 7 Newberg on Class Action § 23.11 (4th ed.) The Eleventh Amendment to the U.S. Constitution does not bar a federal district court from ordering injunctive relief requiring a defendant state official to make payments to a Medicaid provider which are required to fulfill an enforceable provision of the Medicaid law. *Doe v. Chiles*, 136 F.3d 709, 719-20 (11th Cir. 1998), relying in turn on *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 694-95 (11th Cir. 1997) (per curiam).

13. Defendants cite to cases involving the circumstances where a government official may be held liable for an employee's "randomized acts," typically under a theory of *respondeat superior*. *See, e.g., Ky. v. Graham*, 473 U.S. 159 (1985) (seeking damages against police commissioner for alleged

violation of constitutional rights committed by police officer.) This case, however, involves claims against state officials for direct liability based on state policies, not vicarious liability for the acts of state or local employees. *See, e.g, Shakhnes ex rel. Shakhnes v. Eggleston*, 740 F. Supp. 2d 602, 621 -22 (S.D.N.Y. 2010) (discussing distinction). To the extent certain of Plaintiffs' claims involve reimbursement rates and other actions taken by private parties such as managed care organizations, it is well-established that state officials cannot avoid liability for compliance with federal law based on a decision to rely on private entities to administer services. *See West v. Atkins*, 487 U.S. 42, 56 (1988); *Catanzano by Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995); *Tenn. Ass'n of Health Maint. Orgs., Inc. v. Grier*, 262 F.3d 559, 565 (6th Cir. 2001).

## III. RULE 23 CLASS ACTION REQUIREMENTS ARE SATISFIED

14. Rule 23(a)'s requirements for class certification are: (1) the class must be so numerous that joinder of all members is impracticable; (2) there must be a question of law or fact that is common to the class; (3) the class representatives must present claims or defenses typical of those of the class members; and (4) the class representatives must fairly and adequately protect the interests of the class. *See* FED. R. CIV. P. 23(a); *Pickett v. Iowa Beef Processors*, 209 F.3d 1276, 1279 (11th Cir. 2000). A court "must conduct a rigorous analysis of Rule 23 before certifying a class[.]" *Vega v. T-Mobile USA, Inc.*, 564 F.3d 1256, 1266 (11th Cir.

2009). "Rule 23 does not set forth a mere pleading standard. A party seeking class certification must affirmatively demonstrate his compliance with the Rule . . . ." *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011).

15. I previously found the requirements for class certification met and certified a class of "all children under the age of 21 who now, or in the future will reside in Florida and who are, or will be, eligible under Title XIX of the Social Security Act for Early Periodic Screening Diagnosis and Treatment Services." D.E. 671 at 8-9. I reaffirm that conclusion based on the lengthy trial record.

**A. Numerosity**

16. I find that the proposed class is "so numerous that joinder is impracticable." FED. R. CIV. P. 23(a)(1). Defendants' own statistics indicate that more than 1.5 million children were enrolled in Medicaid as of October 2009. DX 262. As of 2012, the enrollment had soared again, this time rising to 1.7 million children. Lewis on 11/29/2011 Rough Tr. at 48-49.

**B. Commonality**

17. Rule 23(a) requires a question of law or fact common to the class. FED. R. CIV. P. 23(a)(2). The commonality requirement "does not mandate that all questions of law or fact are common; a single common question of law or fact is sufficient to satisfy the commonality requirement, as long as it affects all class members alike." *Colomar v. Mercy Hosp., Inc.*, 242 F.R.D. 671, 676 (S.D. Fla.

2007). I find commonality is established in this case.

18. "What matters to class certification … is not the raising of common questions – even in droves – but, rather, the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation." *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011). The common contention "must be of such a nature that it is capable of class-wide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Id.*

19. Nothing in the *Wal-Mart* decision purports to hold class actions are not appropriate in institutional reform cases such as this one. Courts continue to certify classes in institutional reform cases as well as class actions after *Wal-Mart*. *See, e.g.*, *Cronas v. Willis Group Holdings, Ltd.*, Case No. 06civ15295 (RMB), 2011 WL 6778490, *4 (S.D.N.Y Dec. 19, 2011) (certifying a settlement class in a Title VII gender discrimination case brought by women who all worked in one location and who all faced personnel actions by the same decision maker); *Carrera v. Bayer Corp. et al.*, Case No. 08-4716 (JLL), 2011 WL 5878376 (D. N.J. Nov. 22, 2011) (certifying class in consumer protection case brought by indirect purchasers alleging uniform, deceptive marketing practices by defendants); *Wilhoite v. Mo. Dept. of Social Serv.*, Case No. 2:10-cv-03026-NKL, 2011 WL 5025850 (W.D. Mo. Oct. 21, 2011) (certifying class of Medicaid beneficiaries who

claim the state improperly deducted money from unrelated civil settlements or judgments to pay for part of their medical costs).

20. In litigation challenging a government program, all class members do not have to suffer the same injury simultaneously to meet the commonality requirement; it suffices if they are all subject to risk of deprivation of their legal rights. *See, e.g.*, *Baby Neal for and by Kanter v. Casey*, 43 F.3d 48, 60 (3d Cir. 1994). In a case challenging governmental policy, Rule 23(a)(2)'s commonality provision "does not require complete identity of legal claims." *Johnson v. Am. Credit Co. of Ga.*, 581 F.2d 526, 532 (5th Cir. 1978).

21. I find a number of common questions of law and fact inform this action, and that those questions can be answered on a class-wide basis. Those questions include:

- Whether AHCA considers the requirements of federal law when it sets fee-for-service reimbursements rates for Medicaid providers or whether it simply sets rates to ensure budget neutrality;
- Whether reimbursement rates are sufficient to ensure that Class Members have reasonably prompt and equal access to primary providers, medical specialists, and dentists;
- Whether Defendants have failed to ensure compliance with a provision of Florida's state Medicaid plan, prohibiting terminating a child during a period of continuous eligibility;
- Whether Defendants have failed to conduct an effective statewide outreach program designed to inform children

determined to be eligible for Medicaid of their rights to services; and

- Whether Florida's uniform Medicaid application and process serve impose unnecessary obstacles to obtaining care.

22. The Class Members seek prospective relief to compel governmental entities to comply with their statutory mandates. The Eleventh Circuit has explicitly stated that the commonality requirement is satisfied in such cases. *See Haitian Refugee Ctr., Inc. v. Nelson*, 694 F. Supp. 864, 877 (S.D. Fla.1988), *aff'd*, 872 F.2d 1555 (11th Cir.1989) ("Class actions seeking injunctive or declaratory relief . . . by their very nature present common questions of law or fact."). This Court's rulings have been in accord. *See e.g., Edmonds v. Levine*, 233 F.R.D. 638, 641 (S.D. Fla. 2006) (commonality satisfied in case challenging AHCA's criteria for denying Medicaid reimbursement for Neurontin); *Hernandez v. Medows*, 209 F.R.D. 665, 669 (S.D. Fla. 2002) (commonality met by "common issues of fact and law aris[ing] by virtue of the Federal Medicaid Program").

23. *Wal-Mart v. Dukes* is easily distinguished from these cases. In *Wal-Mart*, plaintiffs were claiming, in the face of a corporate policy explicitly prohibiting gender discrimination, that "a strong and uniform 'corporate culture' permits bias against women to infect, perhaps subconsciously, the discretionary decision making of each one of Wal-Mart's thousands of managers – thereby making every woman at the company the victim of one common discriminatory

practice." *Wal-Mart*, 131 S. Ct. at 2548. Here, by contrast, Plaintiffs are challenging Defendants' policies and practices, such as their policy for setting fee-for-service reimbursement rates for providers without considering whether those rates were sufficient to comply with federal requirements.

**C. Typicality**

24. Under Rule 23(a), Plaintiffs' claims must be typical of those of the Class Members. FED. R. CIV. P. 23(a)(3). "A sufficient nexus [to satisfy the typicality requirement] is established if the claims or defenses of the class and the class representative arise from the same event or pattern or practice and are based on the same legal theory." *Kornberg v. Carnival Cruise Lines, Inc.*, 741 F.2d 1332, 1337 (11th Cir.1984); *see also Andrews v. Am. Tel. & Tel. Co.*, 95 F.3d 1014, 1022 (11th Cir. 1996) (quoting *In re Am. Med. Syst., Inc.*, 75 F.3d 1069, 1082 (6th Cir.1996) ("'Typicality' exists when a plaintiff's injury arises from or is directly related to a wrong to a class and that wrong includes the wrong to the plaintiff.").

25. I find that the typicality requirement is readily satisfied here. Each Plaintiff's inability to access care resulted from the same pattern or practice regarding Defendants' administration of the Florida Medicaid system. Factual variations amongst class members do not defeat typicality. *See Prado-Steiman*, 221 F.3d at 1279 n. 14 (typicality can "be satisfied even if some factual differences

exist between the claims of the named representatives and the claims of the class at large" because a "strong similarity of legal theories will satisfy the typicality requirement despite substantial factual differences"); *Appleyard v. Wallace*, 754 F.2d 955, 958 (11th Cir. 1985), *overruled on other grounds*, 474 U.S. 64 (1985) (stating, in case seeking to enforce rights under the Medicaid Act: "The similarity of the legal theories shared by the plaintiffs and the class at large is so strong as to override whatever factual differences might exist and dictate a determination that the named plaintiffs' claims are typical of those of the members of the putative class."); *see Edmonds v. Levine*, 233 F.R.D. 638 (S.D. Fla. 2006) (rejecting defendant's argument that named plaintiffs' claims were not typical because they had various medical conditions, and were prescribed Neurontin for different reasons, because defendants' actions in denying Neurontin coverage and underlying rationale for the denials were identical for all class members.); *Hernandez v. Medows*, 209 F.R.D. 665, 672 (S.D. Fla. 2002) ("[I]ncidental variations in Plaintiffs' factual situations do not defeat typicality because the basic nature of the injury and the legal theory of recovery is typical for the entire class."); *see also Baby Neal*, 43 F.3d at 58 ("Where an action challenges a policy or practice, the named plaintiffs suffering one specific injury from the practice can represent a class suffering other injuries, so long as all the injuries are shown to result from the same practice."); *Perdue*, 218 F.R.D. at 301 (N.D. Ga. 2003)

("Moreover, the named plaintiffs and putative class members all claim injuries arising from systemic deficiencies in the child welfare system, and all request the same system-wide declaratory and injunctive relief.)

**D. Adequacy**

26. Rule 23(a)'s last requirement is that Plaintiffs and their counsel will adequately protect the interests of the Class Members. FED. R. CIV. P. 23(a)(4). The "determining factor" for the adequacy of representation requirement "is the forthrightness and vigor with which the representative party can be expected to assert and defend the interests of the members of the class." *Veal v. Crown Auto Dealerships, Inc*., 236 F.R.D. 572, 578 (M.D. Fla. 2006) (quoting *Lyons v. Georgia-Pacific Corp. Salaried Employees Ret. Plan*, 221 F.3d 1235, 1253 (11th Cir. 2000)). The adequacy of representation requirement has two components: "(1) the class representative has no interests antagonistic to the class and (2) class counsel possesses the competence to undertake the litigation." *Hammett*, 203 F.R.D. 695 (S.D. Fla. 2001); *see also Reese v. Miami-Dade County*, 209 F.R.D. 231, 233 (S.D. Fla. 2002).

27. Plaintiffs are represented by Boies, Schiller & Flexner, LLP, the Public Interest Law Center of Philadelphia, and Louis Bullock of Bullock, Bullock & Blakemore. I find that in the more than six years since this case was filed and during the 22-week trial, these attorneys have demonstrated their commitment to

the named Plaintiffs and to the Class Members and their ability to adequately represent their interests.

28. "[A] party's claim of representative status is defeated only if the conflict between the representative and the class is a fundamental one, going into the specific issues in controversy." *Pickett v. Iowa Beef Processors*, 209 F.3d 1276, 1280 (11th Cir. 2000). "A fundamental conflict exists where some party members claim to have been harmed by the same conduct that benefitted other members of the class." *Valley Drug Co. v. Geneva Pharm., Inc.*, 350 F.3d 1181, 1189 (11th Cir. 2003).

29. Far from being in conflict, Plaintiffs and the Class Members share an overriding interest in bringing Defendants into compliance with federal law. There is no evidence of any conflict between the Class Members, fundamental or otherwise. The Individual Plaintiffs and the Class Members will all benefit from the entry of the injunctive and declaratory relief sought in this case.

30. My finding that Plaintiffs' interests do not conflict with those of the class members is fully supported by precedent. *See, e.g., Hernandez v. Medows*, 209 F.R.D. 665, 667 (S.D. Fla. 2002) (class of current and future Medicaid recipients); *Chisholm v. Jindal*, No. Civ. A. 97-3274, 1998 WL 92272, at *5 (E.D. La. March 2, 1998) (plaintiffs challenging access to EPSDT care and services);

*Karen L. ex rel. Jane L. v. Physicians Health Servs., Inc.*, 202 F.R.D. 94, 102 (D. Conn. 2001) (Medicaid recipients).

### E. Certification Is Proper Under Rule 23(b)(2) Because Defendants Acted Or Failed To Act On Grounds Generally Applicable To The Class

31. Certification is proper under Rule 23(b)(2) where Defendants have "acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." FED. R. CIV. P. 23(b)(2). "Requesting a declaration that Defendants presently are violating the law and an injunction forcing defendants to comply with the law is precisely the type of class appropriate for class certification under Rule 23(b)(2)." *Fabricant v. Sears Roebuck*, 202 F.R.D. 310, 316 (S.D. Fla. 2001); *see also Nat'l Law Ctr. on Homelessness and Poverty, R.I. v. New York*, 224 F.R.D. 314, 325 (E.D.N.Y. 2004) (Certification under Rule 23(b)(2) is "proper where a government entity refuses to comply with federal law.") (citation omitted). Rule 23(b)(2)'s requirements are "almost automatically satisfied in actions primarily seeking injunctive relief." *Baby Neal*, 43 F.3d at 58.

32. A class action is appropriate when "the party opposing the class . . . has established a regulatory scheme Common to all class members . . . . What is necessary is that the challenged conduct or lack of conduct be premised on a

ground that is applicable to the Entire class." *Johnson v. Am. Credit Co. of Ga.*, 581 F.2d 526, 532 (5th Cir.1978). The key to the (b)(2) class is "the indivisible nature of the injunctive or declaratory remedy warranted – the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them." *Wal-Mart*, 131 S. Ct. at 2557 (internal quotation omitted).

33. This is a paradigmatic example of a case in which certification under Rule 23(b)(2) is appropriate. 7 NEWBERG ON CLASS ACTIONS § 23:11 (4th ed.); *see e.g., Hawkins ex rel. Hawkins v. Comm'r of N.H. Dep't of Health and Human Servs.*, No. Civ. 99-143-JD, 2004 WL 166722, at *4 (D.N.H. Jan. 23, 2004) ("Classes certified under Rule 23(b)(2) frequently serve as the vehicle for civil rights actions and other institutional reform cases, including cases alleging deficiencies in government administered programs such as Medicaid.") (internal quotation omitted).

34. Many other courts have certified similar classes. *See Memisovski ex rel. Memisovski v. Maram*, No. 92 C1982, 2004 WL 1878332, at * 1 (N.D. Ill. Aug. 23, 2004) (noting certification of a class consisting of "[a]ll children… in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medicaid Assistance Program ('Medicaid') established under Title XIX of the Social Security Act"); *Okla. Chapter of Am. Acad. of Pediatrics v.*

*Fogarty*, 01-CV-0187 (N.D. Okla. May 30, 2003) (certifying class of "all children under the age of 21 who are now, or in the future will be, residing in Oklahoma and who have been, or will be, denied or deprived of Medical Assistance as required by law"), *overturned on other grounds*, 472 F.3d 1208 (10th Cir. 2007); *Hawkins ex rel. Hawkins v. Comm'r of N.H. Dep't. of Health and Human Servs.*, No. 99-CIV-143-JD, 2004 WL 166722, at *1 (D.N.H. Jan. 23, 2004) (certifying settlement class of "all persons under age 21 who are now enrolled, or who became enrolled during the term of this Decree, in the New Hampshire Medicaid program and are, or will become, entitled to receive EPSDT dental services"); *Thompson v. Raiford*, No. 3:92-CV-1539-R, 1993 WL 497232, at *1 (N.D. Tex. Sept. 24, 1993) (certifying nationwide class of "[a]ll Medicaid-eligible children under age 72 months who are eligible to receive Early and Periodic Screening, Diagnostic, and Treatment ('EPSDT') program services"); *McCree v. Odom*, No. 4:00-173(H)(4), slip op. at 37 (E.D.N.C. Nov. 26, 2002)[4] (certifying class of "all persons under age 21 who are or will be eligible for Medicaid in North Carolina" in suit challenging provision of dental care under Medicaid); *Salazar v. D.C.*, 954 F. Supp. 278, 281 (D.D.C. 1996) (noting previously certified class of "[a]ll persons who have applied, have attempted to apply, or will apply in the future during the pendency of this litigation, for medical assistance pursuant to Title 19 of the Social Security Act

[4] This is an unpublished opinion, previously submitted to the Court as D.E. 281-3.

('Medicaid'), and all persons who have received, are receiving, or will receive in the future during the pendency of this litigation, Medicaid in the District of Columbia"); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 68 (D. Conn. 2001) (certifying class of "all individuals in Connecticut who are or will be eligible for Medicaid managed care Husky A benefits, and are or will be seeking dental services" and a subclass of "children in Connecticut who are now or will be under the age of 21, are or will be seeking dental health services, and are or will be eligible for Medicaid managed care Husky A benefits"); *Sanders v. Lewis*, No. 2:92-CV-0353, 1995 WL 228308, at *1 (S.D. W.Va. March 1, 1995) (certifying class of "[a]ll children who are now, or will in the future be, under the age of 21, in out-of-home care in the legal or temporary legal custody of the West Virginia Department of Health and Human Resources, and eligible for Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services").

## IV. THE MEDICAID STATUTES

### A. The Plaintiffs' Ability To Sue Under §1983 For Alleged Violations Of The Statutes

35. To determine whether a federal statute creates an enforceable right against a state, a court must analyze three factors:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on

> the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

*Blessing v Freestone*, 520 U.S. 329, 340-41 (1997) (citations omitted). For statutory language to satisfy the first factor, it must be "rights-creating" and clearly impart an "individual entitlement" on the plaintiff with an "unmistakable focus on the benefitted class." *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 274, 284 (2002). The provisions at issue in the case meet the three-prong test established in *Blessing*, as refined by *Gonzaga.*

36. The Eleventh Circuit in *Doe v. Chiles*, 136 F.3d 709, 719 (11th Cir. 1998), expressly held that 42 U.S.C. § 1396a(a)(8), which requires medical assistance be provided with "reasonable promptness," meets all three requirements of the *Blessing* test, and *Doe* has not been called into doubt by *Gonzaga. See Bryson v. Shumway*, 308 F. 3d 79, 89 (1st Cir. 2002); *Newark Parents Ass'n v. Newark Pub. Sch.*, 547 F.3d 199, 208 (3d Cir. 2008); *Sabree ex. rel. Sabree v. Richman*, 367 F.3d 180, 189-90 (3d Cir. 2004)*; Doe v. Kidd*, 501 F. 3d 348, 356 (4th Cir. 2007); *Westside Mothers v. Olszewski*, 454 F.3d 532, 536-37 (6th Cir. 2006).

37. 42 U.S.C. 1396a(a)(10) provides that a state plan for medical assistance must "provide for making medical assistance available." Medical assistance includes a guaranty that EPSDT services be provided to children, 42 U.S.C. § 1396 a(a)(10)(A), and confers enforceable rights. *See Newark Parents*

*Ass'n*, 547 F. 3d at 208; *Sabree*, 367 F.3d at 190; *S,D, ex rel Dickson v. Hood*, 391 F.3d 581, 607 (5th Cir. 2004); *Westside Mothers*, 454 F.3d 532, 536-37; *Katie A. ex rel Ludin v. L.A. County*, 481 F. 3d 1150, 1153 n 7 (9th Cir. 2007); *Watson v. Weeks*, 436 F. 3d 1152, 1154 (9th Cir. 2006).

38. 42 U.S.C. Section 1396a(a)(30)(A) requires a state program to:

> ["P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and *are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . .*"

(Emphasis supplied).

39. As I have previously held, the individual plaintiffs may bring an action under 1396a(a)(30)(A) in light of *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 519-20 (1990). In *Wilder*, the Supreme Court held that health care providers could sue to enforce the Boren Amendment because they were the "intended beneficiaries" of a provision that imposed a "binding obligation" on states to adopt reasonable rates. *See id*. at 509-510.

40. The Wilder Court's analysis was expressly preserved by *Gonzaga*, which stated that the language of the Boren Amendment "left no doubt of its intent for private enforcement . . . because the provision required States to pay an 'objective' monetary entitlement to individual health care providers." *See*

*Gonzaga*, 536 U.S. at 281. *Wilder*, then, remains good law. Indeed, *Wilder* has been cited this term with approval by the U.S. Supreme Court in *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, -- S. Ct. --, 2012 WL 555204 (Feb. 22, 2012).

41. Section "1396(a)(30)(A) imposes a mandate on states that mimics the Boren Amendment and contains similar "rights-creating language." *See Gonzaga*, 536 U.S. at 290. The Boren Amendment required states to create programs that provided reasonable payment to provide access to adequate medical assistance, while 1396(a)(30)(A) requires states to create programs that provide sufficient payment to ensure that adequate access to medical assistance is "available under the plan."

42. The "structure and language of [the Boren Amendment and § 1396a(a)(30)(A)] are nearly identical, and each focuses on mandatory obligations [that] a state plan must meets" there is "no principled basis to say that a private right of action is unavailable in this case." *See Memisovski v. Maram*, 2004 WL 1878332, at *8 (N.D. Ill. 2004). *See Penn. Pharm. Ass'n v. Houston*, 283 F.3d 531, 538 (3d Cir. 2002) (*en banc*) (Alito, J) (holding that 1396(a)(30)(A)'s provision for quality of care and adequate access were draft[ed] . . . with an unmistakable focus on Medicaid beneficiaries"); *see also Clark v. Richman*, 339 F. Supp. 2d 631, 639-40 (M.D. Pa. 2004) (applying the reasoning of *Memisovski* to find that § 1396a(a)(30)(A) confers privately enforceable rights); *Pediatric*

*Specialty Care, Inc. v Ark. Dept. of Human Servs.*, 443 F.3d 1005, 1014-16 (8th Cir. 2006) (finding that § 1396a(a)(30)(A) confers a privately enforceable right to Medicaid recipients), *cert. granted and order vacated as to individual defendants only*, 551 U.S. 1142 (2007).

43. Post *Gonzaga* a number of Courts of Appeal other than the Eleventh Circuit have held Section 1396a(a)(30)(A) is not enforceable by Medicaid providers and/or recipients, *e.g.*, *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007); *Westside Mothers v. Olszewski*, 45 F. 3d 532, 542 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3rd 1051, 1060-61 (9th Cir. 2005); *OKAAP v. Fogarty*, 472 F.3rd 1208, 1210, 1215 (10th Cir. 2007); *Mandy R . ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Long Term Care Pharm Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004). Respectfully, I find these courts have not distinguished the U.S. Supreme Court's holding in *Wilder*. D.E. 672 p. 6.

44. On February 22, 2012, the United States Supreme Court decided *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, -- S. Ct. --, 2012 WL 555204 (Feb. 22, 2012). In that case, California Medicaid recipients and providers, in light of the holding in *Sanchez v. Johnson*, 416 F.3rd 1051, 1060 (9th Cir. 2005), that 1396a(a)(30)(A) was unenforceable under 42 U.S.C. § 1983, instead sought to enforce 1396a(30)(A) through the Supremacy Clause to the U.S. Constitution

against a California statute cutting Medicaid reimbursement rates. In its opinion, the Supreme Court, in light of developments after certiorari was granted, remanded the case for further proceedings by the Ninth Circuit without deciding whether section 1396a(a)(30)(A) may be enforced through the Supremacy Clause. Significantly, the Opinion for the Court in *Douglas*: (a) did not contain any discussion of whether section 1396a(a)(30)(A) may or may not be enforced through 42 U.S.C. § 1983 and (b) cited to its opinion *Wilder v. Va. Hosp. Ass'n.*, 496 U.S. 498 (1990) without any intimation that *Wilder* is not still good law. Because I have found that Section (30)(A) is enforceable under 42 U.S.C. §1983, I have not had to reach the issue of whether jurisdiction to enforce Section (30)(A) would independently exist under the Supremacy Clause.

45. Section 1396a(a)(43)(A), which provides a right to outreach and information, also confers enforceable rights on the plaintiffs.

> "First, the Eleventh Circuit in a pre- Gonzaga case, *31 Foster Children v. Bush*, 329 F.3d 1255 (11th Cir. 2003), held that this provision created enforceable rights. Second, I do not think *31 Foster Children* has been called into question by *Gonzaga*, and I concur with those other district courts that have addressed this issue post- *Gonzaga* and concluded that §1396a(a)(43)(A) confers enforceable rights on the plaintiffs. *See Clark v. Richman*, 339 F. Supp. 2d 631, 638-640 (M.D. Pa. 2004); *Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, *8-11 (N.D. Ill. 2004); *Health Care for All v. Romney*, 2005 WL 1660677, *13 (D. Mass. July 14, 2005); *Westside Mothers v. Olszewski*, 368 F. Supp. 2d 740, 769-770 (E.D. Mich. 2005); *A.M.H. v. Hayes*, 2004 U.S. Dist. Lexis 27387, *19 (S.D. Ohio 2004). The provision at issue requires the defendants to provide basic outreach and information to the plaintiff class. As a result, Congress must have

> intended that the provision in question benefit the plaintiffs, and the clear right that is protected by the provision is neither "vague" nor "amorphous."

Order denying Defendants Motion to Dismiss, January 11, 2007, D.E. 40. More recently, the enforceability of Section 1396a(a)(43)(A) has been reconfirmed in *John B. v. Goetz*, 626 F.3d 356, 362 (6th Cir. 2010).

46. 42 U.S.C. § 1396a(a)(43)(B) and 42 U.S.C. §1396a(a)(43)(C), which provide rights to treatment for children who request care, also satisfy all three *Blessing* factors, and contain private rights of action. This has been the conclusion of every court to consider this issue since *Gonzaga*. *See S.D. ex rel Dickson v. Hood*, 391 F.3d 581, 603-04 (5th Cir. 2004); *Hunter ex rel. Lynah v. Medows*, Case No. 08-2930, 2009 WL 5062451, at *2-3 (N.D. Ga. Dec. 16, 2009); *D.W. v. Walker*, No. 09- 00060, 2009 WL 1393818, at *6 (S.D. W. Va. May 15, 2009); *Parent League for Effective Autism Servs. v. Jones-Kelley*, 565 F. Supp. 2d 895, 904 (S.D. Ohio 2008); *Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050, 1111 (N.D. Okla. 2005), *reversed on other grounds*, 472 F. 3d 1208 (10th Cir. 2007); *Clark v. Richman*, 339 F. Supp. 2d 631, 640 (M.D. Pa. 2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92-1982, 2004 WL 1878332, at *8-11 (N.D. Ill. Aug. 23, 2004); *Health Care for All, Inc. v. Romney*, No. 00-10833, 2004 WL 3088654, at *2 (D. Mass. Oct. 1, 2004); *Kenny A. ex rel. Winn v. Perdue*, 218 F.R.D. 277, 293-94 (N.D. Ga. 2003); *John B. v. Emkes*, Civil Action

No. 3:98- cv-0168 in the United States District Court for the Middle District of Tennessee, Memorandum Opinion and Order, Document Number 1572, pp. 5-8, filed February 14, 2012.

47. Defendants argue "medical assistance" as used in the statute does not allow anything more than payment for services and creates no right to actual receipt of medical assistance. I rejected this agreement previously and do so again. In *Doe v. Chiles*, 136 F.3d 709 (11th Cir 1998).

> "the Eleventh Circuit followed *Sobky v. Smoley*, 855 F. Supp. 1123, 1145 (E.D. Cal 1994), which held that "medical assistance under the plan…can only mean medical services." *See* 136 F.3d 709, 716 n.13. Based on this understanding *Doe* upheld a claim that the Florida Department of Health & Rehabilitative Services violated § 1396a (a)(8) by failing to provide medical assistance, which consisted of the "therapies, training and other active treatment to which [the plan participants were] entitled." *Id.* at 711. The Eleventh Circuit in *Doe*, then, considered and rejected the argument that the term "medical assistance" is limited to payment alone. Indeed, the state had argued that it had "no obligation to place individuals in facilities; but were obligated only to reimburse the ICF providers with reasonable promptness." *See* Brief of Appellee at 17-18, *Does v. Chiles*, No. 96-5144 (11th Cir. April 9, 1997)."

Order denying Defendants' Motion for Summary Judgment, September 30, 2009, D.E. 672 p. 7-8.

48. The Eleventh Circuit's broad interpretation of "medical assistance" as including medical services is supported by decisions of the First and Ninth Circuit, though there is admittedly a split in the circuits. *See Bryson v. Shumway*, 308 F.3d, 79, 89 (1st Cir. 2002); *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d at

1154. *But see Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724, 728-29 (5th Cir. 2009) (holding that medical assistance means payment for medical services); *Westside Mothers*, 454 F. 3d at 540-41 (same); *Bruggeman ex rel Bruggeman v. Blogojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (same); (dictum) OKAAP, 472 F.3d at 1214 (same).

49. The Medicaid Act defines "medical assistance" as "payment of part or all of the cost of the [listed] care and services." 42 U.S.C. 1396(a). Additionally, § 1396(a)(10) states that a plan must provide "for making medical assistance available, *including at least the care and services* listed" in 1396d(a), which specifies access to hospital services and physician services. *See §* 1396a(a)(10) (emphasis added); §§ 1396a(a)(10) (d)(l),(d)(5). Because the word "include" shows that the statute's drafters "intended to provide a non-exhaustive list of examples to clarify the meaning of a term," the structure of § 1396a(a)(10), read together with § 1396d(a) suggests that care and services contained within the definition of medical assistance. *See Jean v. Nelson*, 863 F.2d 759, 777 (11th Cir. 1988). Several other provisions in §1396a(a) also describe "medical assistance" as including care and services. *See, e.g.*, §§ 1396d(a)(43), 1396a(10)(C)(iii) and (C)(iv). Additionally, regulations enacted pursuant to the Medicaid Act require that a state plan "specify that" recipients are "furnished" listed "services," *see* 42 C.F.R. 440.210, 440.220, and require the state agency administering EPSDT

provide recipients "services" including dental care and immunizations. *See* 42 C.F.R. 441.56(c). These regulations are consistent with the plaintiffs' definition of "medical services." Even if the statutory language is ambiguous, the agency's interpretation is entitled to deference so long as it is reasonable. *See Friends of Everglades v. S. Fla. Water Mgt. Dist.*, 570- F.3d 1210, 1227-28 (11th Cir. 2009). *Id. a*t p. 8 §n 6.

50. Any issues previously created by the definition of medical assistance in 42 U.S.C. § 1396d(a) were resolved by the enactment on March 23, 2010 of the Patient Protection and Affordable Care Act" (hereafter referred to as" PPACA"). *See* Pub L. No. 111-148, 124 Stat. 119. Section 2304 of PPACA, which is headed "Clarification of Definition of Medical Assistance" and amends the Medicaid Act, 42 U.S.C. sec. 1396d(a) (Social Security Act sec. 1905d(a)) to add to the provision below the italicized language.

> The term medical assistance means payment of part or all of the cost of the following care or services, *or the care and services themselves, or both* if provided in or after the third month in which the recipient makes application for assistance…..

This change eliminated the legislative basis for Judge Posner's dictum in *Bruggeman* and those courts that have followed his view.

51. The legislative history of this amendment demonstrates that the Congress intended this amendment to resolve the split in the Circuit Court cases

and that Congress always had intended that medical assistance include care and/or services. H.R. Rep. No. 111-299 at 649-50.

> Section 1905(a) of the Social Security Act defines the term "medical assistance." The term is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. The Committee, which has legislative jurisdiction over Title XIX of the Social Security Act, has always understood the term to have this combined meaning. Four decades of regulations and guidance from the program's administering agency, the Department of Health and Human Services, have presumed such an understanding and the Congress has never given contrary indications.
>
> Some recent court opinions have, however, questioned the longstanding practice of using the term "medical assistance" to refer to both the payment for services and the provision of the services themselves. These opinions have read the term to refer only to payment; this reading makes some aspects of the rest of Title XIX difficult and, in at least one case, absurd. If the term meant only payments, the statutory requirement that medical assistance be furnished with reasonable promptness "to all eligible individuals" in a system in which virtually no beneficiaries receive direct payments from the state or federal governments would be nearly incomprehensible.
>
> Other courts have held the term to be payment as well as the actual provision of the care and services, as it has long been understood. The Circuit Courts are split on this issue and the Supreme Court has declined to review the question. To correct any misunderstandings as to the meaning of the term, and to avoid additional litigation, the bill would revise section 1905(a) to read, in relevant part: "The term 'medical assistance' means payment of part or all of the cost of the following care and services, or the care and services themselves, or both." This technical correction is made to conform this definition to the longstanding administrative use and understanding of the term. It is effective on enactment.

The Eleventh Circuit in a post-PPACA decision, *Moore ex rel Moore v. Reese*, 637

F.3d 1220, 1232 (11th Cir. 2011), recognized that "medical assistance" means provision of medical services," without citing PPACA. *See also Disability Rights New Jersey, Inc. v. Velez*, CIV-05 – 4723 (AET), 2010 WL 5055820 (D.N.J. Dec. 2, 2010) at *2; (taking account of PPACA).

**B. The Substantive Standards of the Medicaid Act**

52. Medicaid is a cooperative federal/state program through which the federal government grants funds to participating states to provide health care services to needy individuals. *See* 42 U.S.C. § 1396-1; *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 L. Ed. 2d 455, 110 S. Ct. 2510 (1990). State participation in Medicaid is voluntary, but if states choose to participate, they must comply with the requirements outlined in the Medicaid statute. *Wilder*, 496 U.S. at 502. Florida has elected to participate in the Medicaid program. To qualify for federal funds, a state must submit a plan to the Secretary of Health and Human Services (HHS) which complies with all fifty-eight subsections outlined in 42 U.S.C. § 1396a(a). *Id.*

53. **EPSDT Services:** When Congress amended the Medicaid statutes in 1989, it made the provision of "early and periodic screening, diagnostic, and treatment services ("EPSDT" services) to Medicaid-eligible children mandatory for participating states. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2261-2265, 2268, 2269 (codified as amended at 42

U.S.C. § 1396d(r)(2005)); 42 U.S.C. § 1396d(a)(4)(B),-(r). 42 U.S.C. § 1396a(a)(10)(A) requires that states provide "for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5)…of Section 1396d(a) of this title, to … all individuals [who are eligible]."

54. 42 U.S.C. § 1396d(a)(4)(B), in turn, defines "medical assistance" to include "early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) [42 U.S.C. § 1396 d (r)] for individuals who are eligible under the plan and are under the age of 21." And 42 U.S.C. § 1396d(r) specifically sets out the mandatory EPSDT services that must be provided to all eligible individuals under the age of 21:

> (1) Screening services, which at a minimum must include (i) "a comprehensive health and developmental history (including assessment of both physical and mental health development)" (ii) "a comprehensive unclothed physical exam"; (iii) "appropriate immunizations… according to age and health history"; (iv) "laboratory tests (including lead blood level assessment appropriate for age risk factors)"; and (v) "health education";
>
> (2) Vision services, including diagnosis and treatment for vision defects;
>
> (3) Dental services, including "relief of pain and infections, restoration of teeth, and maintenance of dental health";
>
> (4) Hearing services, including diagnosis and treatment for defects in hearing; and
>
> (5) All medically necessary health care services "…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."

55. There are additional requirements concerning EPSDT services in 42 U.S.C. §1396a(a)(43), which states that a state plan must contain provisions:

> (B) providing or arranging for the provision of such screening services in all cases where they are requested; (C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services; and (D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:
>
> (i) the number of children provided child health screening services,
>
> (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),
>
> (iii) the number of children receiving dental services and other information relating to the provision of dental services to such children described in section 2108(e) [42 USCS § 1397hh(e)], and
>
> (iv) the State's results in attaining the participation goals set for the State under section 1905(r) [42 USCS § 1396d(r))].

56. In connection with its duties under EPSDT, a state Medicaid agency must implement a periodicity a schedule for screening services that: "(a) meets reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations in child health care; (b) specifies screening services applicable at each state of the recipient's life,

beginning with a neo-natal examination, up to the age at which an individual is no longer eligible for EPSDT services." 42 CFR 441.58 (a) and (b).

57. These "EPSDT Requirements" differ from merely providing "coverage" for or "access" to services; the Medicaid statute places affirmative obligations on states to assure that these services are actually provided to children on Medicaid in a timely and effective manner. *See, e.g., Stanton v. Bond*, 504 F.2d 1246, 1251(7th Cir. 1974) ("EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose."); *Memisovski v. Maram*, 2004 U.S. Dist LEXIS 16772 (N.D. Ill. 2004) at 49-150.

58. Indeed, the statute and regulations require states to make sure the screening services are delivered to the greatest number of children possible. "Congress' intent to ensure that Medicaid-eligible children actually receive services is underlined by provisions in the statute that place explicit duties on states to (a) mandate outreach, (b) provide or arrange for screening services in all cases where they are requested, (c) arrange for whatever corrective treatments are discovered to be needed; and (d) report on their results. *See* § 1396a(a)(43); 42 C.F.R. § 441.56(a)(1), – .61, -.62 (2005).

59. "When a state elects to provide an optional service [under Medicaid] that service becomes a part of the state Medicaid plan and is subject to the

requirements of federal law." *Doe v. Chiles*, 136 F.3d 709, 714, (11th Cir. 1998 (citing) *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F. 3d 693, 698 (11th Cir. 1997) (per curium). Because Florida has chosen to provide continuous eligibility as part of its state plan, PX 712 at FL-MED 08335, that requirement is enforceable as part of federal law. *Doe v. Chiles*, 136 F.3d at 714. Under continuous eligibility, children under the age of five cannot, with very limited exceptions, have their eligibility terminated until they have been on Medicaid for 12 months from the time of their last eligibility determination. Lewis on 10/20/2010 Final Tr. at 4654:10 – 4655:4; PX 712 at FL-MED 08335. For children between the ages of 5 and 18, the period of continuous eligibility is six months. *Id.*

60. **Reasonable promptness:** 42 U.S.C. § 1396a(a)(8), frequently referred to as the "Reasonable Promptness" provision, requires that a participating state plan for medical assistance:

> …provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to *all eligible* individuals.

61. **Equal Access:** U.S.C. § 1396a(a)(30)(A), which is frequently referred to as the "Equal Access" provision, requires a state plan to:

> …provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan…as may be necessary…to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan

> at least to the extent that such care and services are available to the general population in the geographic area.

The term "general population" in 42 U.S.C. § 1396a(30)(A) means the population which has public or private insurance other than Medicaid; it does not include the uninsured population. *See Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F. 3d 519, 527 (8th Cir. 1993).

62. There is no single approach that must be used for defining a relevant geographic medical care market. *See Methodist Hospitals, Inc. v. Sullivan*, 91 F. 3d 1026.1029 (7th Cir. 1996). Courts have in the face of significant statewide disparities in reimbursement rates, combined with multiple instances of disparities to access in multiple areas of the state found a Section 30(A) violation. *See OKAAP v. Fogarty*, 366 F. Supp. 1050, 1119 (N.D. Okla. 2005); *Ark. Med. Soc'y, Inc. v. Reynolds*, 834 F. Supp. 1097 (E.D. Ark. 1992) (focus on level of physician participation in program and level of reimbursement to determine compliance with equal access provision).

63. **Effective Outreach:** 42 U.S.C. §1396a(a)(43) provides that a state plan must contain provisions (A)"Informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(r) [42 USCS § 1396d (r)], of the availability of early and periodic screening, diagnostic, and treatment services as

described in section 1905(r) [42 USCS § 1396d(r)] and the need for age-appropriate immunizations against vaccine-preventable diseases[.]"

64. **Paragraph 64, was deleted because it is a duplicate of paragraph 62.**.

65. The requirement that states inform eligible children of EPSDT services has both procedural and substantive implications. States must draft guidelines by which the information regarding EPSDT services is to be transmitted; they must also ensure that effective notice, in fact reaches children and their families. *See Stanton v. Bond*, 504 F.2d 1246, 1250 (7th Cir. 1974) ("The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the 1967 act and by the interpretative regulations and guidelines."); 42 C.F.S. § 441.56(a)(1) (2005). If a state's scheme for informing children of their rights is ineffective or conveys out-of-date or inaccurate information, the state is not in compliance with the law. *See Health Care for All v. Romney*, 2005 U.S. Dist. LEXIS 14187, Civ. No. 00-10833RWZ, 2005 WL 1660677, at *14 (D. Mass. July 14, 2005) (Zobel, J.) (concluding that the state violated its duty to inform children of EPSDT services where notices sent to children and their families contained "incorrect or outdated guidance on obtaining services"); *cf. Pediatric Specialty Care*, 29d F.3d at 481

("The state may not shirk its responsibilities [under § 1396a(a)(43)] to Medicaid recipients by burying information about available services in a complex bureaucratic scheme.") *Rosie D. v. Romney*, supra, 410 F. Supp 2d at 26-27.

66. **Judicial & Administrative Requirements:** A state which chooses to have part or all of its Medicaid program delivered by HMOs may not thereby escape legal responsibility if the HMOs fail to make care and services available as required by federal law. *See John B v. Menke*, 176 F. Supp. 2d 786, 801 (M.D. Tenn. 2001). *See Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 997 (N.D. Calif. 2010); *McCartney by and through McCartney v. Cunsler*, 608 F. Supp. 2d 694 (E.D.N.C. 2009); *Salazar v. D.C.* , 596 F. Supp. 2d 67 (D.D.C. 2009).

67. The United States Court of Appeals for the Eleventh Circuit has recently pointed out in language applicable to this case: "However pressing budgetary burdens may be, we have previously commented that cost considerations alone do not grant participating states to shirk their statutory duties under the Medicaid Act." *Moore v. Reese*, 637 F.3d 1220, 1259 (11th Cir. 2011) (citing *Tallahassee Mem.*, 109 F.3d at 704 (per curiam).

68. The fact that 42 U.S.C. 1396(c) gives the Secretary of federal HHS power to cut off federal funding of a state's Medicaid funding if the state doesn't comply substantially with the law does not preclude Medicaid recipients from maintaining an action under sections of the act which contain rights creating

language such as a(a)(8) and a(a) (10)for the state's violations affecting them. *See Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004).

69. Nor does the fact that a state's Medicaid Plan contains a fair hearing mechanism in compliance with 42 U.S.C. a(a)(3) demonstrate that the state has a comprehensive remedial scheme which causes a Medicaid recipients' claim under a(a)(8), a(a)(10), a(a)(30)(A) or a(a)(43)to fail the third prong of the test in *Blessing v. Freestone*, 520 U.S. 329(1997). *See Sabree v. Richman*, 367 F. 3d 180, 193 (2004).

70. Courts look to various factors in determining whether a state is in violation of provisions of the Medicaid Act. As one court noted:

> Two major factors used frequently by the Secretary of Health and Human Services and the courts are the level of physician participation in the Medicaid program and the level of reimbursement to participating physicians. As to the first factor, a longstanding criterion used by the Department of Health and Human Services and its predecessor agency, the Department of Health, Education and Welfare, for implementing the equal access requirement is a two-thirds participation ratio.

*Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D. Calif. 1990), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 985 (9th Cir. 1992). *Clark*, 758 F. Supp. at 576.

71. In addition, the court also considered: whether "providers [are] widely opting out of the Medicaid program or restricting their Medicaid caseloads"; "whether there is a steady stream of reports that recipients are having difficulty obtaining care"; and admissions by state agency personnel "that reimbursement

rates are inadequate and that the equal access provision is being violated." *Id.* at 577-78. Further, the court looked to the "utilization rate" as another relevant factor. *Id.* at 578.

72. These factors have been cited approvingly by other courts. *See Okla. Chapter of the Am. Acad. of Pediatrics (OKAAP) v. Fogarty*, 366 F. Supp. 1050, 1105-06 (N.D. Okl. 2005)[5]; *Clark v. Richman*, 339 F.Supp.2d 631, 644 (M.D.Pa.2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332 at *42 (N.D. Ill. Aug.23, 2004); and *Ark. Med. Soc'y, Inc. v. Reynolds*, 834 F. Supp. 1097, 1100 (E.D. Ark.1992). *Health Care for All, Inc. v. Romney*, 2005 U.S. Dist. LEXIS 14187 (D. Mass. 2005) at 32-33.

73. In both OKAAP *v. Fogarty* and the *Memisovski* case, the court found the defendants in violation of the Medicaid Act. In *OKAAP v. Fogarty*, from 1995 to 2003, the state's fee-for-service schedule never exceeded 72 percent of Medicare. *OKAAP v. Fogarty*, 366 F. Supp. at 1059. Just before the trial, the state raised the rates for evaluation and management codes to 90% of Medicare; the rate for most codes was 71% of Medicare. *Id.* Specialists were paid approximately 72% of Medicaid for most services. *Id.* at 1060; *see also id.* at 1074. In *Memisovski*, expert testimony showed that Medicaid, at most, paid 55%

[5] A subsequent order in this case was overturned by the Tenth Circuit on other grounds. *See Oklahoma Chapter of American Academy of Pediatrics v. Fogarty*, 472 F. 3d 1208 (10th Cir. 2007)), cert denied, 552 U.S. 813 (2007).

of the rate that Medicare paid for the same service, and that the Medicaid rate was a lower percentage of the rates paid by private insurance. *Memisovski*, 2004 WL 1878332 at *43.

74. The Department of Health and Human Services has taken a similar view. In 2001, the Department of Health and Human Services issued a Dear State Medicaid Director letter, providing guidance to states on what would constitute a violation of sections 1396a(a)(8) and (a)(30), and emphasized the importance of paying competitive rates. PX 447. The Department said, in an opinion consistent with the ruling in *Clark v. Kizer*, "Lack of access due to low rates is not consistent with making services available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at CRALL00751.

75. The Department further said: "[S]ignificant shortages in beneficiary receipt of dental services, together with evidence that the Medicaid reimbursement rates falls below the 50$^{th}$ percentile of providers fees in the marketplace, creates a presumption of noncompliance with both these statutory requirements." *Id.* While that statement concerned dental care, it is equally applicable to medical care, except that a different benchmark, in lieu of the 50$^{th}$ percentile of usual and customary fees, would apply to medical fees. As the above case law shows, the most appropriate benchmark is Medicare reimbursement rates.

76. Other facts that courts have placed weight upon, include: CMS 416 results; HEDIS reports; whether rates cover providers' average costs; promptness of payments; difficulty referring children on Medicaid to other providers, wait times and travel distances to see providers, comparative experience of children on private insurance, testimony of beneficiaries, admissions in legislative budget requests, and immunization rates. *See generally OKAAP* and *Fogarty*.

77. Congress' recognition of the importance of increasing reimbursement rates to ensure adequate access to care is reflected in section 1202(a)(1) of the Patient Protection and Affordable Care Act (PPACA) 42 U.S.C. § 1396 a(a)(13)(C), which provides that:

> Payment for primary care services…furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine or pediatric medicine at a rate not less than 100% of the payment rate that applies to such services under Part B of Title XVII.

(*i.e.*, Medicare) with respect to evaluation and management codes and services related to certain immunization administration for vaccine codes. Section 1202(a)(2) of PPACA, 42 U.S.C. § 1396a-2(f) requires that payments for such primary services in managed care plans be "consistent with" the said minimum payment rates.

## V. THE NAMED PLAINTIFFS AND ORGANIZATIONS

### A. Legal Requirements for Standing

1. The Named Plaintiffs Have Standing

78. In order to prosecute a case as a class action, "the named plaintiffs must have standing[.]" *See Vega v. T-Mobile USA Inc.*, 564 F.3d 1256, 1265 (11th Cir. 2009) (citations omitted). Standing requires a showing that:

> (1) the plaintiff . . . suffered an injury in fact--an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) there must be a causal connection between the injury and the conduct complained of-- the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court; and (3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

*Bloedorn v. Grube*, 631 F.3d 1218, 1228 (11th Cir. 2011) (citations omitted). "[T]he essence of [the] standing question is whether the plaintiff has alleged such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues[.]" *Harris v. Evans*, 20 F.3d 1118, 1121 (11th Cir. 1984) (internal quotation marks omitted).

79. Standing is determined as of the time of filing an action. *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167 (2000). Plaintiffs need show only a "minimal injury" to satisfy the threshold standing inquiry. *Council of Ins. Agents & Brokers v. Molasky-Arman*, 522 F.3d 925, 932 (9th Cir. 2008) (holding that "an identifiable trifle" is sufficient to establish

standing) (quoting *U.S. v. Students Challenging Regulatory Agency Procedures (SCRAP)*, 412 U.S. 669, 689 n.14 (1973)).

80. As this Court has explained, "In a case seeking prospective relief, the focus under the injury element is on prospective harm." (D.E. 541, Order on DCF/DOH Summ. J. Mot. at 5.) A child need not wait until he or she has been unable to access EPSDT services in order to obtain preventative relief. (*See id.* (citing *Fla. N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1161 (11th Cir. 2008)).) For an injury to satisfy this element it must be "immediate," which "requires only that the anticipated injury occur within some fixed period of time in the future, not that it happen in the colloquial sense of soon or precisely within a certain number of days, weeks, or months." (*Id.* at 6 (citing *Browning*, 522 F.3d at 1161).) The injury must also be "likely," which means that it "must pose a 'realistic danger' and cannot be merely hypothetical or conjectural." (*Id.* (citing *Browning*, 522 F.3d at 1161).) An injury can result from the "delay and denial of healthcare, and need not be accompanied by an adverse health consequence." (*Id.* at 7.)

81. A party's continued exposure to the policies or practices from which he seeks prospective relief is sufficient to confer standing upon the party. *See, e.g.*, *31 Foster Children v. Bush*, 329 F.3d 1255, 1266 (11th Cir. 2003) ("The alleged systemic deficiencies in the Florida foster care system are similar to an injurious policy, and different from the random act at issue in *Lyons*."); *Church v. City of*

*Huntsville*, 30 F.3d 1332, 1338 (11th Cir. 1994) ("Because of the allegedly involuntary nature of their condition [of poverty and illness], the plaintiffs cannot avoid future exposure to the challenged course of conduct in which the City allegedly engages.") (internal quotation marks and citation omitted); *see also Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008) (rate cut affecting "those individuals most directly affected by the administration of [a state welfare] program is sufficient to allow petitioners to seek injunctive relief in federal court") (internal quotation marks and citation omitted).

82. Applying *Lyons*, the Eleventh Circuit Court of Appeals has recognized a distinction between two types of future injuries: "[F]uture injury that depends on either the random or unauthorized acts of a third party is too speculative to satisfy standing requirements," but, "when the threatened acts that will cause injury are authorized or part of a policy, it is significantly more likely that the injury will occur again." *31 Foster Children v. Bush*, 329 F.3d 1255, 1266 (11th Cir. 2003); *see also Church v. City of Huntsville*, 30 F.3d 1332, 1339 (11th Cir. 1994) (holding that plaintiffs had standing where they "alleged that it is the custom, practice, and policy of the City to commit the constitutional deprivations of which they complain"). Quoting the foregoing passage from the *31 Foster Children* decision, I have applied that distinction in holding that plaintiffs had standing to challenge a county government's strip-search policy. *See Haney v. Miami-Dade County*, No.

04-20516, 2004 WL 2203481, at *3 (S.D. Fla. Aug. 24, 2004) (Judge Jordan) ("The plaintiffs allege that there is a policy of conducting strip and body cavity searches on all pre-first appearance, non-felony female detainees. . . . Therefore, there is a substantial likelihood that the plaintiffs and others similarly situated will be injured in the future."). Throughout this litigation, I have recognized this important distinction. *See, e.g.*, D.E. 541, Order re Partial Summ. J. at 7 ("This case is about the alleged systemic problem of delay and denial of health care."); D.E. 671, Order re Class Cert. at 3-5 (rejecting Defendants' argument that Plaintiffs lack standing).

83. A plaintiff need not wait for an injury to occur to satisfy the "injury-in-fact" requirement; an allegation of future injury satisfies this prong so long as the alleged injury is not merely "conjectural" or "hypothetical." *See Los Angeles v. Lyons*, 461 U.S. 95, 101-02 (1983). Moreover, an injury need not be physical in nature; as this Court has recognized, a violation of one's statutorily granted rights constitutes an injury for standing purposes. *See* D.E. 541, Order re Partial Summ. J. at 4. The issue is whether there is a likelihood of future denials of the rights secured by federal law. *See also Fla. State. Conf. of the NAACP v. Browning*, 522 F.3d 1153, 1163 (11th Cir. Fla. 2008) ("probabilistic harm is enough injury in fact to confer . . . standing in the undemanding Article III sense." (internal quotation marks omitted)).

84. As recognized by the Court of Appeals in *Thomas v, Bryant*, 614 F.3d 1288 (11th Cir. 2010), "the irreparable injury requirement [for injunctive relief] may be satisfied by demonstrating a history of past misconduct, which gives rise to an inference that future injury is imminent." *Id.* at 1318 (citing cases). In *Thomas*, the Court of Appeals found sufficient risk of irreparable injury even though such injury depended upon the plaintiff having future psychological disturbances, being returned to Florida State Prison ,and again subjected to spraying with chemical agents. *Id.* at 1319. The likelihood of named Plaintiffs here facing future issues with the Florida Medicaid program is at least as imminent given the evidence of systemic problems and their past history of problems in accessing care.

85. The standing inquiry does not turn on whether an individual child received a certain service from a particular provider at some time in the past. Instead, because Plaintiffs "seek[] only injunctive relief and not individualized damages or benefits awards, the Court's focus will be on Defendant's actions (or inactions) and not individual plaintiffs. . . . [T]he Court will not be ensuring that every individual class member receives the full [public] benefits to which he or she is entitled; instead, the Court's focus will be on whether Defendant has complied with his obligations to implement" the Florida Medicaid program. *Xiufang Situ v. Leavitt*, 240 F.R.D. 551, 561 (N.D. Cal. 2007); *see also Risinger v. Concannon*, 201 F.R.D. 16, 20-21 (D. Me. 2001) ("The Court will evaluate Plaintiffs' systemic

challenge without engaging in an evaluation of the individualized needs of each class member.").

86. Throughout this litigation, Defendants have misconceived the standing inquiry. They would have this Court take an Alice-in-Wonderland approach by which the Court would have to decide the merits of the Named Plaintiffs' claims in order to determine if the Named Plaintiffs have standing to litigate those claims. Unsurprisingly, Defendants cite no authority to support such an approach. Even a plaintiff who currently was not eligible for Medicaid was found standing to seek prospective relief against the state Medicaid program "because it is highly likely that [the family] will qualify for [M]edicaid in the future." *McCree v. Odom*, No. 4:00-CV-173(H)(4), slip opinion at 19 (E.D.N.C. Nov. 26, 2002).

87. Defendants rely upon *Lewis v. Casey*, 518 U.S. 343, 350-51 (1996), which sets forth a heightened standing requirement – but that requirement applies only to cases like *Lewis*, where the claim at issue (inadequate legal resources for prisoners) was derivative of an underlying Constitutional right (inmates' access to courts). *See Benjamin v. Fraser*, 264 F.3d 175, 185 (2d Cir. 2001). It is not applicable "where the right at issue is provided directly by . . . federal law," as in the Medicaid litigation; *see also Al-Amin v. Smith*, 511 F.3d 1317, 1334 (11th Cir. 2008).

88. Where the plaintiff is a participant in the challenged governmental program, "there is ordinarily little question that the action or inaction [of the government] has caused the plaintiff injury and that a judgment preventing or requiring the action will redress it." 25 FED. PROC., L. ED. § 59:11. To satisfy the standing inquiry's causation requirement, Plaintiffs need only show that their prospective harms are "fairly traceable" to Defendants' non-compliance with the Medicaid Act. *See Sicar v. Chertoff*, 541 F.3d 1055, 1059 (11th Cir. 2008). To satisfy the redressability requirement, Plaintiffs need only show that their prospective injuries will be remedied by a favorable outcome. *See, e.g.*, Fla. *State Conference of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1159 n.9 (11th Cir. 2008) (alleged injury would be redressed by injunction against state official in legal challenge to state voting statute).

89. Several courts have held that there is a "direct connection between Medicaid recipients' access to medical care and services and low reimbursement rates" sufficient to prove causation and redressability. *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 701 n.5 (5th Cir. 2007) (citing *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050, 1106-07 (N.D. Okla. 2005)); *see also Memisovski ex rel. Memisovski v. Maram*, No. 92C1982, 2004 WL 1878332, at *42 (N.D. Ill. 2004); *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 (E.D. Cal. 2003), *rev'd on other grounds*, 140 F. App'x 677 (9th Cir. 2005); *Clark*

*v. Kizer*, 758 F. Supp. 572, 577 (E.D. Cal. 1990), *aff'd in relevant part*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992); *Thomas v. Johnston*, 557 F. Supp. 879, 903-04 (W.D. Tex. 1983). With respect to non-monetary aspects of Plaintiffs' claims redressability is inherent in a declaration, and if necessary, an injunction, against such future terminations of continuous eligibility or switching, or requiring the eliminations of barriers, such as in the Florida ACCESS application, to enrollment and receipt of service.

90. Defendants also confuse the standing doctrine with that of mootness. While standing is measured at the time of filing of a complaint, the related doctrine of mootness preserves the Article III requirement of a live case or controversy throughout the litigation. In a case seeking prospective relief, a plaintiff's claims are not moot so long as the challenged policy or practice is still in existence and so long as the plaintiff remains subjected to it. *See McLaughlin v. Hoffman*, 547 F.2d 918, 920-21 (11th Cir. 1977).

91. When plaintiffs are challenging systemic problems, the capable-of-repetition-but-evading-review doctrine is often applicable is the plaintiff's claim might otherwise be moot. *See, e.g., Norman v. Reed*, 502 U.S. 279, 287-88 (1992). Similarly, defendants cannot moot plaintiffs' claims by pointing to evidence showing that they have ceased certain practices that have caused harm to the plaintiffs:

> It is well settled that a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice. If it did, the courts would be compelled to leave the defendant free to return to his old ways. In accordance with this principle, the standard we have announced for determining whether a case has been mooted by the defendant's voluntary conduct is stringent: A case might become moot if subsequent events made it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.

*Sheely v. MRI Radiology Network, P.A.*, 505 F.3d 1173, 1183-84 (11th Cir. 2007) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs, Inc.*, 528 U.S. 167, 189 (2000)).

92. Moreover, in a certified class action, "termination of a class representative's claim does not moot the claims of the unnamed members of the class." *Gerstein v. Pugh*, 420 U.S. 103, 111 n.11 (1975). In *Gerstein*, the court ruled that it was unnecessary to determine whether any of the named plaintiffs had non-moot claims at the time of class certification because, *inter alia*, "the constant existence of a class of persons suffering the deprivation is certain." *Id.*

93. Applying these principles, I find the named individual plaintiffs have standing to maintain this action.

94. I have previously found that S.M. has standing to assert counts I and IV against the Secretary of AHCA, and that J.S. has standing to assert Count II against AHCA. D.E. 671 at 4-5. I adhere to those rulings. I also previously found

that S.M. had standing to assert courts I and IV against the Secretary of DCF. D.E. 541 at 4-9. I adhere to that ruling as well.

95. I previously found that Thomas Gorenflo had standing to assert counts I and II against the Secretary of DOH, also known as the Surgeon General. D.E. 541 at 13-17. Thomas Gorenflo is now deceased and accordingly does not have standing in an action seeking prospective relief only, and is hereby dismissed as a named plaintiff. I find that Nathaniel Gorenflo, who is also enrolled in the CMS program run the Florida's Department of Health, does have standing to bring counts I and II against the Secretary of DOH.

96. Because plaintiffs are seeking prospective relief, the focus under the injury element is on prospective harm. D.E. 541 at 5.

97. The evidence adduced at trial shows that S.M. faces a "realistic danger" of not receiving EPSDT care and effective outreach. *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979). For instance, the evidence, considered in section IV.B. below, amply demonstrates that children on Medicaid are regularly switched, that their care is frequently and significantly delayed by switching, and that the actions of both AHCA and DCF contribute to switching. The evidence, discussed in that same section, also shows that children on Medicaid regularly are terminated in violation of their right to continuous eligibility, their care is frequently and significantly delayed by improper terminations, and that the

actions of both AHCA and DCF contribute to improper terminations of eligibility. Similarly, the evidence, considered below in section IV.4. shows that the defendants have curtailed their outreach program, that Florida has a large population of children eligible for but not enrolled in Title XIX, and that many enrollees do not receive any preventative care. A ruling awarding prospective relief favorable to the plaintiffs would prevent or minimize such injuries in the future, and according the redressabilty prong of the standing inquiry is met as well. D.E. 541 at 9.

98. While it is in no way essential to my ruling, S.M.'s past experiences with Florida Medicaid are illustrative of his standing. He was switched at least twice, and as a result of one switch, his 18-month child health check up was delayed by two months. *Infra* at ¶¶ 121-128. His eligibility was terminated twice in violation of his right to continuous eligibility. *Id.* And his mother did not know he was entitled to free transportation to medical appointments. *Id.*

99. Thus, I find there is a "realistic danger" S.M. may be terminated in violation of his rights of continuous eligibility, switched, deprived of information he needs, and not provided services when he requests them. Accordingly, I find that S.M. may bring claims against the Secretaries of AHCA and DCF on Count I under both a(8) and (a)(10); and County IV under a(43)(A), (B), and (C).

100. In my prior ruling on J.S., I focused on whether she had standing to bring Count II against the Secretary of AHCA. I find again that she does.

101. The evidence adduced at trial shows that J.S. faces a "realistic danger" of not being able to obtain equal access to specialty care, as compared to children with private insurance. *Babbitt*, 442 U.S. at 298. The evidence, summarized below in sectionVI.D., shows that children on Medicaid throughout Florida have difficult accessing specialty care, and often must wait considerable periods or travel significant distances to obtain such care.

102. As to causation and redressabilty, I find both the many specialty providers currently do not participate in Florida Medicaid or sharply curtail their participation, because of Florida's low reimbursement rates and further find that the evidence establishes that a significant increase in Medicaid reimbursement rates would lead to a significant increase in specialists' participation in Medicaid and so, improved access to specialty care.

103. Again, J.S.'s past experiences with the Medicaid system, while not at all pivotal to my ruling, are illuminating. Three times in the last 10 years or so, J.S. has broken her ankle or wrist, gone to the emergency room, and been directed to see an orthopedist for follow-up care. *See infra* at180-188. In all three instances she had difficulty, in varying degrees, locating an orthopedist who would agree to treat her as a Medicaid patient.

104. The issue is not, as Defendants argued, *see* D.E. 934-2 at 20, whether J.S. will again have trouble accessing orthopedic care in the future. Rather, the issue is whether she will have trouble accessing any type of medical or dental care covered by the Medicaid Act. Nor is the issue whether AHCA might have been able to assist her in obtaining care in the past, had she contacted the local AHCA area office. Rather, the issue is whether she has a "realistic danger" of not having equal access in the future to covered care.

105. I find the factual record in this case show she faces a "realistic danger" of not receiving specialty care in the future, that her injury would be caused by AHCA's conduct, that a ruling in plaintiff's favor would prevent or minimize future injuries, and hence that J.S. has standing to bring count II against the Secretary of AHCA.

106. I find Nathaniel Gorenflo has standing to bring Counts I and II against the Secretary of DOH. Nathaniel is enrolled in CMS. He faces a "realistic danger" of not being able to obtain specialty care, as well as a danger of not being able to obtain primary care or dental care through CMS. For example, the evidence, considered below at VI.D., shows that children on Medicaid have trouble accessing specialty care and that those problems extend to children on CMS. The issue is not, as Defendants have claimed, whether Nathaniel Gorenflo will likely suffer a "recurring injury related to ENT care," D.E. 934-2 at 13, but rather whether is

faces a "realistic danger" of not receiving any type of care to which he is entitled under federal law. I find, based on the evidence of widespread deficiencies in the Florida Medicaid system, that he does. As I also previously found, D.E. 541 at 15-16, because CMS regional medical directors sometimes use discretionary funds to pay providers rates in excess of the Medicare rates when they cannot otherwise not obtain care for CMS children on Medicaid, the causality prong of standing as to the Secretary of DOH is also met.

107. More generally I find that all named plaintiffs have standing to bring claims under Counts I, II, and IV against AHCA. With the exception of J.W., nothing in the record suggests that any of the children will soon become ineligible for Medicaid or will age out of the program in the near future. And as to J.W., the record indicates he is likely to be eligible for Medicaid again in April. *See* D.E. 1072 and Ex. A. Because J.W. is likely to be enrolled in Medicaid again shortly, the fact that he is not currently enrolled does not deprive him of standing if he otherwise meets the requirements for standing. *See McCree v. Odom*, No. 4:00-CV-173(H)(4), at 19; (finding standing for individual not currently eligible for Medicaid because it is "highly likely" she will be eligible in the future).

108. The factual record in this case contains substantial evidence of widespread deficiencies in Florida's Medicaid program including but not limited to widespread deficiencies concerning children's access to EPSDT care, dental care,

and specialty care. The record also establishes that improper termination of eligibility and switching occur on a regular basis and lead at a minimum to a delay in children obtaining care; that since the elimination of the statewide outreach program in 2003, Defendants have not had a coordinated and effective statewide outreach campaign regarding EPSDT services; and that the on-line application is a substantial obstacle to children obtaining care. Based on that factual record, I find that all the named plaintiffs face a "realistic danger" of not receiving the medical or dental care and information about ESPDT service which they are entitled to receive under the Medicaid Act.

109. For children in the Florida Medicaid Program, as explained above, those likely injuries would be caused by the actions of AHCA and DCF and for children in CMS, by DOH as well, and so the causality prong of standing is readily met.

2. Organizational Plaintiffs Have Derivative Standing To Assert Third Party Claims of their Members.

110. Organizations have associational standing to assert the claims of their members. If their members have standing to assert claims of third parties, then the organizations have associational standing to assert their members' claims on behalf of third parties. *Pa. Psych. Soc. v. Green Spring Health Servs.*, 280 F.3d 278, 293 (3d Cir. 2002) ("So long as the association's members have or will suffer sufficient injury to merit standing and their members possess standing to represent the

interests of third-parties, then associations can advance the third-party claims of their members[.]").[6]

111. An organization has associational standing to bring suit on behalf of its members when (1) its members would have standing to sue in their own right; (2) the interest the organization seeks to protect are germane to the organization's interests; and (3) the participation of individual members in the lawsuit is not required for either the claim asserted or the relief sought. *See Fla. State Conf. of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1160 (11th Cir. 2008); *United Food and Commercial Workers Union Local 751 v. Brown Group, Inc.*, 517 U.S. 544, 553 (1996).

112. Here, the members of FPS and FAPD have standing to sue in their own right.

113. FPS has about 2,200 dues paying members. St. Petery on 12/7/2009 Final Tr. at 84:4-6. Numerous FPS' members treat children on Medicaid and are injured by Defendants' failure to comply with the requirements of the Medicaid Act. FPS members are injured because they: (1) periodically treat children who have been switched away from their practice, even though there is no guarantee they will be paid for providing such care. Middlemas on 1/31/2012 Rough Tr. at

[6] I previously did not decide the issues of organizational standing because there was at least one named plaintiff with standing. D.E. 40 at 2-3. At this juncture, with the case being tried, considerations of judicial efficiency support making findings on organizational standing so that there is a complete record on appeal.

22-23; Silva on 5/20/2010 Final Tr. at 2798:12-15; St. Petery on 11/11/2008 Depo Desig. at 190:10-19; (2) have their staff spend time trying to help patients who have been switched navigate the Medicaid system and get returned to their practice. Cosgrove on 5/19/2010 Final Tr. at 2583:13 – 2584:3; Silva on 5/20/2010 Final Tr. at 2801:1-9; 2798:16 – 2799:3; Schechtman on 5/20/2010 Final Tr. at 2847:25 – 2848:4; Isaac on 8/11/2010 Final Tr. at 3896:25 – 3897:7; (3) treat children who have had their eligibility terminated in violation of their rights to continuous eligibility. Silva on 5/20/2010 Final Tr. at 2804:12 – 2805:9; St. Petery on 11/11/2008 Depo. Desig. at 106:12 – 107:12; Isaac on 8/10/2010 Final Tr. at 3916:9-21; Ritrosky on 11/10/2008 Depo. Desig. at 97:9 – 98:2; 98:15 – 99:25; 101:7-16; (4) spend significantly more time trying to refer children on Medicaid to specialists than they do children on commercial insurance. Cosgrove on 5/19/2010 Final Tr. at 2562:19 – 2563:8; 2572:21 – 2573:6; Schechtman on 5/20/2010 Final Tr. at 2835:22 – 2836:18; 2839:3-11; 2850:11 – 2851:15; Silva on 5/20/2010 Final Tr. at 2779:3 – 2780:8; Seay on 11/14/2008 Depo. Desig. at 15:9 – 16:24, 20:2-9, 57:7-21; 103:7-20; St. Petery Depo. Desig. on 11/11/2008 at 191:1-4, 195:7 – 196:11, 197:15-25; 198:21 – 199:10; Knappenberger on 11/20/2008 Depo. Desig. at 32:9 – 33:5; 99:12 – 100-8; Curran on 10/7/2008 Depo. Desig. at 30:4 – 31:8, 32:16 – 34:14, 37:13 – 38:11, 55:8 – 56:4; Ritrosky on 11/10/2008 Depo. Desig. at 17:17 – 18:14; 27:18-22; 39:9 – 40:3l; 45:2 – 47:7; 50:8 – 51:1;

and (5) and treat children on Medicaid at inadequate reimbursement rates that are significantly less than what they are paid by private insurance companies and that strain their economic viability. St. Petery on 12/10/2009 Final Tr. at 556:11 – 558:4; Silva on 5/20/2010 Final Tr. at 2798:16 – 2799:3; 2825:6-20; Cosgrove on 5/19/2010 Final Tr. at 2560:25 – 2561:3; 2607:6-8; 2617:4-11; 2635:2-5; Schechtman on 5/20/2010 Final Tr. at 2895:5 – 2896:5; *see also infra* at IV.A and VI.B. (discussing switching, improper terminations, and reimbursement rates).

114. FAPD has about 135 active members and 30 plus members who are faculty, students, lifetime, or retired. Primosch on 8/10/2010 Final Tr. at 3736:11-14. Similarly, FAPD has members that provide services to children enrolled in Medicaid. Deposition of Peter Claussen, FAPD 30(b)(6) designee 3/14/2008 at 40:2-5. Those members are injured by the low reimbursement rates that Florida Medicaid pays dentists for treating children on Medicaid. Claussen on 3/14/2008 Depo. Desig. at 7:9-10; 14:2-3; 39:22-25; 14:17 – 15:4, 110:10-16; 118:13-24, 119:13 – 122:18; 140:11 – 142:4; McIlwaine on 11/13/2008 Depo. Desig. at 4:13-17; 5:4-17; 10:13-15;18:1-12; 21:4-17; 22: 2-4; *see also infra* at VI.E. (discussing dental reimbursement rates).

115. These injuries to FPS and FAPD members are current and ongoing and absent relief will continue to manifest future injury and suffice to confer standing on the doctors and dentists. *See Singleton v. Wulff*, 428 U.S. 106, 112-

113 (1976); *Am. Iron & Steel Inst. v. O.S.H.A.*, 182 F.3d 1261, 1274 n.10 (11th Cir. 1999); *Planned Parenthood of the Atlanta Area, Inc. v. Miller*, 934 F.2d 1462, 1465 n.2 (11th Cir. 1991). In this action, the interests that FPS and FAPD seek to protect are germane to the organizations' interests. The FPS is an advocacy organization consisting of physicians, and its mission is to enhance the health of the children of Florida, and to support the pediatricians who care for those children. St. Petery on 12/7/2009 Final Tr. at 83:20-22. The FAPD is an advocacy organization consisting of dentists, and its mission is to practice the art and science of pediatric dentistry and to promote optimal health care for infants, children, and persons with special health care needs. Primosch on 8/10/2010 Final Tr. at 3738:23 – 3739:1; PX 307. The interests at stake in this litigation, *i.e.*, Defendants' failure to adequately fund or provide legally required healthcare services to children eligible for Medicaid, are germane to the Organizational Plaintiffs' interests and their respective missions. St. Petery on 12/10/2009 Final Tr. at 539:21 – 541:7; Primosch on 8/10/2010 Final Tr. at 3740:23 – 3741:15.

116. Where an organization seeks only prospective relief and its members have standing, participation of the members in the lawsuit is not required. *Browning*, 522 F.3d at 1160-61; *see also Brown Group*, 517 U.S. at 522, 546, 553-54. Here, the two organizations seek only prospective relief.

117. Third party standing may be asserted when (1) the litigant has also suffered an injury in fact giving them a concrete interest in the issue in dispute, (2) the litigant has a close relationship to the third party, and (3) there exist some hindrance to the third party's ability to protect their own rights and interests. *Powers v. Ohio*, 499 U.S. 400, 410-411 (1991) (holding that a defendant had standing to bring action on behalf of jurors allegedly dismissed due to their race); *see also Singleton v. Wulff*, 428 U.S. 106, 114-17 (1976) (holding physicians had third-party standing to bring action on behalf of patients against interference in patients' rights to obtain Medicaid benefits for abortion services).

118. As already noted, the members of FPS and FAPD have suffered an injury in fact. They also have a close relation to the children on whose behalf they sue. The doctor-patient relationship is sufficiently close so as to allow doctors to assert patients' rights. *See, e.g.*, *Singleton*, 428 U.S. at 117 ("the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against" a Medicaid patient); *Pa. Psychiatric Soc'y v. Green Spring Health Servs.*, 280 F.3d 278, 289 (3d Cir. 2002); *Nasir v. Morgan*, 350 F.3d 366, 376 (3d Cir. 2003) (third-party standing and doctor-patient relationship); *Aid for Women v. Foulston*, 441 F.3d 1101, 1109-14 (10th Cir. 2006) (physicians could assert rights of minor patients); *see also Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 1810 (2005) ( "[Teachers] are often in the best position to vindicate the

rights of their [minor] students because they are better able to identify discrimination and bring it to the attention of administrators.")

119. I also find that children on Medicaid face a considerable hindrance to bringing suit on their own. Many of these children and their guardians are not even aware of their legal rights, including their right to EPSDT services and their right to seek legal recourse if they don't receive them. Many are also afraid to bring suit against state agencies because they are fearful of retaliation, including loss of benefits for their children. St. Petery on 2/9/2010 Final Tr. at 1493:18 – 1494:17. Moreover, many welfare recipients are living day to day, struggling to make ends meet, and cannot take on the added burden of serving as a plaintiff in a lawsuit, including sitting for a deposition and traveling to court to testify.

120. Accordingly, I find, consistent with numerous similar court decisions, that FPS and FAPD have associational standing to raise claims of their members, and that doctors and dentists have third-party standing to assert the claims of Florida children who are eligible for Medicaid. *See Pa. Psychiatric Soc'y v. Green Spring Health Servs.*, 280 F.3d 278, 293 (3d Cir. 2002) (reversing district court's decision that organization consisting of psychiatrists could not assert the psychiatrists' third-party claims on behalf of patients); *Ohio Ass'n of Indep. Sch. v. Goff*, 92 F.3d 419, 421-22 (6th Cir. 1996) (organization consisting of member schools could assert schools' third-party claims on behalf of parents of

schoolchildren); *Public Citizen v. FTC*, 869 F.2d 1541, 1551 (D.C. Cir. 1989) (organization consisting of, inter alia, parents could assert parents' third-party claims on behalf of children); *Mgmt. Ass'n for Private Photogrammetric Surveyors v. United States*, 492 F. Supp. 2d 540, 548 (E.D. Va. 2007) ("[S]everal circuits have permitted such 'derivative standing,' apparently concluding…that the requirements of third party and associational standing, faithfully applied, are sufficiently rigorous to ensure the concrete adversity of interests necessary for an Article III 'case.'").

**B. Proposed Findings of Fact As To All Named Plaintiffs**

1. S.M.

121. S.M. became eligible for Medicaid shortly after he was born in August 2006. PX 583-2 at TPF02294-98, TPF02305-07. S.B., S.M.'s mother, chose Dr. Simmons, who practices with the Tallahassee Pediatric Foundation ("TPF") and who was her pediatrician for about 16 years, to be S.M.'s doctor. S.B. on 2/11/2010 Final Tr. at 1782:9-22. S.M. was on MediPass and assigned to TPF from October 1, 2006 through June 30, 2007. PX 582 at 5. S.M. lost eligibility for Medicaid on June 30, 2007, in violation of his right to twelve months of continuous eligibility, as confirmed by a FMMIS print screen from AHCA's computer system. *Id.*; PX 583-2 at TPF002308. S.M.'s eligibility was restored

retroactively, making it appear as if he had never lost eligibility. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1491:3-7.

122. S.M. was again on Medicaid and again assigned to TPF from August 1, 2007 through September 30, 2007. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1486:21 – 1487:5, 1491:3-18. S.M.'s Medicaid eligibility was terminated again on September 30, 2007, two months after his Medicaid eligibility started on August 1, 2007, in violation of his right to 12 months of continuous eligibility. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1486:21 – 1487:5, 1491:3-18; 1494:2-17; McCormick on 8/12/2010 Final Tr. at 4132:24 – 4133:8; S.B. on 2/11/2010 Final Tr. at 1787:9 – 1788:1; PX 583-2 at TPF02295,TPF002310. Once again, his eligibility was retroactively restored. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1494:14 – 1495:11.

123. From September 30, 2007 until November 1, 2007, S.M. was not assigned to TPF. PX 582 at 5. S.B.'s Medicaid eligibility resumed on November 1, 2007, and he was again assigned to TPF. *Id.*

124. S.M. was scheduled to see Dr. Simmons in February 2008 when he was 18 months old for a well child check-up. S.B. on 2/11/2010 Final Tr. at 1788:11 – 1789:14. Dr. Simmons' office told S.B. not to bring her son in because S.M had been assigned or "switched" to a Medicaid HMO. S.B. on 2/11/2010 Final Tr. at 1788:11-1789:14; St. Petery on 12/10/2009 Final Tr. at 1389:17 –

1391: 25; *see also* PX 658 at Simmons000002. A FMMIS print screen shows S.M. was assigned to a Medicaid HMO from February 1, 2008 through March 31, 2008. McCormick on 8/12/2010 Final Tr. at 4136:25 – 4138: 21; PX 583-2 at TPF02319.

125. S.B. did not receive a letter during that time period from Florida Medicaid or any other state agency that she did not open; nor did she receive a letter that she did not respond to. S.B. on 2/11/2010 Final Tr. at 1789:15 – 1790:3. Her grandmother let her know if she received any mail at her former address. *Id.* at 1784:6-21, 1821:12-22.[7]

126. S.M. was not switched back to MediPass until March 31, 2008. S.B. on 2/11/2010 Final Tr. at 1790:23-25, 1804:24 – 1805:7, 1817:18 – 1818:7. During that interval, S.B. was not able to take her son to see Dr. Simmons and was concerned about her son's health. S.B. on 2/11/2010 Final Tr. at 1791:9 – 1792:7.

127. S.B. would travel an hour by bus to Dr. Simmons' office. *Id.* at 1784:24-1785:12. Dr. Simmons referred S.M. to a laboratory for a lead blood screening test. S.B. was not able to get her son's blood tested for exposure to lead

[7] An employee of Medicaid Options, which handled plan assignments for Medicaid in non-Reform counties, said S.B. received a letter asking her to choose a Medicaid plan and was auto-assigned to a Medicaid HMO when she allegedly failed to make a choice. PX 583-2 at TPF02312-13. There is no evidence, however, that such a letter was actually sent, let alone received, and if S.M. had not been improperly terminated short of 12 months of continuous eligibility, his mother would not have had to apply for reinstatement, S.B. on 2/11/2010 Final Tr. at 1821:23 – 1822:7, let alone choose a Medicaid plan for him again. And if she had been automatically re-assigned to her former PCP, she would not have been switched.

because of transportation problems. S.B. on 2/11/2010 Final Tr. at 1793:17 – 1794:11, 1798:19 – 1799:17; S.B. on 12/06/2011 Rough Tr. at 111, 143, 146. She also missed appointments with Dr. Simmons because of transportation problems. *Id.* at 145-46. She did not know she was entitled through Medicaid to free transportation. *Id.* at 144-46.

128. In addition, Dr. Simmons office was not able, during either of two separate visits to recommend a dentist that would treat S.M. when he was under five years of age. *Id.* at 145-49. S.B. called several dentists who purportedly accepted young children on Medicaid but was not able to find a dentist for S.M. *Id.* at 147, 149, 151-52.

129. S.B. voluntarily sent S.M. to live with his father in August of 2011 so she could devote more time and energy looking for a job and an apartment where she could live with her three minor children. S.B. on 12/06/2011 Rough Tr. at 90, 135. Later, S.M. and S.B.'s two other minor children were removed from her legal custody as the result of a court order and proceedings initiated by DCF. *Id.* at 89-90, 135.[8]

[8] While S.B. did not inform her counsel on one occasion when she moved, *id.* at 105-106, that does not undermine her adequacy as a class representative. S.B. sat for a deposition and testified twice in court, once traveling to Miami to do so, and once testifying by video hook-up from the federal courthouse in Tallahassee. Nor does the fact that she was warned about Dr. Simmons' office about missing appointments and dropped as a patient by Dr. Simmons, *id.* at 122-23, mean she is not an adequate class representative. Not only did she subsequently seek a new

130. While S.M. is living with his father about 25 minutes outside Tallahassee, S.B. has continued to see her son every week. *Id.* at 136. Those weekly visits are not supervised by DCF. *Id.* at 154.

131. Even though S.B. currently does not have legal custody of S.M., S.B. is still a proper and appropriate next friend. An individual may serve as a "next friend" of a minor as long as the "next friend's" interests are not adverse to the minor and the "next friend" is sufficiently dedicated to the minor's interest. *Gonzalez ex rel. Gonzalez v. Reno*, 86 F. Supp. 2d 1167, 1185 (S.D. Fla. 2000) *aff'd sub nom. Gonzalez v. Reno*, 212 F.3d 1338 (11th Cir. 2000). A parent may sue as a "next friend" even if he or she has lost custody to the state and his or her rights have been terminated provided the parent is advancing the child's interests, and not his own. *Miracle by Miracle v. Spooner*, 978 F. Supp. 1161, 1163-64, 1168 (N.D. Ga. 1997). The key issue is whether the next friend's interests are aligned with those of the minor child. *See Dolin on Behalf of N.D. v. W.*, 22 F. Supp. 2d 1343, 1353 (M.D. Fla. 1998), *aff'd sub nom. Dolin v. W.*, 207 F.3d 661 (11th Cir. 2000) ("parent may not sue on behalf of a child where the parent's interests are not aligned with those of the child").

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pediatrician for her children, *id.* at 126, her adequacy is judged by her ability to represent the interests of the class in this action. *See London v. Wal-Mart Stores, Inc.*, 340 F.3d 1246, 1253 (11th Cir. 2003) ("considering "the forthrightness and vigor with which the representative party can be expected to assert and defend the interests of the members of the class").

132. S.B. has no interests antagonistic to S.M.'s interests, and, in fact, no motive to serve as his next friend other than to advance his interests and the interests of other children on Medicaid. S.M.'s father, T.M., is also willing to serve as S.M's next friend. *See* PX 788 (Declaration of T.M., filed on 01/31/2012, D.E. 1121). His son has been living with him since August, and T.M. has no interest in this litigation other than to look out for the interests of his son. *Id.* at ¶¶ 1-8. If for any reason S.B. is not able to continue as next friend for S.M., I find that T.M. is an appropriate, substitute next friend for S.M.

2. L.C.

133. L.C. was hospitalized for seizures when he was about 15 months old and had seizures later as well. PX 655 at Tridas Center000008; PX 651 at Peace River000016. L.C. moved into S.C.'s home as a foster child when he was two years, eight months old, and S.C. later adopted him. S.C. on 1/11/2010 Final Tr. at 1319:21 – 1320:1; 1322:1-3. As a child adopted through foster care, L.C. is eligible for Medicaid regardless of income. *Id.* at 1322:4-9.

134. In August of 2004, when L.C. was about 7 years old, S.C. took him to be evaluated by a developmental pediatrician because of his developmental delays and his anxiety, which manifested itself in panic attacks and other extreme behavior. *Id.* at 1327:13 – 1329:15; PX 655 at Tridas Center000001, 000003,

000007. The doctor recommended intense psychological services. S.C. on 1/11/2010 Final Tr. at 1331:21 – 1332:1; PX 655 at Tridas Center000011.

135. The appropriate modality of therapy for a young child such as L.C., especially a child with delays in comprehension of oral language, is play therapy, which is what the doctor recommended. Dr. Elias Sarkis on 1/19/2012 Rough Tr. at 44-47.

136. Based on her doctor's recommendation, S.C. took L.C. to see Elizabeth Craig, who had an extensive history working with children with attachment disorder. S.C. on 1/11/2010 Final Tr. at 1332:19 – 1333:10. Ms. Craig, who does not take Medicaid, recommended weekly play therapy. PX 652 at Craig000105; S.C. on 1/11/2010 Final Tr. at 1336:20-21. In September of 2004, S.C. took her son to Peace River, the exclusive Medicaid mental health provider in her area. *Id.* at 1336:22 – 1338:12; PX 651 at Peace River000009. Peace River, however, was not able provide play therapy, let alone from a registered play therapist, and was not able to provide weekly therapy. *Id.* at 1338:13-17; 1338:20 – 1341:25; PX 740 at DEFENDANTS011707.[9] And the therapist Peace River wanted L.C. to see was leaving Peace River because she had a case load of 110.

[9] The therapist plan offered by Peace River called for therapy twice a month as needed, PX 651 at Peace River000008, meaning he would be seen at most twice a month. S.C. was told by the therapist that her son would be seen only once a month. S.C. on 1/11/2010 Final Tr. at 1374:14-21.

S.C. on 1/11/2010 Final Tr. at 1342:19 – 1343:25.[10] Because her son could not get the care he needed at Peace River, L.C. paid for her son to see Ms. Craig weekly for play therapy. *Id.* at 1345:18 – 1346:6. Although these sums were ultimately reimbursed, her son was denied the care on Medicaid to which he was entitled.

137. L.C. also suffered harm from lack of proper medications. In 2005, a developmental pediatrician recommended starting L.C. on certain medications. In 2007, Dr. Hubbard refused to continue to see L.C. *Id.* at 1355:2 – 1357:24. S.C. returned to Peace River because she needed a psychiatrist to prescribe and monitor L.C.'s medications. *Id.* at 1357:12-15; PX 651 at Peace River000053. One of the medications L.C. was on was Depakote. S.C. on 1/11/2010 Final Tr. at 1357:16-18; PX 651 at Peace River000054 ("Current Mental Health Medications" include "Depakote 500 m.g. S.C. told the people at Peace River that she needed a psychiatrist to write a refill of L.C.'s prescriptions, that she had only a week left of Depakote, and that abrupt removal of Depakote can cause seizures. S.C. on 1/11/2010 Final Tr. at 1357:19-24; PX 651 at Peace River000053. Despite explaining the urgency of the situation, S.C. was not able to obtain a prompt appointment for her son to see a psychiatrist but was rather going to have to wait two to three months. S.C. on 1/11/2010 Final Tr. at 1357:19 – 1358:16; 1385:15 – 1386:3. Desperate for someone to help her son, S.C. paid Dr. Hubbard to monitor

[10] The therapist said she was quitting because she "could not deliver adequate service to her clients because of her large caseload." PX 650 at LCOL0000001.

her son's psychotropic medications for about two years. *Id.* at 1358:17-25; 1359:7-9, and was accordingly injured by having to pay out of pocket for treatment that should have been covered by Medicaid. Dr. Hubbard had previously accepted payment though Medicaid but would not continue to see L.C. through Medicaid. *Id.* at 1359:1-3.

138. With the help of DCF, S.C. was later able to get her son in to see a psychiatrist at The Sweet Center in Winter Haven, who continued to monitor his medications. *Id.* at 1361:9 – 1362:23.

139. Dr. Elias Sarkis is board certified in both general psychiatry and also in child and adolescent psychiatry, and is a past president of the Florida Psychiatric Society, among other positions. Sarkis on 1/19/2012 Rough Tr. at 6-9, 13; PX 647 at Ex. B.

140. Dr. Sarkins opined that it was important for L.C. to be seen by a licensed therapist, because his was a complicated case and he needed a therapist with sufficient experience. Sarkis on 1/19/2012 Rough Tr. at 47-48. A caseload of 110 patients is unheard of in private practice and is so demanding that a therapist could not provide adequate care to children with such a heavy caseload. *Id.* at 48-49, 52-53, 79-80.

141. Depakote is an anti-convulsant and is also prescribed to control aggressions and mood liability (intense mood shifts or changes). Sarkis on

1/19/2012 Rough Tr. at 44-47. Terminating Depakote abruptly in children can cause significant health risks, including seizures, and is inconsistent with the standard of care. *Id.* at 34-35, 37-38, 41, 112. Because L.C. had been on Depakote for more than a year halting the medication suddenly would be especially risky for him. *Id.* at 35-36. Making S.C. wait two to three months for an appointment for L.C. to see a therapist, when L.C. was about to run out of Depakote, was not medically reasonable and was below the standard of care. *Id.* at 36-37, 43, 53.[11]

3. K.K.

142. A.D. is the mother of K.K., one of the named plaintiffs in this action. A.D. on 8/12/2010 Final Tr. at 4046:22 – 4047:13. K.K was born in December of 2003; at the time, A.D. was living in Lehigh Acres, near Ft. Myers. *Id.* at 4049:8-9. K.K. went on Medicaid at birth. *Id.* at 4050:5-6. A.D. herself has been on Medicaid on and off since then. *Id.* at 4050:1-2.

143. A.D. periodically has to renew her son's Medicaid. She can call and get a packet by mail to fill out or fill out the renewal form on line but in either case she has to figure out how to complete the form on her own. Sometimes she had to call five times per day. *Id.* at 4069:5-11; 4072:1-14. K.K. was switched from

[11] A number of the named plaintiffs were reluctant to serve as plaintiffs in this case because they were fearful of retaliation by the Defendants. K.S. on 5/17/2010 Final Tr. at 1978:18-24; S.C. on 1/11/2010 Final Tr. at 1365:1-7; 1365:14 – 1366:1; E.W. on June 16, 2010 Depo. Desig. 87:12-23.

MediPass to a Medicaid HMO called Prestige, without her knowledge or consent. *Id.* at 4055:24 – 4056:14.

144. As a young child, K.K. suffered from chronic and recurring ear infections. PX 612 at K Kel 00008. On March 9, 2005, A.D. took K.K. to the emergency room at Cape Coral hospital because he was bleeding from his ear. A.D. on 8/12/2010 at 4056:18-22; 4057:13-25; PX 604 at Cape Coral000008. K.K. was discharged shortly after midnight and directed to see an ENT specialist in the morning. *Id.* at 4058:18-25.

145. The next morning, A.D. called and made an appointment with the office of Dr. Liu, the ENT who had already seen K.K. several times and performed ear balance surgery and put tubes in both K.K.'s ears. *Id.* at 4059:1-13. She soon received a call back, informing her that because K.K. was on, Staywell, the doctor could not see him, even though he had been seen at that office before. *Id.* at 4059:14-21; 4087:8-15.

146. A Staywell representative told A.D. she had to go to Sarasota to see an ENT affiliated with Staywell. *Id.* at 4059:22 – 4060:25; 4061:1-6; 4081:3-7. A.D. did not own a car at the time and had a sick baby to take care of and was not able to go to Sarasota. *Id.* at 4061:1-10. "Sarasota is probably an hour and 45 minutes to two hours depending on where you're going in Sarasota. With no vehicle, that's pretty far." *Id.* at 4061:17-20.

147. Dr. Donaldson, Dr. Liu's partner, ended up seeing K.K. later that day. PX 612 at K KEL 00006. K.K. had puss running out of his left ear, a tube displaced in his right ear, and an effusion behind the middle ear. *Id.* at K KEL 00006.[12] Dr. Donaldson saw K.K. even though he did not accept Staywell. Donaldson Depo. Desig. at 78:18 – 80:18; 206:21-25. Because Dr. Donaldson was not a Staywell provider, he risked not getting paid for seeing K.K. Becker on 2/1/2012 Rough Tr. at 30, 59-61.

148. Dr. Marie Becker is a board certified otolaryngologist who has been in private practice since 1995, treating children and adults covered by both private insurance and Medicaid. Becker on 2/1/2012 Rough Tr. at 9-10. I find her credible and knowledgeable and certify her as an expert in otolaryngology.

149. Ear nose and throat diseases such as otitis media, sinusitis, and tonsillitis are frequently encountered illnesses with the pediatric population, and Staywell should have had an ENT on its panel in a metropolitan area such as Ft. Myers. *Id.* at 27. Children on private insurance would not be subjected to the

[12] The emergency room physician called Dr. Liu while K.K. was in the ER at Cape Coral Hospital. PX 604 at Cape Coral 000010. Dr. Liu indicated that his partner, Dr. Donaldson, would see K.K. the next day because Dr. Liu himself was going to be operating. *Id.*; A.D. on 8/12/2010 Final Tr. at 4089:14-24. That does not indicate that Drs. Liu and Donaldson accepted Staywell. K.K. was previously on MediPass, which they accept, and Dr. Liu cannot be expected to know when called after midnight that one of his patients had changed to a Medicaid HMO, which he does not accept, less than ten days ago. Testimony of A.D. on 8/12/2010 Final Tr. at 4073:19 – 4074:4.

hardship of traveling to a different metropolitan area to obtain routine ENT care.[13] *Id.* at 28. The mother of a child with private insurance would not have had to go through the steps A.D. did in order to get K.K. seen by the partner of his former doctor without any assurance the doctor would be paid. *Id.* at 30-31.

150. A.D. did not know that K.K. was entitled to dental coverage through Medicaid until after she became a plaintiff. A.D. on 8/12/2010 Final Tr. at 4063:13-21. She did not realize, even after receiving a letter dated December12, 2007 from AHCA regarding well child check-ups, that Medicaid covered dental care for A.D. *Id.* at 4064:11-25; 4106:17 – 4108:2; 4066:13 – 4067:1; PX 612 at K KEL00097.

151. K.K. was diagnosed with attention deficit hyperactivity disorder or ADHD. A.D. on 1/25/2012 Rough Tr. at 54; DX 55C at Associates in Pediatrics000366-67. In November 2009, he was prescribed Adderall. DX 55C at Associates in Pediatrics000366-67. A.D. and K.K.'s pediatrician went through a process of trial and error lasting several months to find out what medication and at what dosage was most beneficial for K.K. A.D. on 1/25/2012 at 55-56; DX 55C at Associates in Pediatrics000278, 295-96, 300, 322, 324. Eventually they settled on

[13] The fact that Staywell had ENT providers near Ft. Myers on its panel as of May of 2009, *see* DX 65A, does not mean that those providers would have accepted K.K. as a patient in May of 2009, and it certainly does not indicate that they were affiliated with Staywell and were willing or able to treat K.K. four years earlier in March of 2005.

Vyvance at about 50 m.g. a day. A.D. on 1/25/2012 Rough Tr. at 56. At that dosage, K.K., who failed kindergarten the year before, became a straight A student. *Id.* at 56-57.

152. K.K. was not on Medicaid for a few months in late 2010 through early 2011 because A.D. at that time was making more money. *Id.* at 70. Then she lost her job in January, and in February K.K. was back on Medicaid. *Id.* at 70. A.D. was asked to pick a plan for K.K. and chose MediPass. *Id.* at 71-72. K.K. however, was assigned to Staywell, though A.D. did not request Staywell. *Id.* at 58. Nor did she know her child was being assigned or "switched" to Staywell. *Id.* at 58.[14]

153. The result of the switch was harmful to K.K.. Staywell denied the prescription for Vyvance because K.K. first needed to fail on Dextroamphetamine, the key ingredient in Adderall. DX 55C at Associates in Pediatrics000076.

154. While appealing Staywell's denial, *id.*; A.D. on 1/25/2012 Rough Tr. at 57-59, the pediatrician put K.K. back on Adderall, as a "substitute," because that is what the insurance company would pay for. DX 55C at Associates in Pediatrics000076-77; A.D. on 1/25/2012 Rough Tr. at 59-60, 63. When K.K. went back on Adderall, his teacher complained about his conduct; his mother also saw a

[14] K.K. was also switched on another occasion to a Medicaid HMO K.K's pediatrician's office did not accept. A.D. on 1/25/2012 Rough Tr. at 73.

significant deterioration in his conduct. *Id.* at 64-65; DX 55C at Associates in Pediatrics000076-77.

155. A.D. was able to get K.K. back on MediPass, and on Vyvance about mid-May. A.D. on 1/25/2012 Rough Tr. at 75. The doctor had to increase the dosage of Vyvance to get it to work as it had before. *Id.* at 65.

4. Nathaniel Gorenflo

156. Rita Gorenflo is the mother of Nathaniel Gorenflo, one of the named plaintiffs in this action. Gorenflo on 5/18/2010 Final Tr. at 2290:23 to 2291:2.[15] The Gorenflos live in Palm Beach County. *Id.* at 2298:3-4.

157. Ms. Gorenflo is a registered nurse who spent 18 years working in the emergency department at different hospitals in Ohio and Florida. *Id.* at 2289:19 – 2290:7; 2290:11-13. She has adopted seven children with special health care needs who were in foster care. *Id.* at 2291:3-6, 2291:15-16; 2292:1-8. All the children are enrolled in CMS and all are eligible for Medicaid regardless of the family's income because they were adopted through foster care. *Id.* at 2291:17-21; 2291:22-25.

158. Nathaniel's mother was on cocaine at the time of Nathaniel's birth. *Id.* at 2293:16-21. He later developed AIDS. *Id.* at 2293:20-22; 2294:11-12. He

[15] Ms. Gorenflo has agreed to allow her name and her children's name to be used in these proceedings. *Id.* at 2288:21-23.

is developmentally delayed and has multiple psychiatric issues, *id.* at 2294:6-10, sees a number of different medical providers and specialists. *Id.* at 2294:20-22.

159. In 2005, Ms. Gorenflo was unable to obtain timely ENT care for Nathaniel. The incident began on July 13, 2005, when Ms. Gorenflo called her nurse coordinator at CMS and said Nathaniel needed to see an ENT physician right away. *Id.* at 2295:23 – 2296:23; PX 617 at NG_CMS000756. Ms. Gorenflo called CMS because she did not know of any ENT in Palm Beach County that accepted Medicaid other than through C*MS.* *Id.* at 2297:24 – 2298:4.

160. When Ms. Gorenflo called CMS to request an ENT appointment for Nathaniel, her son was in pain. *Id.* at 2299:2-23. He could not tell her where the pain was but he would "scream and bang his head" and put the whole house in "total chaos." *Id.* at 2299:24 – 2300:6. Ms. Gorenflo told CMS when she called that her son was in pain because she was trying to explain why he needed to get in right away. *Id.* at 2300:7-13.

161. Ms. Gorenflo wanted her son seen quickly because he has AIDS and so has a compromised immune system. *Id.* at 2311:24 – 2312:5. She also wanted him seen quickly because she knew he had a history of ear problems and suffers from chronic sinusitis. *Id.* at 2294:17-19; 2311:14-23.

162. When Ms. Gorenflo called CMS on July 13, the next available appointment in the ENT clinic was in six months. *Id.* at 2300:14-18.[16] Ms. Gorenflo said a six-month wait was not acceptable because Nathaniel was in pain and needed an ENT evaluation to get to the bottom of his ear pain. *Id.* at 2302:10-20.[17] After numerous phone calls stretching out over several days, Nathaniel was finally seen in an ENT physician's office on July 18 – five days after his mother said he need an appointment right away. *Id.* at 2303:13 – 2304:8; 2305:11 – 2306:4; 2310:4-8; 2310:15 – 2311:13; PX 617 at NG_CMS00756.

163. Paula Dorhout is the nursing director at the Children Medical Service's office that serves Palm Beach County. Dorhout on 4/4/2011 Rough Tr. at 3. She agrees that Ms. Gorenflo is a very dutiful caregiver and that if she said her son was in pain, Ms. Dorhout would accept Ms. Gorenflo's judgment. *Id.* at

[16] The July 14, 2005 entry in the CMS nursing notes, which indicates that Ms. Gorenflo called on July 13 and asked for an ENT appointment for Nathaniel ASAP, does not say Ms. Gorenflo was offered an appointment in six months. However, the notes are incomplete and in fact there is a 16 or 17 month gap at one point between entries even though Ms. Gorenflo never went that long without taking Nathaniel to a CMS clinic. Gorenflo on 5/18/2010 Final Tr. at 2300:23–2302:7; PX 617 at NG_CMS000756.

[17] Ms. Gorenflo also called CMS in February of 2008 to see how long the wait would be for another of her children to get into a CMS ENT clinic; the wait was four months." Gorenflo ON 5/18/2010 Final Tr. at 2315:3 – 2316:5. Ms. Dorhout, the CMS nursing supervisor in Palm Beach County, testified that in April of 2011 the waiting list for the CMS ENT clinic was probably two to three months. Dorhout on 4/4/2011 Rough Tr. at 52.

144. The proper procedure for a child who is in great deal of pain from his ear is for the child to see an ENT physician immediately. *Id.* at 145.

164. I find Ms. Gorenflo to be a credible witness and credit her testimony that her son was in pain and that she said her son was in pain when she called CMS and the ENT's office in July of 2005 and asked for a prompt appointment for Nathaniel.

165. Dr. Marie Becker is a board certified otolaryngologist who has been in private practice since 1995, treating children and adults covered by both private insurance and Medicaid. Becker on 2/1/2012 Rough Tr. at 9-10; PX 597 Appendix B (Becker resume). I find her credible and knowledgeable and certify her as an expert in otolaryngology.[18]

166. Nathaniel has a history of chronic sinusitis, as evidenced by his medical records. Becker on 2/1/2012 Rough Tr. at 12; DX 43 N.G._CMS000717, 731, and 734. That history makes it more likely he will suffer from sinusitis again. Becker on 2/1/2012 Rough Tr. at 14. Because Nathaniel had AIDS, he was immune-compromised and susceptible to infection. *Id.* at 15. The fact that he had

[18] Defendants have objected to Dr. Becker and the other witnesses who have given expert testimony as to the named plaintiffs' lack of adequate and prompt care. I have considered these motions to exclude the expert witness testimony and deny them as each of these experts is competent to testify as an expert based on a review of the medical records and the trial testimony. Further, I find their testimony more credible than the conclusory opinion of Ms. Sreckovich, defendants' expert, a non-physician, regarding the care afforded each of the named plaintiffs.

AIDS made it important that he be seen and diagnosed quickly, before any infection could spread. *Id.* at 14-15, 19-21. Pain is one of the key signs an infection is progressing. *Id.* at 15. Typically, th*e* person who spends most time with the child is most knowledgeable about whether the child's behavior is normal, and because Nathaniel was developmental delayed and could not express through words whether he was in pain, what his mother said about his condition was particularly important. *Id.* at 15-16. Given his symptoms, the fact that he was in pain, and suffered from AIDS, Nathaniel should have been evaluated by an ENT physician the day his mother requested an appointment or at the latest on the next day. *Id.* at 19-21.

167. A patient with the same symptoms and private insurance would have been seen by an ENT either the same day or at the latest, the following day. *Id.* at 21-22.[19]

168. Nathaniel experienced much greater difficulty accessing care than would a similarly situated child with private insurance. *Id.* at 23. Having Nathaniel wait five days for an ENT evaluation was "unreasonable." *Id.* at 25. He

[19] In her practice, Dr. Becker makes sure to see a child in pain the same day or at the latest the next day, regardless of whether the child is HIV positive or has AIDS. *Id.* at 22. If a child is HIV positive or had AIDS that adds to the importance of seeing the child quickly. *Id.* at 22. She also makes sure, if she receive a call about a child in pain on a Friday, to see the child that day so the child does not have to wait until Monday for an appointment. *Id.* at 22-23.

should have received an ENT evaluation the same day his mother called or at the very the latest, the next day. *Id.* at 25.

5. N.A.

169. C.R., next friend of plaintiff N.A., has been N.A.'s guardian since he was less than a week old, first as a foster mother and now as his adoptive mother.[20] C.R. on 1/14/2008 Depo. Desig. at 18:2-16. C.R. and N.A. reside in Tallahassee, Florida. *Id.* at 7:6.

170. N.A.'s birth mother voluntarily gave up her parental rights to N.A. *Id.* at 18:17-22. N.A. was exposed to cocaine and marijuana in utero, *see* DX 20 at TPF02293, and is at risk for developmental delays. C.R. on 1/14/2008 Depo. Desig. at 51:25 – 52:3.

171. Within a month of N.A.'s placement in C.R.'s home, he became sick and was hospitalized. What started as cold symptoms developed into respiratory syncytial virus (RSV) and necessitated an eight-day stay in the hospital's intensive care unit. *Id.* at 24:8-16; 65:15-22.

172. On the morning of January 19, 2007, just two months after his eight-day hospital stay, N.A. awoke coughing and congested, so C.R. called his doctor to

[20] Since his adoption, the boy's initials are now N.R. *See* DX 20 at TPF02210-02211. He is referred to here as N.A. because that is the way he was referred in the record during the key times at issue. On March 1, 2007, shortly after the incident in question, C.R. enrolled N.A. in CMS. C.R. on 2/24/2008 Depo. Desig. at 31:10-22.

schedule an immediate appointment. *Id.* at 26:12-14. It was not until that time that C.R. was informed that N.A. had been randomly assigned to a different insurance plan, a Medicaid HMO called Buena Vista, and assigned to a pediatrician located in Monitcello, about thirty minutes away from her home. DX 20 at TPF02229.

173. Although N.A. never resided with his birth mother, AHCA sent a request to her, not C.R., to choose a Medicare provider for N.A.; because N.A.'s birth mother did not respond, N.A. was auto-assigned. D.E. at 19 (Pretrial Stipulation, stipulated fact No. 111); Lewis on 11/29/2011 Rough Tr. at 39; Sreckovich on 12/13/2011 Rough Tr. at 94.

174. Because of his history of RSV and hospitalization, simple cold symptoms can quickly progress to significant problems for N.A. C.R. on 1/14/2008 Depo. Desig. at 65:15 – 66:4. When C.R. contacted Buena Vista, the representative refused to discuss N.A. with her because they lacked record of her relationship to N.A. *Id.* at 27:3-5.

175. Ultimately Tallahassee Pediatrics instructed C.R. to bring N.A. for treatment with his regular pediatrician, Dr. Charles Long, and said they would try to resolve the insurance issues later. *Id.* at 27:5-12; DX 20 at TPF02229. N.A. was seen that same morning, only because the doctor's office agreed to see him without confirmation that the office would be reimbursed for the visit. Middlemas on 1/31/2012 Rough Tr. at 22-23.

176. Later that same day, C.R. went to the pharmacy to fill two prescriptions for N.A. *Id.* at 27:16-20. The pharmacy was unable to process N.A.'s Medicaid number. *Id.* at 27:25 – 28:4. C.R. had to pay approximately $70 out of pocket for N.A.'s medications. *Id.* at 28:4-5; 29:15-17; 30:13-14; DX 20 at TPF02229.

177. At C.R.'s next trip to the pharmacy on the following Monday, a different pharmacist found the Buena Vista insurance numbers needed to process claims for medication for N.A. and also reimbursed C.R. for medication she had paid for on Friday. C.R. on 1/14/2008 Depo. Desig. at 30:7-13.

178. Dr. Middlemas practiced as a pediatrician, treating children on private insurance and Medicaid for 42 years, before recently retiring. Middlemas on 1/31/2012 Rough Tr. at 5-6. In the later years of his practice, he worked as a clinical instructor in the family practice residency program at Tallahassee Memorial Hospital. *Id.* at 5-6.

179. I find Dr. Middlemas qualified as an expert in pediatric medicine and find his testimony credible. Children with commercial insurance are never switched to another primary care provider with their parents' knowledge or consent. *Id.* at 21. Children on Medicaid sometimes are. *Id.*[21] A parent whose

[21] Dr. Middelmas' testimony is equally applicable to S.B., K.K, and J.W., who were also switched.

child had private insurance would not have had these obstacles in obtaining care for her child. *Id.* at 23.

6. J.S.

180. K.S. is the mother and next friend of J.S., one of the named plaintiffs in this action and lives in Jupiter. K.S. on 5/17/2010 Final Tr. at 1953:24-25; 1955:23 – 1956:5. J.S. has been on Medicaid since birth. *Id.* at 1957:13-14.

181. J.S. has variable immune deficiency, which means she lacks an immune system and can get sick very easily. *Id.* at 1958:11-19; 1958:23 – 1959:2. J.S. sees Dr. Gary Kleiner at the University of Miami for her immune deficiency. *Id.* at 1959:16-21. She has to see him on Thursday when he has clinic appointments because she has Medicaid. *Id.* at 1959:22 – 1960:4. He also sees patients on other days, but J.S., who is on Medicaid, can only see him on Thursdays. *Id.* at 1960:13-18. She has had to wait up to a month for an appointment. *Id.* at 1960:19-21.

182. J.S. has broken her ankle on several occasions. The first time was in 2000. *Id.* at 1961:10-13. K.S. took her daughter to Jupiter Medical Center, where they splinted her ankle, and told her to see an orthopedist. *Id.* at 1961:10-19. The orthopedist that the hospital recommended did not take Medicaid, and it took K.S. several days calling orthopedists in the phone book to find one to treat J.S. *Id.* at 1961:20 – 1962:5.

183. J.S. injured her ankle a second time in 2003 on a Saturday when she was seven year old and slipped on some water in a Winn Dixie. *Id.* at 1962:6-13; PX 743 at JMC000152. She took her daughter to the Jupiter Medical Center again, and again, they put on a splint, gave her crutches, and referred her to an orthopedist for follow-up care. *Id.* at 1962:14-21; PX 743at JMC000147-157. That orthopedist agreed to see her daughter but only if she paid for the visit. K.S. on 5/17/2010 Final Tr. at 1962:19 – 1963:4. The initial visit alone was going to cost about $300. *Id.*

184. K.S. then called a 1-800 Medicaid number for suggestions for an orthopedist. *Id.* at 1965:17-22. She called all the doctors she was given but none agreed to treat her daughter because she was on Medicaid. *Id.* at 1965:23 – 1966:5; 1967:10-13. She also called orthopedists listed in the Yellow Pages for Palm Beach County but without success. *Id.* at 1966:6-18; 1967:10-13. She tried call St. Mary's Hospital for a referral but could not find an orthopedist that way either. *Id.* at 1966:19-22. None of the orthopedists she called would agree to treat her daughter as a Medicaid patient. *Id.* at 1967:17-19; 1996:22 – 1997:13; 2023:18 – 2024:1.

185. Finally, with help from a law firm, she obtained an appointment with an orthopedist. *Id.* at 1967:20 – 1968:7; 2024:2-3. In 2007, J.S. injured her wrist, K.S. on 5/17/2010 Final Tr. at 1971:1-6; 2001:4-12, was given a splint in the E.R.

and referred to an orthopedist. *Id.* at 1971:7-13. K.S. called the orthopedist that the emergency room recommended, but she was not able to get an appointment. *Id.* at 1971:14-23. Again, she was unable to locate an orthopedist who would see her daughter despite extensive efforts. *Id.* at 1971:21 – 1973:6.

186. Finally, she was referred to the University of Miami, which gave her some suggestions for an orthopedic doctor. *Id.* at 1973:7-14. Two of those doctors told her that they could not see J.S. for a couple of weeks, even though K.S. explained that her daughter had a broken wrist and needed follow-up care. *Id.* at 1973:15-16; 1973:22 – 1974:3. The third doctor, Dr. Aileen Danko, agreed to see J.S. three days after she broke her wrist. *Id.* at 1973:20-21; 1974:14 – 1975:9; 2023:1-3; PX 746 at DANKO000001 to 000020.[22] Dr. Danko's office is in Coral Springs and is about an hour and a half drive each way from K.S.'s home. *Id.* at 1975:10-15. K.S. had to take her daughter to see Dr. Danko about four to five times. *Id.* at 1975:16-18.

187. The dentist who used to see J.S. and bill Medicaid for her treatment refused to continue seeing her when J.S. turned 14. *Id.* at 1976:25 – 1977:5. K.S. called a number of dentists trying to find a dentist who would accept Medicaid and

[22] Defendants asked this court to take judicial notice of the distance and purported driving time, according to Google and MapQuest, from Jupiter to Dr. Danko's office. *See* D.E. 1127, 1136, and 1137. Both the distance and driving time are farther if one starts from K.S.'s actual home address, not simply from Jupiter.

treat her, but could not find a Medicaid dentist for her. *Id.* at 1977: 6-11. Eventually, her old dentist agreed to see her.

188. To maintain J.S.'s Medicaid, K.S. has to go through a recertification process every six months. *Id.* at 1977:14 to 1987:4. When she has tried to call the Medicaid office, she had difficulty getting through because the line was busy. *Id.* at 1978:5-17.

7. N.V.

189. N.V. was born in February of 2004, in New Jersey. K.V. on 8/13/2010 Final Tr. at 4228:16-17. N.V. suffers from hydrocephalus and was ultimately diagnosed with Shwachman Diamond Syndrome, which causes pancreatic insufficiency. *Id.* at 4229:6-20; 4243:3-9. Proper nutrition is therefore critical to N.V.'s health. *Id.* at 4242:23 – 4243:2.

190. K.V. applied for Medicaid for N.V. while the family was still residing in New Jersey. *Id.* at 4230:3-16. N.V. is disabled, by social security standards, and thus entitled to receive Medicaid. *Id.*

191. K.V. and her family moved to Florida in 2005. *Id.* at 4246:22 – 4247:1. When N.V. was about three, he developed tooth decay, which he is prone to as part of Shwachman Diamond Syndrome. *Id.* at 4243:17-25.

192. K.V. took N.V. to Dr. Robbins, who treated N.V. for his tooth decay and administered his cleanings from January to September, 2007. *Id.* at 4236:18-

20. In September 2007, however, Dr. Robbins advised K.V. he would no longer treat N.V. because N.V. needed caps, and he explained further, that if the child lost a cap, Medicaid would not pay for a replacement. *Id.* at 4238:18-22.[23] Dr. Robbins told K.V. it would be "very hard" "to find someone who will accept Medicaid to do that work." *Id.* at 4278:11-23.

193. Using the Medicaid handbook, K.V. made multiple calls to multiple offices but could not a dentist in her area willing to treat N.V. *Id.* at 4240:10-16. She said nothing about N.V.'s complex medical condition; she did, however, identify Medicaid as the form of payment. *Id.* at 4241:13-16.

194. Ultimately, she was referred to Dr. Schneider whose office is two hours from her home. *Id.* at 4231:11-16; 4242:8-19; 4243:22-25. A month later, N.V. had his first appointment with Dr. Schneider. *Id.* at 4242:13-17; PX 673. By this time, N.V.'s appetite had diminished because of the tooth decay to the point that he was only drinking milk. *Id.* at 4243:15-19. Dr. Schneider was the only dentist K.V. could find who was willing to treat N.V. *Id.* at 4279:7-10; 4279:18-25. N.V. continues to see Dr. Schneider. *Id.* at 4231:11-20. K.V. takes N.V. to

[23] Though Dr. Robbins' notes include a notation that he does not do "white" fillings, PX 672, K.V. recalled the only reason Dr. Robbins told her for refusing to treat N.V. was that Medicaid would not pay for a second cap in the event the child lost one. *Id.* at 4239:3-15. Ultimately N.V. got both stainless and white caps. *Id.*at 18-20.

see Dr. Schneider four times a year due to his proclivity to tooth decay. *Id.* at 4243:22-25.

195. In the Fall of 2011, N.V.'s treating neurosurgeon Dr. Olivera referred him to see a neuropsychologist, and K.V. encountered difficulty in obtaining an appointment with a neuropsychologist. K.V. on 2/1/2012 Rough Tr. at 75.

196. Dr. Olivera made the referral as a result of K.V. reporting to him that N.V. was experiencing difficulty in comprehension at school. *Id.* at 73. Because, Dr. Olivera explained to K.V., learning problems are a common issue for children with hydrocephalus, he referred N.V. for an evaluation with a neuropsychologist before the start of the school year. *Id.*

197. Dr. Olivera referred N.V. to a neuropsychologist group with two offices: one in Orlando, near N.V.'s home, the other in Melbourne. *Id.* at 74-75. In early September, K.V. attempted to make an appointment, saying her son was on Medicaid. *Id.* at 74-75. She was not able to make an appointment to be seen at all in the Orlando office, and was not offered a date until January 2012 for N.V. to be seen by Dr. Lyons in the Melbourne office. *Id.* at 76-77. Moreover, Dr. Lyons's office did not commit to seeing N.V. at that appointment in January, but instructed K.V. to call back for confirmation of whether N.V. could be seen. *Id.* at 76. K.V. called back to the office every week for the next six weeks to find out whether or not Dr. Lyons would agree to treat N.V. *Id.* at 77-78. During this

period, K.V. asked both Dr. Lyons's and Dr. Olivera's treating neurosurgeon for a referral for a neuropsychologist who would accept Medicaid, but neither could provide one. *Id.* at 77. Finally, with assistance from Dr. Olivera, K.V. was seen by Dr. Lyons about two months after N.V. first sought an appointment. *Id.* at 77-79.

8. J.W.

198. In 2004 and until otherwise specified, J.W. resided in Pensacola, Florida with his grandmother, E.W., who serves as his next friend in this action. On December 21, 2004, E.W. took J.W. to see his pediatrician because he was complaining of a pain in his thigh. PX 629 at Whibbs000008. The pediatrician ordered x-rays of his knee and femur, and found a tumor on J.W.'s thigh. E.W. 6/16/2010 Depo. Desig. at 11:24 – 12:10.

199. The physician referred J.W. to an oncologist at the Nemours Hospital in Pensacola for an urgent consult. The oncologist examined J.W. a few days later, and because it was almost Christmas, agreed to let J.W. go home for the holiday, and began treatment immediately thereafter. PX 630 at JW_CMS000027.[24] On December 27, 2004, less than a week from the time when J.W. went to his

[24] The admission history states the x-ray was made on 10/22/04, PX 630 at JW_CMS000027, but that is clearly a typographical error because the x-ray was done on 12/22/04.

pediatrician, he was operated on and a tumor was removed from his left thigh. PX 630 at JW_CMS000031; E.W. 6/16/2010 Depo. Desig. at 12:11 – 14:14.

200. On July 20, 2005, J.W. complained of pain in his neck that was like the pain in his thigh six months before, and his grandmother took him to Nemours to see Dr. Assanasen, the oncologist who treated him previously. E.W. 6/16/2010 Depo. Desig. at 19:22 – 20:17. Dr. Assanasen suspected a recurrence of his tumor, saying the complaints of "neck pain" "were highly concerning of new disease," PX 634 at Nemours000145, and wanted to perform an imaging study, either a CT scan or an MRI, to see if the tumor had returned. PX 634 at Nemours000157.

201. At that time, J.W. was on Medicaid, and assigned to Health Ease, a Medicaid HMO. Dr. Assanasen's office sought authorization from Health Ease on July 20, 2005 to perform an imaging study, the same day Dr. Assanasen saw J.W. and the same day he ordered a neck CT. PX 634 at Nemours000145; 000157. On August 2, the request was still pending and Dr. Assanasen personally called the HMO to try to expedite authorization for the CT scan. PX 634 at Nemours000157 (8/2/2005 note at 11:45 a.m.). Authorization was still further delayed. Nemours000145 ("difficulty obtaining authorization for imaging studies"); Nemours000065 ("difficulty abtaining [sic] imaging studies"); E.W. on 6/16/2010 Depo. Desig. at 26:22-25; 31:6-19; 36:17-24; 137:2-24; 195:5-22.

202. E.W. and the rest of the family were deeply concerned. PX 634 at Nemours000157, as J.W.'s pain was getting worse. E.W. on 6/16/2010 Depo. Desig. at 27:6 – 28:15. E.W. called Dr. Assanasen's office every day to see if he had been able to obtain authorization for an imaging study. *Id.* at 27:25 – 28:15; 29:9-20. The study was finally done on August 24, about five weeks from when J.W.'s oncologist ordered an imaging study and had his staff seek authorization from the insurance company. PX 634 at Nemours000219-22. While Defendants note this was same date that his follow-up appointment had been scheduled, it appears reasonable to infer a more timely imaging study would likely have resulted in an earlier appointment and commencement of treatment.

203. The study revealed that the tumor had spread to E.W.'s neck and caused "significant bony disruption and tumor infiltration to the spinal canal." PX 634 at Nemours000143. "The site of this new lesion was highly concerning for cervical instability as well as risk of spinal cord depression if the mass was allowed to spread." PX 634 at Nemours000145. J.W. was "emergently admitted" for evaluation by both oncology and pediatrics. *Id.* The doctors began treating J.W. with chemotherapy and placed him in a Philadelphia collar to stabilize his neck. PX 634 at Nemours000149.

204. His oncologist wanted to administer the chemotherapeutic agents through an infusaport because the agents are caustic and could burn his skin, but

due to delay in receiving approval, this was not done. PX 634 at Nemours000146 ("therapeutic agents which can if extravasated into peripheral skin cause significant burns"); *id.* at Nemours000150 ("The chemotherapy was given through a peripheral vein, as we have not yet received approval from Health Ease to have a surgical consultation for Port-A-Cath placement.") The doctors began administering the chemotherapy intravenously, through a syringe in late August, so there would not be a delay. PX 634 at Nemours000149; E.W. 6/16/2010 Depo. Desig. at 57:5-15; 58:2 – 59:15; 149:8-19. The infusaport was subsequently approved by the Medicaid HMO, and installed on September 15, 2005, more than two weeks after the chemotherapy began. PX 631 at Sacred Heart000117.

205. Part of the delay in approving the imagining study apparently resulted from the fact that the Medicaid HMO had switched J.W.'s primary care provider without the knowledge or consent of E.W., who was her grandson's medical care taker. J.W.'s primary care provider was Dr. Whibbs. PX 629 at Whibbs000008; PX 630 at JW_CMS000003; E.W. 6/16/2010 Depo. Desig. at 46:16 – 47: 8. J.W. was subsequently switched to Dr. Murray, without E.W.'s knowledge or consent. E.W. 6/16/2010 Depo. Desig. at 49:23 – 50:23. E.W. had to take J.W. to see Dr. Murray, as part of the process of getting Health Ease to approve the imagining study to see if the tumor had spread to J.W.'s neck. PX 632 at Murray00001-3; E.W. 6/16/2010 Depo. Desig. at 51:21 – 52:16.

206. Dr. Middlemas practiced as a pediatrician, treating children on private insurance and Medicaid for 42 years, before recently retiring. Middlemas on 1/31/2012 Rough Tr. at 5-6. As part of his 42 years of practice, he ordered imaging studies on children at least 40 to 50 times, and also treated children with cancers and tumors. *Id.* at 65. In the later years of his practice, he worked as a clinical instructor in the family practice residency program at Tallahassee Memorial Hospital. *Id.* at 5-6.

207. I find Dr. Middlemas qualified as an expert in pediatric medicine and find his testimony credible. A child with private insurance whose physician ordered an imaging test because he suspected the child had a tumor would likely be able to obtain an imaging study within a day or two, and in no event, would have to wait more than a week. The treatment that J.W. received, waiting five weeks for a study, was below the standard of care.

208. J.W. was later switched for a second time, this time from Health Ease to straight Medicaid in about March of 2007. E.W. 6/16/2010 Depo. Desig. at 64:23 – 66:2; 67:22 – 69:3. E.W. did not request the switch and had to pay for J.W.'s psychologist herself because the psychologist would not accept straight Medicaid. *Id.*

209. E.W. later had trouble obtaining dental care for J.W. and there was a period of several months when he did not have dental care until E.W. heard about a new dental clinic at Sacred Heart Hospital. *Id.* at 74:2-24.

210. Still later, E.W. had trouble renewing J.W.'s Medicaid and had to call the 800 number to try to fix the problem. Every time she called the 800 number she had to spend two hours on hold. *Id.* at 76:16 – 77:15. J.W. was off Medicaid for about six weeks before E.W. was able to negotiate the bureaucracy and get his Medicaid renewed. *Id.* at 79:2-9. She had to pay out of pocket for J.W.'s ADHD medicine because he could not go without the mediation. Since she did not have the money her daughter paid for the medication for her. *Id.* at 80:24 – 81:25. E.W. has had repeated problems with the Medicaid application and thinks it is far more complicated than it should be. *Id.* at 199:11-19.

211. As of November 2011, J.W. was incarcerated and as a result lost eligibility for Medicaid during the period of his incarceration. Mr. Lewis on 11/29/2011 Rough Tr. at 6-7. The only reason he lost eligibility was because of his incarceration. *Id.* He is expected to be released in April 2012, when he will still be 18 years old, and should be eligible for Medicaid again. D.E. 1072 and Ex. A; Fla. R. 65 FL ADC 65A-1.703(3).

## VI. PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW AS TO PLAINTIFFS' CLAIMS

### A. Florida Medicaid Reimbursement Rates (Fee for Service)

212. AHCA is responsible for setting the reimbursement rates paid to physicians who provide Medicaid services. *See* FLA. STAT. § 409.902.

213. AHCA sets Medicaid rates for physicians' services as a fraction of Medicare rates, which are determined by the federal government. *See* PX 128A, 1/3/08 Memorandum from B. Kidder to D. Snipes; PX 685, HB 329 AHCA Bill Analysis at AHCA00755762; PX 495, Dr. Samuel Flint Report at 13-14. The "Medicare fee schedule is derived and updated through a complex process done in collaboration with . . . medical provider groups as well as health policy researchers." PX 495, Flint Report at 13. That process results in the Resource Based Relative Value System ("RBRVS"), by which all health care services are assigned a code and a total relative value based on physician work, practice expense, and malpractice expense. *See* PX 128A; PX 685 at AHCA00755762. The federal government adjusts the Medicare rates for each procedure code to account for geographical practice cost variations. *See* PX 495, Flint Report at 13. Even though the resulting Medicare rates "historically have been below private market rates[,]" they are intended to "provide current, fair relative reimbursement rates through [a] quasi-public utility model driven by production cost theory and tempered by real world data and clinician review." *Id.* at 13-14.

214. AHCA determines Florida Medicaid rates for physician services, except for certain codes that are held apart from the normal budgetary process, by

applying a conversion factor to the Medicare rates so that total expected outlays for Medicaid services fit within the program's appropriations from the Florida Legislature. *See* PX 128A; PX 685. In other words, to achieve budget-neutrality, AHCA uses a conversion factor to convert Medicare's reimbursement rates into lower rates for use in the Florida Medicaid program. As an internal State memorandum explains:

> The Agency determines physician fees using the Medicare Resource Based Relative Value System. . . . The relative value is multiplied by a conversion factor to determine the fee. The Agency for Health Care Administration calculates a conversion factor to maintain budget neutrality, unless the legislature provides additional funding for the physician services budget.

PX 128A; *see also* PX 685; Snipes on 12/9/2009 Final Tr. at 354:19 (Florida "places relative value and relative weights on certain practitioner procedures [and] utilizes those relative values and weights each year in calculating the practitioner fees."); Kidder on 5/19/2010 Final Tr. at 2490:3-23.

215. In 2008, the conversion factor was 34.0682 for Medicare, compared with just 19.6332 for Medicaid. *See* PX 128A at AHCA00981413; Snipes on 12/9/2009 Final Tr. at 357:7-23. Generally speaking, this means that Medicaid rates for children's primary care services are about 40% less than Medicare rates for comparable services, both in the fee-for-service and the managed care contexts.

*See* PX 128A; PX 495, Flint Report at 13–14 (comparing Florida Medicaid rates for primary care and specialty care services to Medicare rates).[25]

216. Dyke Snipes, a former AHCA Medicaid director testified:

> "Really, what contributes to the level that Medicaid is of Medicare is the amount of funding that's put in the program by the Florida legislature." Snipes on 12/9/2009 Final Tr. at 360:6-8.
>
> • "[T]he agency is limited to establishing the fees in accordance with the funding that we get from the Florida legislature when they pass the budget." *Id.* at 361:24 – 362:4.
> • "Q:[T]he reason that Medicaid fees are 40 percent [less than] Medicare fees is not based on a judgment that that's appropriate in terms of operating the program, it's a function of how much money the Florida legislature has put into that program, right? A: That is correct." *Id.* at 360:12-17.
> • "[T]he fees are . . . based on what's built into the budget[.]" *Id.* at 362:4.
> • "The Court: [D]o you take any other factors [other than the budget] into account in setting rates for a given year, in the aggregate? A: I believe the answer to that is probably no. If we were to do anything other than that, that would increase or decrease spending in the aggregate, then we would be out of compliance with what drives the budget." *Id.* at 364:21 – 365:2.

217. In discharging its responsibility to set physician reimbursement rates, AHCA does not consider whether the reimbursement rates are sufficient to ensure that children on Medicaid have access to health care services equal to that of other children in the general population. *See* Snipes on 12/9/2009 Final Tr. at 360:9-20; Kidder on 5/19/2010 Final Tr. at 2492:14 – 2494:19. Nor does AHCA consider

[25] Medicaid reimbursement in the context of managed care is discussed below. Most HMOs that contract with the states pay physicians at the state's Medicaid fee-for-service level at most. Flint on 8/3/2010 Final Trial Tr. at 2976:13 –2977:8.

whether the rates are sufficient to ensure that EPSDT services are made available with reasonable promptness. *Id.* In fact, in this litigation, the State repeatedly has disavowed any legal responsibility for ensuring that health care services are made available to children on Medicaid, arguing that its only duty is to cut checks with reasonable promptness when such services are rendered. *See*, *e.g.*, D.E. 548-3 (Def. Mot. for Summ. J. at 5).

218. Because AHCA does not consider the Medicaid Act's mandates when it sets physicians' fees, it has not bothered to study whether those fees are sufficient to comply with the law. *See*, *e.g.*, Snipes on 12/9/2009 Final Tr. at 360:21 – 362:23; *see also* Kidder on 5/19/10 Final Tr. at 2649:2-18 (AHCA has not conducted any studies since that referenced in a 2003 LBR stating that AHCA had "found critical shortages of Medicaid participating physicians in the state.").

219. Although certain codes for office-based and preventative health care visits are held outside the "budget neutrality" and conversion factor analysis, the overwhelming number of codes are not. *See* Williams on 10/17/2011 Rough Tr. at 133-134; Kidder on 5/19/2010 Final Tr. at 2502:5-14; DX 470. Even for those codes, trial testimony shows that current Florida reimbursement for Medicaid is substantially below the level provided for Medicare reimbursement for the same office-based services that are the most commonly billed codes. *See* Kidder on 5/19/2010 Final Tr. at 2497:16 – 2499:1.

220. The following table, reflecting undisputed testimony at trial and rates the Court has taken judicial notice of from official websites, reflects the difference for commonly based office services between current Medicaid and Medicare rates for Florida outside of the Miami and Ft. Lauderdale areas. *See* PX 781, Louis St. Petery Demonstrative Exhibit A.

| Code | Description | 2012 Medicaid Rates | 2012 Medicare Rates | Medicaid / Medicare Percentage |
|---|---|---|---|---|
| 99201 | Office/outpatient visit, new | $32.45 | $42.50 | 76% |
| 99202 | Office/outpatient visit, new | $34.01 | $72.59 | 47% |
| 99203 | Office/outpatient visit, new | $50.63 | $106.14 | 48% |
| 99204 | Office/outpatient visit, new | $71.59 | $162.74 | 44% |
| 99205 | Office/outpatient visit, new | $90.98 | $201.91 | 45% |
| 99211 | Office/outpatient visit, est | $12.48 | $19.51 | 64% |
| 99212 | Office/outpatient visit, est | $26.45 | $42.50 | 62% |
| 99213 | Office/outpatient visit, est | $32.56 | $70.65 | 46% |
| 99214 | Office/outpatient visit, est | $48.27 | $104.45 | 46% |
| 99215 | Office/outpatient visit, est | $62.68 | $140.50 | 45% |

221. Thus, for areas in Florida outside of Miami and Ft. Lauderdale, office-based services under Medicaid for primary care physicians serving children are

compensated at rates that for most codes are less than half of the Medicaid rate. *See* PX 781, Louis St. Petery Demonstrative Exhibit A.

222. The following table, reflecting undisputed testimony at trial and rates the Court has taken judicial notice of from official websites, reflects the difference for commonly based preventative services between current Medicaid and Medicare rates for Florida outside of the Miami and Ft. Lauderdale areas. *See* PX 781, Louis St. Petery Demonstrative Exhibit A.

| Code | Description | 2012 Medicaid Rates | 2012 Medicare Rates | Medicaid / Medicare Percentage |
|---|---|---|---|---|
| 99381 | Prev visit, new, infant | $71.59 | $108.07 | 66% |
| 99382 | Prev visit, new, age 1-4 | $71.59 | $112.59 | 64% |
| 99383 | Prev visit, new, age 5-11 | $71.59 | $116.85 | 61% |
| 99384 | Prev visit, new, age 12-17 | $71.59 | $132.28 | 54% |
| 99385 | Prev visit, new, age 18-39 | $71.59 | $128.90 | 56% |
| 99391 | Prev visit, est, infant | $71.59 | $96.20 | 74% |
| 99392 | Prev visit, est, age 1-4 | $71.59 | $103.13 | 69% |
| 99393 | Prev visit, est, age 5-11 | $71.59 | $102.80 | 70% |
| 99394 | Prev visit, est, age 12-17 | $71.59 | $112.24 | 64% |

| Code | Description | 2012 Medicaid Rates | 2012 Medicare Rates | Medicaid / Medicare Percentage |
|---|---|---|---|---|
| 99395 | Prev visit, est, age 18-39 | $71.59 | $114.60 | 62% |

223. The cost of living adjustments to Miami and Ft. Lauderdale Medicare rates are higher in those areas, whereas Medicaid reimbursement is the same statewide. Thus, the differential between Medicaid and Medicare reimbursement is greater in the Miami and Ft. Lauderdale areas, with Medicaid paying an even lower percentage of Medicare reimbursement. *See* PX 780 (Medicare Rates); PX 781 (Medicaid Rates).

224. Medicaid reimbursement in Florida is even further below levels of private reimbursement programs. Andrew Agwunobi, former secretary of AHCA acknowledged that "one thing is very clear: [p]roviders are in general underpaid in contrast to commercial insurance and Medicaid." PX 126a at 6. A number of primary care providers testified that Medicaid reimbursement is substantially below private insurer reimbursement for the same procedures in the same geographical areas. *See* Schechtman on 5/20/2010 Final Tr. at 2867:19 – 2868:3 (one of the largest pediatric practices in Palm Beach County); Schechtman on 10/19/2010 Final Tr. at 4439:14 – 4440:22 (CPT codes 99213 and 99214 account for approximately 25% of his practice and are compensated at 55-60% of commercial insurance rates); *id.* at 4444:24 – 4446:15 (numerous ancillary services

billable under commercial insurance are not reimbursed or billable under Medicaid, up to $115 vs. $20 for Medicaid); Cosgrove on 1/31/2012 Rough Trial Tr. at 138. (For CPT code 99213 "Medicaid pays 32.56. The Medicaid HMO, Well Care, pays 35.82; Health First, which is a local HMO pays $80.13; CIGNA pays 58.60; Blue Cross/Blue Shield PPO pays 82.87; and Aetna pays 51.63.") *Id.* at 140 (for CPT code 99383 "Medicaid pays $71.59; the Medicaid HMO Well Care pace 78.75; Health First pace 122.67; CIGNA pays $93.15; Blue Cross/Blue Shield PPO pays 121.14; Aetna pays 105.42."); Nancy Silva on 5/20/2010 Final Tr. at 2826:7-10 (makes less than commercial insurance every time she sees a Medicaid patient); Jerome Isaacs on 8/11/2010 Final Tr. at 3856:16 – 3858:11 (two largest commercial insurance carriers in his practice pay from 50% more to double what Medicaid pays for four most common non CHCUP CPT codes); *Id.* at 3858:12 – 3861:4 (commercial insurance pays 20% more for CHCUP codes plus $40 to $50 for additional components that Medicaid does not pay for); Louis St. Petery on 2/2/2012 Rough Tr. at 48-52 (detailing rate differential for primary care physicians between commercial insurance and Medicaid for common CPT codes, commercial rates ranged from 160 to 289% of Medicaid rates.)

225. The difference between Medicaid reimbursement and private reimbursement is also true for specialists. *See* Postma on 8/4/2010 Final Tr. at 3193:9 – 3195:5; PX 144 (Medicaid reimbursement less than half of private

reimbursement for top 25 ENT procedures that generate 90-99% of revenue); Adam Fenichel on 10/18/2010 Final Tr. at 4340:7-13 (commercial insurance pays about 30% of standard charge rate where Medicaid pays less than 10%); Ricardo Ayala on 8/9/201 Final Tr. at 3587:2-24 (for the six CPT codes that make up bulk of his practice commercial insurance pays more than Medicare, which pays more than Medicaid); Brett Baynham on 1/24/2012 Rough Tr. at 11 (Medicaid reimburses at 55 to 65% of Medicare rates, while commercial insurers generally range from 110 to 150% of Medicare rates); Louis St. Petery on 2/2/2012 Rough Tr. at 48-52 (detailing rate differential for specialists between commercial insurance and Medicaid for common CPT codes, commercial rates ranged from 129 to 233% of Medicaid rates, most exceeded 200%).

226. Primary care fees were increased in 2000 by a total of $1.8 million for 3 office visit codes; in 2002, the Florida legislature authorized a 4% increase for all providers treating children. No other increases for primary care providers for children have occurred since 2000.[26] PX 128A. Rather, in October of 2008, the legislature cut by one-third from $3 to $2, the monthly per child fee paid primary care providers participating in the MediPass system for managing the care

[26] Minor budget neutral changes have been made, both increases and decreases, in reimbursement rates for individual codes based on the annual Resources Based Relative Value System adjustments.

provided to children on Medicaid. St. Petery on 12/10/2009 Final Tr. at 625:11-15; Williams on 10/17/2011 Rough Tr. at 141.

227. Certain specialists received an increase in 2004 of 24% for treating children on Medicaid. *See* PX 128A – this is the only adjustment in nearly 10 years –and leaves specialist reimbursement substantially below the current Medicare levels for office-based services, as reflected on the following table:

| Code | Description | 2012 Medicaid Specialist Rates | 2012 Medicare Rates | Medicaid/ Medicare Percentage for Specialists |
|---|---|---|---|---|
| 99201 | Office/outpatient visit, new | $40.24 | $42.50 | 95% |
| 99202 | Office/outpatient visit, new | $42.17 | $72.59 | 58% |
| 99203 | Office/outpatient visit, new | $62.78 | $106.14 | 59% |
| 99204 | Office/outpatient visit, new | $88.77 | $162.74 | 55% |
| 99205 | Office/outpatient visit, new | $112.82 | $201.91 | 56% |
| 99211 | Office/outpatient visit, est | $15.48 | $19.51 | 79% |
| 99212 | Office/outpatient visit, est | $32.80 | $42.50 | 77% |
| 99213 | Office/outpatient visit, est | $40.37 | $70.65 | 57% |
| 99214 | Office/outpatient visit, est | $59.85 | $104.45 | 57% |
| 99215 | Office/outpatient visit, est | $77.72 | $140.50 | 55% |

PX 780; PX 781; *see also* St. Petery Demonstrative Exhibit B.

228. The difference between Medicaid reimbursement levels and those for Medicare will likely increase in coming years as Medicare reimbursement accounts for cost-of-living changes whereas Florida's Medicaid program does not. *See* Williams on 10/17/2011 Rough Tr. at 131.

229. Florida's Medicaid reimbursement level was in the lowest quintile of states in the United States as of 2003, and given the lack of increases since that time, they have declined further relative to other states. Flint on 8/5/2010 Final Tr. at 3521:2-20.

230. The inadequacy of Florida's reimbursement for Medicaid providers has been acknowledged by AHCA in a series of legislative budget requests proposed over a number of years to the Florida legislature. These legislative budget requests included both the need for an increase in the compensation paid for healthy kid check-ups as well as for specialist care. As explained by Dyke Snipes, the agency singled out 4 specialty areas (dermatologists, neurologists, neurosurgeons, and orthopedists) for modest fee increases, not because these were the only areas in which an increase was needed, but in hopes that a modest request would be more politically acceptable. Notwithstanding this approach, and the fact that requests were renewed annually for a number of years, and were at the top of the legislative priority list for AHCA proposals, none of these proposed increases was enacted. The legislative budget proposals from AHCA made in each

legislative year from the 2005-2006 legislative session through the 2009-2010 legislative session called for an increase in child-health check-up fees. PX 92-96; PX 702-703; PX 734. In addition, AHCA proposed increases in 2008-2009 and 2009-2010 budgets for a 40% increase for four specialty areas. Those, too, were rejected each year. PX 89-90; PX 727; Snipes on 12/9/2009 Final Tr. at 405:21 – 406:14. Finally, a $2 fee proposal made to incent physicians to collect lead blood specimens also was made but failed to pass each year for each legislative year from 2005-2006 through 2009-2010. PX 97-98; PX 704-705.

231. The Defendants, and certain of their witnesses, claim that these legislative budget requests were predicated on exaggerated and inaccurate information. *See* Williams on 10/17/2011 Rough Tr. at 163-164; Kidder on 10/3/2011 Rough Tr. at 77. The Court finds these explanations advanced at trial unpersuasive. The legislative budget requests were prepared by officials who recognized their obligation to be accurate and honest in presenting the views of their agency to the governor and the legislature. Moreover, these very witnesses had admitted under oath as agency representative witnesses during deposition that the legislative budget requests were truthful and correct. Finally, the asserted inaccuracies in the requests are in the nature of certain relationships between fee levels and usage being overly simplistic or that certain data was not updated. Neither of these alleged inaccuracies challenges the conclusion that the agency

itself – out of court – acknowledged regarding the importance of reimbursement increases, repeatedly in submissions to the legislature. As former Medicaid Director Snipes acknowledged, these requests were indicative not of simply wanting to pay doctors more but of a substantial problem in current reimbursement levels. Snipes on 12/9/2009 Final Tr. at 380:4 – 381:10; Snipes on 1/8/2010 Final Tr. at 1243:6-23; *see also* PX 701; PX 727. I agree and find these submissions to the legislature to be tantamount to admissions by defendants that the current level of primary and specialist reimbursement for Florida Medicaid is inadequate. Inadequate. *See also Cockrum v. Califano*, 475 F. Supp. 1222, 1227 n. 1 (D.D.C. 1979) (Secretary of Health, Education and Welfare estopped from asserting claimants responsibility for delays in administrative hearings by his admissions elsewhere that the delay problem was nationwide in scope.)

232. Based on this data, expert testimony at trial competently supported the proposition that the Florida Medicaid reimbursements levels are not sufficient for Florida Medicaid to be a competitive purchaser for medical services. Dr. Samuel Flint – an Assistant Professor of Public Affairs at Indiana University Northwest who has published extensively on health economics – studied the health care market in Florida and concluded that "the Florida Medicaid program is not a competitive purchaser for pediatric care at this time." PX 495, Flint Report at 20; *see also id.* at 2.

233. Prof. Flint measured the difference in 2008 rates between Medicaid and Medicare for common office based procedure codes and concluded: "Florida Medicaid reimburses primary care physicians at slightly more than one-half of what Medicare pays, and specialists receive about two-thirds of Medicare rates." *Id.* at 2; *see* also PX 782. This is a straight-forward comparison that the Court finds essentially undisputed.

234. Defendants noted correctly that Prof Flint could have compared the rates for Medicare for EPSDT codes, even though Medicare does not actually compensate for such services. While the constructed Medicare reimbursement for such EPSDT services is less than the differential for office-based non preventative care visits, the difference for current rates is still substantial. For 2012, Medicaid reimbursement for such procedures measured against Medicare – constructed reimbursement levels ranges from 51 to 74% of the Medicare reimbursement levels. PX 783; *see also* PX 782 (2008 comparison); St. Petery on 2/2/2012 Rough Trial Tr. at 38-42.

235. Dr. Flint also compared Florida Medicaid rates against cost measures, finding that "a primary care practice comprised of 75% Medicaid patients could not remain solvent, even if the physician worked for free." PX 495, Flint Report at 19.

236. Defendants' expert witness Catherine Sreckovich admittedly did not conduct any analysis of the adequacy of Florida reimbursement rates. Sreckovich on 1/10/2012 Rough Tr. at 140-141.

237. Based on the evidence at trial, I find that Florida's Medicaid program has not compensated primary physicians or specialists at a competitive rate as compared with either that of Medicare or private insurance payors.

238. I further find that Florida's structure for setting physician reimbursement does not seek to account for any of the statutorily mandated factors in the Medicaid Act, such as the level of compensation needed to assure an adequate supply of physicians so as to discharge the mandate to provide EPSDT services or set rates at a level that will promote quality of care, let alone equal access to care as required under 42 U.S.C. § 1396a(a)(30)(A). Indeed, on the contrary, except for certain codes held outside the normal budgetary process, Florida's conversion ratio and budget-neutrality mandates results in artificially setting rates for many services without any consideration of the costs incurred by physicians or what is needed for even a minimally competitive rate or a rate sufficient to attract medical providers.

239. Defendants argue that it is not necessary for states to conduct studies in order to set rates in accordance with Section 30(A)'s Equal Access requirements. Whether or not studies are required, it is clear that a system which

mandates budget neutrality as the determining factor in rate-setting, and takes no consideration of the factors required by federal law, cannot be squared with federal law. The Eleventh Circuit's statement in *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, supra 109 F. 3d at 704 is applicable here:

> "Defendant AHCA seems to concede that budgetary constraints and the failure of the Legislature to adopt a provision for inappropriate level of care services, have left it incapable of compensating Plaintiffs for medically necessary outpatient psychiatric services provided in an in-patient setting. However, as the Tenth Circuit has held:
>
> > While budgetary constraints may be a factor to be considered by a state when amending a current plan, implementing a new plan, or making the annually mandated findings, budgetary constraints alone can never be sufficient. *Illinois Hosp. Ass'n [v. Illinois Dept of Public Aid*, 576 F. Supp. 360, 368 (N.D. Ill. 1983).] If a state could evade the requirements of the [Medicaid] [**36] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the Congressionally imposed standards at will. *Alabama Nursing Home Ass'n v. Califano*, 433 F. Supp. 1325, 1330 (M.D. Ala. 1977), *rev'd and vacated in part on other grounds, sub nom.*, 617 F.2d 388 (5th Cir. 1980).
>
> *AMISUB (PSL), Inc. v. Colo. Dept. of Social Serv.*, 879 F.2d 789, 800-01 (10th Cir. 1989), cert. denied, 496 U.S. 935, 110 S. Ct. 3212, 110 L. Ed. 2d 660 (1990). Yet this is precisely what the State of Florida has attempted to do in the case at bar."

240. Even for those codes set by statute outside the normal budgetary process, there is no process for evaluating the sufficiency of those rates to attract a sufficient supply of primary and specialist physicians to treat Medicaid children. There also is no process to adjust those rates for increases in the cost of living.

Factually, while the Medical cost of living index has increased over the past decade, there has not been any commensurate increase in Medicaid reimbursement, and accordingly the gap between Medicaid reimbursement and that of Medicare has widened for most codes, and will continue to do so.

**B. Newborns, Continuous Eligibility and Switching**

1. Continuous Eligibility

241. Florida must provide children under the age of five with 12 months of continuous eligibility and children between the ages of 5 and 18 with six months of continuous eligibility. PX 712 at FL-MED 08336. Children should not lose eligibility within that period unless they move out of the state or die. Lewis on 10/20/2010 Final Tr. at 4654:10 – 4655:4. Every time a child is determined or re-determined to be eligible for Medicaid, a new period of continuous eligibility starts. *Id.* at 4661:11 – 4662:1.

242. The undisputed evidence shows that thousands of children lose their eligibility in their first year of life in violation of their right to continuous eligibility.

243. Defendants' expert, Ms. Sreckovich, indicates in her initial report that between 2004 and 2008 the Medicaid eligibility of children under one year of age for Medicaid was terminated 2.1% to 2.9% of the time and for children one to five years of age, their eligibility was terminated 6.8 % to 7.0 % of the time. DX 607 at

¶ 22. These numbers reflected only children whose eligibility was terminated and subsequently reinstated during a single fiscal year. Sreckovich on 1/12/2012 Rough Tr. at 96-97. In the case of the children aged one to five this would be approximately a total of 65,000 children in the course of a year. *Id.* at 93-96. Those figures are an underestimate since, among other reasons, they exclude children who never regained eligibility. St. Petery on 2/2/2012 Rough Tr. at 75-76.

244. Because those children had their eligibility reinstated, they could not have died or moved out of the state. Sreckovich on 1/12/2012 Rough Tr. at 97. Ms. Sreckovich acknowledged that for children under one all those terminations were improper. *Id.* at 98. (She also acknowledged that for older children some of those terminations were improper. *Id.* at 97-98.) That means, based on the range of improper terminations (2.1 to 2.9%) and the number of children enrolled in Medicaid, from 3,234 to 4,466 children were improperly terminated in one fiscal year in violation of their right to continuous eligibility. *Id.* at 98-99. Ms. Sreckovich acknowledged those children were wrongfully terminated. *Id.* Dr. St. Petery pointed out that Ms. Sreckovich's own report demonstrates that many thousands of Florida children under five years of age had their eligibility terminated and then restored when they should have had continuous eligibility. St. Petery on 2/02/2012 Rough Tr. at 73-76.

245. DCF acknowledged that for each federal fiscal year from 2003 to 2007, at least 25,000 (and sometimes more than 31,000) children under five years of age had their eligibility terminated before they had received 12 months of continuous eligibility. PX 737 at answer to Interrogatory No. 1. By DCF's own admission, the percentage of children under five enrolled in Medicaid whose Medicaid eligibility was terminated ranged each year from less than 3.5% to less than 5%. *Id.* Those figures are an underestimate. They do not include children whose eligibility was retroactively restored making it seem as if they had not lost eligibility, and so understates the number of improper terminations. St. Petery on 12/10/2009 Final Tr. at 593:19 – 594:19; PX 688. Those figures, even if an underestimate, quantify the minimum number of children wrongfully terminated. St. Petery on 2/2/2012 Rough Tr. at 74-75.

246. DCF officials have acknowledged a "tremendous problem with the issue of maintaining continuous eligibility" and "that the problem was that [DCF's] eligibility system does not automatically know what period of continuous eligibility a child" is entitled to so that "it is dependent on staff, when they're ready to close a Medicaid case that involves children, that there's a child inside who may be entitled to continuous period of eligibility and should not be terminated." Lewis on 10/20/2010 Final Tr. at 4656: 2-4; 4657:18 – 4658:22. Mr. Lewis acknowledged at trial: "That problem continues to this day." *Id.* at 4658:23-24.

247. DCF conducted a Medicaid eligibility quality control analysis study in 2010 for federal CMS, and reported, in a Sept. 20, 2010 letter to the acting regional administrator of CMS, that based on a review of 1200 cases, that there were 7% of the cases "in which the Medicaid coverage was not provided through the entitlement period." DX 169a at 2; Lewis on 10/20/2010 Final Tr. at 4660:24 – 4664:8. Mr. Lewis conceded that is not an "acceptable" error rate. Lewis on 11/29/2011 Rough Tr. at 16-17. Among the reasons for these "incorrect actions" were closing a Medicaid category without simultaneously opening the new Medicaid category. Lewis on 10/20/2010 Final Tr. at 4666:14-25.

248. As part of the same analysis sent to federal CMS, DCF also looked more generally at whether or not there had been wrongful denials of coverage or terminations and found that twenty percent of the terminations of both children and adults were in error. DX 169a at 3-4; Lewis on 10/20/2010 Final Tr. at 4667:16-25, 4671:1-12. Mr. Lewis knew of no reason why the percentage of termination for adults or children would differ. *Id.* at 4671:13-18.

249. DCF states it has been trying since 2002 to fix the problems that cause some children to be terminated in violation of their rights to continuous eligibility. Poirier on 10/5/2011 Rough Tr. at 71-72. For years, DCF has been considering implementing a computerized system for monitoring continuous eligibility of Medicaid Children, but has not done so–even though there's no technical problem

that would prevent DCF from instituting an automatic system for ensuring continuous eligibility. Lewis on 10/21/2010 Final Tr. at 4800:10 – 4801:15.

250. DCF officials have repeatedly acknowledged the young infants are sometimes improperly terminated. A DCF employee acknowledged receiving "a string of inquiries" from Carol McCormick of the Tallahassee Pediatric Foundation concerning "newborns being cut from their Medicaid coverage too soon." PX 345 at L-STP-R 000496. The DCF worker told her colleagues, "Each one that I have looked into was just that." *Id.* She said she had received about 32 such inquiries in the last two months. *Id.*; *see also* McCormick on 8/12/2010 Final Tr. at 4123:13 – 4125:19. Another DCF official admitted to Dr. St. Petery that it was not uncommon that DCF case workers would inadvertently terminate a child's eligibility when the mother's pregnancy Medicaid terminated. St. Petery on 12/10/2009 Final Tr. at 572:18 –573:10.

251. Dr. St. Petery is the executive director of Tallahassee Pediatric Foundation (TPF), which has access to FMMIS print screens which provide certain information regarding a child's eligibility and assignment to a primary care provider. St. Petery on 12/10/2009 Final Tr. at 554:19 – 555:10. Dr. St. Petery has personally seen cases of improper termination of continuous eligibility with patients of TPF by studying those patients' FMMIS print screens from which he

could tell their eligibility had been incorrectly terminated and then restored retroactively. *Id.* at 555:1-21, 575:18 – 576:11.

252. Primary care providers regularly see children who lose their Medicaid eligibility in their first year of life. Cosgrove on 5/19/2010 Final Tr. at 2586:16 – 2587:10; Silva on 5/20/2010 Final Tr. at 2804:10 – 2805:9; J. St. Petery Depo. Desig. on 11/11/2008 at 194:6-13; J. Ritrosky, Depo. Desig. on 11/10/2008 at 97:4 – 98:2, 98:15 – 99:25.

253. When a child's Medicaid eligibility is incorrectly terminated, the physician to whom the child presents has the choice of treating the patient and likely not get paid (unless eligibility is retroactively restored, the physician's office finds out about it, and incurs the expense of resubmitting its prior bill) or not treating the child. St. Petery on 12/10/2010 Final Tr. at 594:20 – 596:6.

2. Switching

254. "Switching' is the situation when a child appears at a pediatrician's office for care, the pediatrician queries the Medicaid system and determines that the child, without the parent's knowledge or consent, and without the physician's office previous knowledge, has been switched to a different Medicaid plan from the one the child was on previously, frequently a plan for which that physician is not a provider." St. Petery on 12/10/2009 Final Tr. at 548:13-19. As explained below, improper termination is a common cause of switching.

255. When patients are switched they are most frequently switched from Medipass to a Medicaid HMO, but they can also be switched from one provider to another within the same program. *Id.* at 549:25 – 550:5. "Switching most commonly comes to light when the parent brings her child to a physician and is told, 'Sorry, you can't come here today; it looks like Medicaid has changed you to another provider, another plan, and you have to go there.'" *Id.* at 550:7-10. The physician finds out that a child has been switched to another provider by checking the Florida Medicaid Management Information System (FMMIS) to make sure the child is eligible for Medicaid and that the physician will be reimbursed by Medicaid for treating that child. *Id.* at 550:11-24. Typically, the parent of the child does not realize the child has been switched until the doctor's office informs them. *Id.* at 554:5-18.

256. When a child is switched, the physician's office has the choice of seeing the child and risk not getting paid or declining to see the child until or unless the child is switched back. *Id.* at 556:11 – 557:15. "Many times the provider's staff spends a lot of time trying to fix the problem so that the child can come back to their practice." *Id.* at 558:1-4. A primary care doctor from whom a child has been switched no longer can authorize a referral for further care, even for an x-ray. *Id.* at 559:6 – 560:9. Generally, if a child has been switched to an HMO,

the HMO will not pay the physician to whom the child was previously assigned. *Id.* at 558:5-19.

257. Switching is an obstacle to Medicaid children's accessing care. *Id.* at 560:18-20. Because switching moves children from one medical home to another, it interferes with continuity of care, and may delay care and can lead to children not receiving care at all. *Id.* at 560:23 – 561:10. Switching does not occur with privately-insured patients. *Id.* at 561:1-6.

258. Switching is not a new problem. Dr. St. Petery has been complaining to ACHA and DCF about switching for 20-25 years, but the problem still continues. *Id.* at 572:7-19.

259. Robert Sharpe was ACHA Medicaid Director from 2000 to 2004 and assistant Medicaid Director 1998-2000. Sharpe on 11/16/10 Final Tr. at 4926:19 – 4927:2; 4929:24 – 4930:8. Dr. St. Petery met with him on multiple occasions to discuss switching. *Id.* at 4932:22 – 4933:2. Mr. Sharpe had his staff investigate cases brought to him by Dr. St. Petery and they determined that the children were indeed switched without the parent requesting a change of provider. *Id.* at 4933:2:2 – 4933:12.

260. Phyllis Sloyer, then assistant director of CMS, also complained to Mr. Sharpe about switching and how it affected continuity of care for children in the CMS program. *Id.* at 4933:13 – 4935: 9. Mr. Sharpe was not able to eliminate

switching, which remained a problem during his entire tenure as deputy secretary of Medicaid. *Id.* at 4935:10-15; 4936:13-15.

3. Evidence of switching

261. Several of the named plaintiffs in this case were switched – S.B, K.K. J.W. – some multiple times, and their switching lead to delayed or interrupted care. For S.B. his 18-month check-up was delayed. Because K.K. was switched, he had to change from Vyvance, an ADHD drug that was working for him, to Adderall, one that was not. In J.W.'s case, on one occasion switching contributed to a five-week delay in performing an imaging study to see if a tumor had reappeared on his neck, and in another, it caused his family to have to pay out of pocket for his ADHD medication. *See supra* at 208.

262. Testimony at trial showed that switching is a regular occurrence for primary care providers. Dr. Lisa Cosgrove is a primary care physician who practices in Merritt Island, Florida which is in Brevard County. Cosgrove on 05/19/2010 Final Tr. at 2550:8-9, 2552:15-25. Dr. Cosgrove's Medicaid patients are switched to other plans on a "regular basis"; it occurs on a daily basis. *Id.* at 2575:16 – 2577:19. Some of Cosgrove's patients who get switched end up in the emergency room. *Id.* at 2579:1-4, 2580:14-20. Switching interferes with continuity of care. *Id.* at 2581:15 – 2582:13. Switching also consumes time of

office staff who try to assist patients in getting switched back to her practice, for which there is no compensation. *Id.* at 2583:13 – 2584:5.

263. Nancy Silva is a pediatrician who practices in Brandon, Florida. Silva on 5/20/2010 Final Tr. at 2767:19-21; 2768:1-2. Dr. Silva's Medicaid patients are switched "all the time" from one primary care provider to another and one insurer to another. *Id.* at 2796:11-21. Seldom does the primary care doctor to whom the patient has been switched give authorization to Dr. Silva's office to see the child unless there is an acute significant illness. Without authorization for a child no longer assigned to Dr. Silva, she cannot get paid for any care provided. *Id.* at 2798:16 – 2799: 3. Switching interferes with continuity of care. *Id.* at 2799:4-20. Switching results in lost staff time for pediatricians and is a deterrent to participating in Medicaid. *Id.* at 2799:21 – 2800:11. It takes approximately six weeks to get a Medicaid child who has been switched to another provider reassigned to her practice. Silva on 1/19/2012 Rough Tr. at 147-48.

264. Jerome Isaac is a pediatrician who practices in Sarasota and Bradenton. Isaac on 8/11/2010 Final Tr. at 3852:13-14; 3853:20-21. Dr. Isaac's Medicaid patients are sometimes switched away from his practice. *Id.* at 3894:12-20. Generally, after a couple of months they return to his practice after getting switched back. *Id.* at 3895:8-25. Switching generally leads to delayed care. *Id.* at 3896:15-24.

265. Dr. Delores Falcone Tamer is a pediatric cardiologist at the University of Miami Medical School. Tamer on 10/19/2010 Final Tr. at 4494:13-23. Dr. Tamer currently has a CMS clinic, a private clinic and a clinic for the Jackson Memorial Hospital. *Id.* at 4496:8 – 4497:5. Dr. Tamer becomes aware of switching when, in checking the authorization of the primary care doctor to refer a patient to her, it turns out that primary care doctor no longer has authority to refer because the child has been switched to a different primary care doctor. *Id.* at 4531:9-18; 4532:21 – 4533:13. When such switching occurs, it usually means the procedures are postponed a month. *Id.* at 4533:14-17. Common diagnostic tests that are delayed for a month by switching are: echocardiograms and electrocardiograms which test the competency, anatomy and function of the heart. *Id.* at 4533:25 – 4434:12.

266. Dr. Thomas Schechtman is a pediatrician who practices at three offices in Palm Beach County: Palm Beach Gardens, Jupiter and Boca. Schechtman on 5/20/2010 Final Tr. at 2832:8-13; 2833:7-14; 2833:18-22. Quite frequently in Dr. Schechtman's practice Medicaid patients are, without their knowledge, switched from one primary care provider to another or from one Medicaid product to another. *Id.* at 2847:6-20. The frequency of switching in Dr. Schechtman's practice is several times a day and he has a "person in his business office who spends 50% of her time dealing with Medicaid eligibility, Medicaid

switching and issues along those lines." *Id.* at 2847:21 – 2848:4. Switching causes a number of adverse consequences on the health and well-being of the child being switched including: interrupting continuity of care and delaying check-ups and vaccinations. *Id.* at 2848:5 – 2849:8.

267. Other doctors regularly encounter switching as well. Donaldson Depo. Desig. on 10/15/2008 at 140:9 – 141:4; Knappenberger Depo. Designation on 11/20/2008 at 93:8 –94:12, 95:4-6; Ritrosky, Depo. Designation on 11/10/2008 at 97:4 – 98:2, 98:15 – 99:25; Weber Depo. Desig. on 11/6/2008 at 24:22 – 25:2; J. St. Petery Depo. Desig. on 11/11/2008 at 81:19 – 82:1; 84:22 – 85:7; W. Knappenberger Depo. Desig. on 11/20/2008 at 95:23 – 96:7, 116:15 – 117:1; Ritrosky, Depo. Desig. on 11/10/2008 at 105:5 – 106:22, 107:7-11; Knappenberger Depo. Desig. on 11/20/2008 at 115:20 – 16:9; J. St. Petery Depo. Desig. on 11/11/2008 at 104:9 – 105:21; Knappenberger Depo. Desig. on 11/20/2008 at 117:5-21; Ritrosky, Depo. Desig. on 11/10/2008 at 103:12-14, 107:16-18.

268. In the practice Dr. Louis St. Petery shares with his wife, switching is "almost an everyday occurrence." St. Petery on 12/10/2009 Final Tr. at 561:11 – 562:5; Dr. Julia St. Petery Depo. Desig. on 11/11/2008 at 108:2-12. Dr. Louis St. Petery has since 1984 served as executive director of the Tallahassee Pediatric Foundation ("TPF"). St. Petery on 12/07/2009 Final Tr. at 88:9-14. TPF provides

case management services to 7,200 children in the Tallahassee area, the vast majority of whom are enrolled in Medicaid. *Id.* at 89:15 – 89:20. Dr. St. Petery sees switching occurring with the 7,000 plus patients of TPF in even larger numbers than in his personal practice. St. Petery on 12/10/2009 Final Tr. at 561:24 – 562:5.

269. Getting a child switched back to the original primary care provider can be a time-consuming process because the system only allows a change once a month. *Id.* at 562:14 – 563:15.

4. Reasons for Switching

270. Switching is caused by a termination of eligibility and a subsequent reinstatement.

271. One way switching occurs is when DCF (the Department of Children and Families), which determines eligibility, incorrectly terminates a child's eligibility and then, realizing the error, re-establishes the child's eligibility. Since eligibility information is transported nightly from DCF's computer to ACHA's FMMIS computer system, these actions cause ACHA's FMMIS system to send a letter to the child's parent, as it does to any new Medicaid beneficiary, telling the parent that he or she must chose a plan for the child. Sometimes the parents do not receive the letters because as many as 40% of the letters directing Medicaid beneficiaries to choose a managed care plan come back as undeliverable. Brown-

Woofter on 11/8/2011 Rough Tr. at 149-151. At least in some instances when ACHA investigated examples of switching, it was not able to confirm that a choice letter was indeed sent the beneficiary. Depo. Desig. of Hamilton on 11/6/2008 at 184:9 – 186:12. Sometimes the parents do not understand the letter, perhaps because the parent does not even know the child was terminated and reinstated. St. Petery on 12/10/2009 Final Tr. at 565:10 – 566:6. In either event, the parent does not respond. So when AHCA does not hear back from the child's parent with a plan choice within the allotted time, ACHA then auto-assigns the child to a plan. Brown-Woofter on 11/8/2011 Rough Tr. at 148. By statute, 65% of auto-assignments are to Medicaid HMOs so the child is auto-assigned to an HMO which may not be a plan in which the child's pediatrician is enrolled. St. Petery on 12/10/2009 Final Tr. at 570:1-25; Plaintiffs' Demonstrative Exhibit C on Switching used with Dr. St. Petery.

272. There are multiple eligibility categories for children on Medicaid. Lewis on 10/20/2010 Final Tr. at 4649: 8-10. When a parent makes a change in the family's case "such as applying for food stamps or cash assistance, this can also cause switching". St. Petery on Final Tr. at 571:3-18. This occurs because when DCF makes such a change, even though the child does not lose Medicaid eligibility in DCF's computer system, it sometimes loses eligibility in AHCA's FEMMIS system.

273. During the course of this litigation, DCF discovered that when it deletes the Medicaid eligibility category code for a child and places the child in a new eligibility category, ACHA sometimes interpreted that change as a termination of the child's Medicaid eligibility, even though the second Medicaid category picked up immediately after the first category was terminated. Lewis on 10/20/2010 Final Tr. at 4645:15 – 4646:22. To avoid that situation, instructions were given to DCF case workers to close an old category and open a new category the same time so that ACHA wouldn't confuse a category change with an eligibility termination. Lewis on 10/20/2010 Final Tr. at 4646:23 – 4647:6. That advice was memorialized in a 2009 Memorandum called Minimizing Medicaid File Errors, sent by Mr. Lewis to DCF staff. DX 178 at DEFENDANTS015019 (re Changing Assistance Groups"); DX 175 at 3 (second to last bullet); Lewis on 10/20/2010 Final Tr. at 4653:24 – 4654:6. In fact, DCF not only learned how changes in eligibility categories in its FLORIDA computer system could affect a child's Medicaid eligibility in ACHA's FMMIS system during this litigation, it learned that ***because of*** this litigation. Lewis on 11/29/2011 Rough Tr. at 12-13.

274. DCF has not taken any steps to measure what impact the April 29, 2009 directive in PX 178 has had on "switching." Lewis on 10/20/2010 Final Tr. at 4654:7-9.

275. Switching is related to interruption of eligibility because every time eligibility is interrupted and restored, the patient is required to request a plan and if the patient doesn't, a switch may occur. McCormick on 8/12/2010 Final Tr. at 4148:3 – 4149:14. Switching can occur even following a proper termination and subsequent reinstatement if parents or guardians do not receive or respond to the letter directing them to choose a plan for their child.

276. The requirement that children whose eligibility has been terminated and then within 60 days reinstated are to be assigned back to the plan they originally chose is not always followed, leading to more "switching." McCormick on 8/12/2010 Final Tr. at 4148:3 – 4149:14.

5. Baby Of Process

277. A "presumptively eligible" newborn or PEN baby is a child whose Medicaid eligibility is presumed by DCF based on the pregnant mother's Medicaid eligibility. Lewis on 10/20/2010 Final Tr. at 4650:12-21. The purpose of "presumptive eligibility," also known as the "baby of" process, is to make a child eligible for Medicaid as soon as possible. St. Petery on 12/10/2009 Final Tr. at 602:3-15. It is called the "baby of" process because it describes the practice of a pregnant mother applying to DCF for a Medicaid number for her unborn child. *Id.* at 601:1-11. And when the child is born, the Medicaid number is supposed to be activated. *Id.* at 602:16 – 603:1.

278. Dr. St. Petery has observed three problems with the "baby of" process; (1) the mother is not provided with the opportunity to register in the first place; (2) even if the mother pre-registers, there are delays in activating the child's Medicaid number; and (3) children are sometimes issued two Medicaid numbers which later becomes problematic because, when DCF realizes there are two numbers, it cancels one number and if that is the one the physician has been using, all the services billed are denied even though the child is actually eligible. *Id.* at 603:2-25.

279. Since, under the applicable periodicity schedule, children are supposed to have a visit when they are five days old, the failure of the DCF promptly to activate the child's Medicaid eligibility can cause a delay in the child obtaining care or in the provider getting paid. *Id.* at 604:1-14; 605:19-22. Primary care providers find that the activation process for PEN babies is often delayed. Isaac on 8/11/2010 Final Tr. at 3892:16 – 3893:24; Schechtman on 5/20/2010 Final Tr. at 2849:9 – 2850: 7. Cosgrove on Final Tr. on 5/19/2010 at 2584:6 – 2586:15.

280. Carol McCormick is the administrator and nursing director of TPF. McCormick on 8/12/2010 Final Tr. at 4110:9-19. TPF had about 7,400 children enrolled at the time of her testimony of which 7,300 were enrolled in Medicaid. *Id*. at 4114:22-25. Nurse case managers at TPF frequently encounter newborns presumptively eligible for Medicaid whose Medicaid is not activated and where

children's eligibility has been terminated in less than a year's time. *Id.* at 4118:8-24. In the fall of 2008, when a subpoena for documents was served on TPF, Ms. McCormick instructed her staff to provide her with all the charts of children that the nurses were then currently experiencing eligibility problems with. In response to this request, 90 charts were provided to her. *Id.* at 4120:8 – 4121:20. Twenty-four of those charts involved an issue of continuous eligibility, 15 concerned presumptive eligibility, and 47 were cases in which the parent's choice of health care plan had not been implemented or had been switched; 20 files with other problems. *Id.* at 4121:21 – 4122: 25. Some files reflected more than one problem. *Id*. at 4123:1-5.

281. Until 2008, under the Baby Of process, a mother and her baby each had a separate personal identification number and also a separate case number. In 2008, DCF reprogrammed its computers so that when a pregnant woman applied for Medicaid for herself and her unborn child, both the mother and the child were assigned to the same "case" number, even though the mother and eventually the child would each be assigned a separate Medicaid personal identification number. DCF made this change because under the old system babies were sometimes given two personal identification numbers because of the difficulty of matching the Baby Of application with the actual new born child. Poirier on 10/5/2011 Rough Tr. at 39; 43; *see also* PX 738. And as soon as DCF found out there were two numbers

for a child, it would cancel one. St. Petery on 12/10/2009 Final Tr. at 603:18-25. However, if a number that a provider was billing under was the number that was cancelled, AHCA would deny payment for the services billed under that number. *Id.*

282. The new policy was set forth in a July 2008 memorandum to DCF workers. PX 738. Under that policy, workers must manually input data at 12 different steps. Poirier on 10/5/2011 Rough Tr. at 43-45. If a worker makes a mistake in that manual process, made necessary because DCF has an old computer system that requires complicated work-arounds, a child may be improperly terminated. *Id.* at 45-47, 68-69. Less than a year after that memorandum was issued, DCF changed part of the policy again. *Id.* at 48-51; DX 178.

283. DCF's new procedure has not resolved the problems with the Baby Of process. St. Petery on 12/10/2009 Final Tr. at 607:2 – 607:9. Moreover, the change of placing newborns into the mother's "case" has the potential to increase the amount of switching because it increases the chances that a change in the mother's eligibility category at DCF will trigger ACHA's FMMIS system to deem the child's eligibility cancelled. St. Petery on 2/2/2012 Rough Tr. at 82-83.

284. Despite the issuance in 2009 by DCF of a memo directing that babies be kept in their original Medicaid category for 13 months regardless of household

circumstances, interruptions of eligibility for such children continue to occur all the time. *Id.* at 136.

285. Primary care providers continue to see problems with switching, and terminations in violations of the right to continuous eligibility. Cosgrove on 1/31/2012 Rough Tr. at 154-155; Silva on 1/19/2012 Rough Tr. at 149-150.

6. Legal Conclusions

286. Violations of continuous eligibility deprive the children who are improperly terminated from Medicaid of their rights to EPSDT care and any needed follow-up care under § 1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and also their rights to medical care under the Reasonable Promptness and Equal Access provisions of Title XIX.

287. The improper switching of children from one provider to another without their parents' knowledge or consent deprives the children who are improperly switched of their rights to EPSDT care and any needed follow-up care under §1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and also their rights to medical care under the Reasonable Promptness and Equal Access provisions of Title XIX.

288. The failure of ACHA or DCF promptly to respond to notification that presumptively eligible children (*i.e.* "babies of") have been born by promptly making those babies' Medicaid eligibility operative, deprives those babies of their

rights to EPSDT care and any needed follow-up care under §1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and their rights to medical care under the Reasonable Promptness and Equal access provisions of Title XIX.

### C. Provision/Utilization Of Primary Care (*e.g.*, EPSDT)

289. The purpose of the Early Periodic Screening, Diagnosis, and Treatment Program ("EPSDT") is to identify and correct medical conditions in children and young people before the conditions become serious and disabling; to provide entry into the health care system and access to a medical home for each child; and to provide preventative/well child care on a regularly scheduled basis. PX 31 at AHCA00963753; St. Petery on 12/10/2009 Final Tr. at 518:11 – 519:8.

290. Medicaid eligible children are entitled to check-ups from birth through age 20 in accordance with Florida's periodicity schedule. They should receive check-ups at 2 to 4 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and then once per year from 2 to 6, one at 8, one at 10, and one per year from 11 to 20. A check-up includes a comprehensive medical history, a dental screening, vision screening, hearing screening, appropriate immunizations, and other services. PX 31 at AHCA00963754 – AHCA00963757; St. Petery on 12/10/2009 Final Tr. at 519:9 – 522:6.

291. Children who do not receive check-ups are more than twice as likely to require emergency room care. PX 31 at AHCA00963773; St. Petery on

12/10/2009 Final Tr. at 522:11-23. As Defendants have stated in one of their Legislative Budget Requests ("LBR"), more child checkups "may increase the early identification of medical conditions before they become serious and disabling." PX 95.

1. The CMS 416 Reports

292. More than 380,000 children on Medicaid in Florida who should have received at least one screening examination according to Florida's periodicity schedule did not receive any preventative care in the federal fiscal year ending on Sept. 30, 2007. *See* PX 8 at AHCA0000087 (compare line Line 9, the total eligibles who should have received at least one initial or periodic, with Line 10, the total eligibles receiving at least one initial or periodic screen); Snipes on 12/9/2009 Final Tr. at 369:4 – 370:8. The 380,000 figure represents, not simply the number of children enrolled in Medicaid who did not receive a well child check-up during the year, but rather the number of children who were expected to receive a check-up – given the length of their enrollment in Medicaid and the periodicity schedule for children their age – but did not receive a screen. Snipes on 1/8/2010 Final Tr. at 1261:7 – 1264:19; PX 8 at AHCA0000087; PX 25 (see instructions for line 4 and line 8).

293. Those figures come from a formal report, the CMS 416 report, which Florida and all other states must submit annually to the federal Centers for

Medicare and Medicaid Services. *See* 42 U.S.C. 1396a(a)(43)(D) and Snipes on 1/7/2010 Final Tr. at 1146:25 – 1147:7. The report for the federal fiscal year ending Sept. 30, 2007 is the most recent CMS 416 report in the record.

294. This figure is expressed in The CMS 416 report as a "participation ratio" – the total eligibles receiving at least one initial or periodic screen divided by the total eligibles who should receive at least one initial or periodic screen. PX 25 (see instructions for line 10). For the federal fiscal year ending on September 30, 2007, Florida had a participation ratio of 68%. PX 8 at AHCA0000087; Snipes on 12/09/2009 Final Tr. at 370:10-14. That means that 32% of the children enrolled in Medicaid who were expected to receive at least one preventative screen did not receive any. The federal government has a goal of an 80% participation ratio. Snipes on 12/09/2009 Final Tr. at 370:15-17.

295. Those percentage of children in Medicaid HMOs who received a well child check-up was even lower. For the fiscal year ending Sept. 30, 2007, the combined participation ratio for all Florida Medicaid HMOs was 55.10%. PX 16.

296. While there is some criticism of the methodology underlying the CMS 416 report, and some evidence that the data underlying the reports are not complete, the CMS 416 report is widely considered the best data source available regarding the number of children on Medicaid who receive preventative care as well as the number of children eligible for preventative care through Medicaid but

who do not receive such care. The CMS 416 reports are considered reliable by the federal government and by the health services research community. Flint on 1/24/2012 Rough Tr. at 154.

297. Defendants' expert, Catherine Sreckovich, and other defense witnesses contend that the CMS 416 reports under report the care delivered to children in Florida. They claim the 416 reports do not include some well child check-ups because: (1) There is a time lag in reporting some claims data; (2) Some doctors provide child health check-up services but then bill for those services under another CPT code; and (3) Encounter data from HMOs is not complete. These contentions are speculative and not supported by the record. *See id.* at 154-155.

298. As to potential delay with reporting claims, the federal fiscal year ends on September 30, and the CMS 416 report is not due until April of the following year, providing at least five months for submission of claims or encounter data for services provided on September 30, and proportionally more, for services provided earlier in the year. Flint on 1/24/2012 Rough Tr. at 162. While physicians compensated on a fee for service basis have up to one year from the date of service to submit a claim for reimbursement to AHCA, there is no evidence that physicians wait to submit their claims, and it would be economically irrational for them to do so. *Id.* at 161. Tellingly, while AHCA could submit an amended CMS 416 report to account for any claims omitted during the initial submission because of a so-

called "claims lag," AHCA has never done so, though it is in its clear interest, especially during this litigation, to do so if that would improve its performance on the CMS 416 report. Snipes on 12/9/2009 Final Tr. at 368:15-21; Snipes on 1/8/2010 Final Tr. at 1275:23-25, 1276:7-15; Flint on 1/24/2012 Rough Tr. at 161.

299. For physicians to provide well child screens and then bill under an alternative CPT code would be economically irrational because almost all the alternative codes pay less than the CHCUP codes. Flint on 1/24/2012 Rough Tr. at 155-58.[27] Often the compensation for the physician is twice as high under the EPSDT code as under the alternative codes Ms. Sreckovich claims the doctors actually billed. *Id.* at 158. In any event, Defendants have provided no evidence that such miscoding is systemic or widespread. Ms. Sreckovich admitted she could not quantify any such alleged coding errors. Sreckovich on 1/10/2012 Rough Tr. at 43-44.

300. Defendants also claim that the CMS 416 reports under-report the well child check-up services provided because the encounter data that Florida HMOs provide to AHCA is incomplete and does not capture all the well child check-ups performed by the HMOs. There is no quantification, however, of any significant problems with the reporting of encounter data in Florida or that any such alleged

[27] While one new child codes, 99205, pays more than well child codes, a new child code can only be used once per provider per child.

problems led to under reporting on the CMS 416 report for the federal fiscal year ending on September 30, 2007.

301. Tellingly, Defendants do not rely upon any Florida specific studies or analyses to support the assertions that Florida HMOs encounter data suffers from under reporting or that such under reporting has lead to failure to report well child checkups on the CMS 416 report. The 2007 GAO report, Concerns Remain Regarding Sufficiency of Data for Oversight of Children's Dental Services, noted that the quality and completeness of encounter data had improved since 2001. Flint on 1/30/2012 Rough Tr. at 103-104.

302. Florida HMOs, as part of their contractual requirements with AHCA, are required to provide a mini CMS 416 report. Brown-Woofter 10/26/11 Rough Tr. at 43. They are also required to have that report audited, and to provide a certification that the information on that report is true and correct. Brown-Woofter on 10/18/2011 Rough Tr. at 121-122; Boone on 10/22/2008 Depo. Desig. at 153:10-18. Defendants have not provided any basis for calling into question the accuracy of the audited results, which are incorporated into the final 416 reports. In fact they tout the accuracy of other reporting performed by the Medicaid HMOs and do not provide any basis for singling out the HMOs 416 reports as inaccurate or unreliable. Flint on 1/24/2012 Rough Tr. at 154-155.

303. If anything, as explained by Dr. Tom Darling, the results in the 416 reports overstate the number of children who get care, especially with respect to the screening ratios that compare the total number of healthy kid checkups to the number of expected examinations. Dr. Darling is an associate professor at the University of Baltimore's School of Public Administration and a director of government technology for the Schaefer Center for Public Policy. Darling on 1/6/2010 Final Tr. at 813:24 – 814:9. He has a Ph.D. in public administration and policy from the University of Albany. *Id.* at 815:21 to 816:6. He had served as an expert witness in other cases involving children's Medicaid and he has consulted the State of Maryland's state agencies. *Id.* at 817:3 to 819:24. He is qualified and was accepted as an expert, *id.* at 819:25 – 821:10, and I again accept him as an expert and find his testimony to be credible.

304. First, Florida does not have separate encounter data that would allow it to ensure that children are not double-counted if they move between two HMOs in a year or between fee-for-service and an HMO. That means Florida's reported participation rate is likely inflated as a result of double counting some children. *Id.* at 852:13 – 854:5; 873:14 – 876:16.

305. Second, the federal instructions for compiling the CMS-416s result in an over-reporting of screening ratios for the "less than one" and "one to two year" age groups because the periodicity schedule the periodicity schedule does not

require screens at set intervals, but the CMS reporting requirements assume that it does. Darling on 1/6/2010 Final Tr. at 850:5-17, 857:25 – 859:10. The screening ratio that is reported by Florida is 28.92% higher than what it should be because the error in reporting results in the expected number of screens being too low. *Id.* at 859:11 – 865:21; PX 461 at 32-33.

306. Third, because screenings "flow with the child," that is, are reported in the age category that corresponds to the child's age at the end of the federal fiscal year, there is a 45% over reporting for the 1-2 year category. Darling on 1/6/2010 Final Tr. at 866:12 – 868:15.

307. Once the data are adjusted to account for Dr. Darling's recommended corrections, the screening ratios go down to .62, .61, .62, .66, and .68 for 2003 to 2007 instead of .67, .66, .73., .78, and .81. *Id.* at 869:5-20; PX 461 (Table 2-8). These results reflect that Florida children on Medicaid consistently receive substantially fewer screens than called for under the state periodicity schedule.

308. Defendants contested these statistics. In her analysis, Defendants' expert, Ms. Sreckovich purported to analyze the well child care that Medicaid beneficiaries in Florida received by combining the total number of well child examinations provided to children on Medicaid with certain sick child or "problem-oriented" examinations. Sreckovich on 1/10/012 Rough Tr. at 35.

309. There are serious problems with this analysis. First, the credibility of Ms. Sreckovich and her report were undermined by the fact that her initial report wrongly confused "visits" with "services." Sreckovich 1/10/2012 Rough Tr. at 23-24. She made this mistake even though her own work sheets labeled this same column as "services", not "visits." *Id.* 26-27. She made the identical error in her analysis of dental care provided to children on Medicaid. *Id.* Because, as Sreckovich admitted, it is customary for multiple services to be performed during a child's visit to a doctor or dentists, *id.* at 23, the result was significantly to overstate how much care children in Medicaid were receiving. *Id*. 30-35. She did not learn of this error until she read Dr. Darling's rebuttal report. *Id.* at 23-24. She does not know how she made such a significant error that occurred at several points in her report. *Id.* at 26-27. She also admitted that she did not realize that her analysis, which purported to include only claims data, also improperly included some encounter data, until she read Dr. Darling's rebuttal report. *Id.* at 22-23. If these errors were not detected by Dr. Darling in his responsive report, highly misleading information would have been presented during trial. I find Ms. Sreckovich's error in repeatedly mis-categorizing services, as visits, an error that made it seem as if children on Medicaid were receiving much more care than was the case, undermines her credibility.

310. Second, even in her revised tables purporting to correct two of the errors noted by Dr. Darling, Ms. Sreckovich continued to combine the total number of well child examinations with certain sick child examinations. She calls the combined services "preventative assessment and evaluation services," a made up category without any basis in the CPT codes, which includes 7,000 codes and 5,000 adjustors and modifiers. Flint on 1/24/2012 Rough Tr. at 163. She justified that unprecedented approach by saying that for those sick child visits, the children received at least some components of a well child exam, even though they did not receive all components of a well child exam. Sreckovich on 1/17/2012 Rough Tr. at 109. She acknowledged that she is not aware of any peer review study that has endorsed such an approach. Sreckovich on 1/10/2012 Rough Tr. at 38-40. Dr. Darling, who works extensively with CMS 416 reports, has never seen anyone else combine well and sick child visits, as Ms. Sreckovich did. Darling on 01/23/2012 Rough Tr. at 40-42.

311. Plaintiffs' experts, Drs. Flint and Darling, criticized that approach. They said a sick visit was usually focused around a particular presenting condition, and that there was no evidence that during such visits, children receive preventative care and that such visits were not a substitute or proxy for well child visits. Darling on 1/23/2012 Rough Tr. at 35-38; Flint on 1/24/2012 Rough Tr. at

163-67. Dr. Flint sharply criticized Ms. Sreckovich's analysis. Flint on 1/24/2012 Rough Tr. at 163-64.

312. I agree that sick child visits are not a proxy or substitute for well child visits and do not place any weight on this part of Ms. Sreckovich's analysis.

313. Ms. Sreckovich, in her analysis, also looked at the average number of visits per Medicaid child. Not only did she include both well child visits and certain sick child visits, she did not cap the maximum of visits per child at the number set by Florida's periodicity schedule, as recommended by Dr. Darling; rather she included all visits, no matter how many there were. Darling on 1/23/2012 Rough Tr. at 37; Sreckovich on 1/10/2012 Rough Tr. at 46-47.

314. Because of Ms. Sreckovich's methodology, sick or ill child care provided to certain children can make it seem as if other children obtained care, when in actuality that did not. Sreckovich on 1/12/212 Rough Tr. at 46-47. Both Dr. Darling and Dr. Flint are strongly critical of Ms. Sreckovich's averaging approach, which they clam presents a misleading picture of how much care children on Medicaid are receiving. Darling on 1/23/2012 Rough Tr. at 36-38; Flint on 1/24/2012 Rough Tr. at 163-65. I agree that when it comes to determining

the scope of preventative care provided to children in Florida, an average approach is misleading, and do not place weight on it.[28]

315. The consensus view among health care researchers and others in the field is that the CMS 416 reports are reliable. Flint on 1/30/2012 Rough Tr. at 105-06. The CMS 416 report is the "best yardstick we have now" and is "what CMS relies on." Crall on 1/26/2012 Rough Tr. at 155. I agree that CMS 416 reports are reliable and an important indicator of access to care. In addition, I find Dr. Darling's testimony persuasive and conclude that, directionally, the 416 Reports more likely than not overstate rather than understate the amount of EPSDT screening services actually received.

2. HEDIS Reports

[28] As part of her analysis, Ms. Sreckovich focused on the care provided to the named plaintiffs. While some of the named plaintiffs with chronic medical conditions received a significant amount of specialty care, they did not always receive all their well child check-ups. For instance, J.W. did not receive numerous well child check-ups, according to Ms. Sreckovich's own analysis. Her analysis shows he should have received 5 well child visits during certain years when he was enrolled in Medicaid, but only received one such visit. DX 410 at Table 2B. Similarly, J.S. should have received 6 well child visits but only received three. DX 418 at Table 2B. And S.M. did not receive his 18-month well child check-up on time because he had been switched. *See supra* ¶¶ 121-128. N.A. was switched from his pediatrician in Tallahassee to a pediatrician in another county, and was able to receive a timely sick child visit, only because his pediatrician was willing to treat him, even though N.A. was no longer assigned at that point to the pediatrician and even though the pediatrician risked not being paid for the visit. *See supra* ¶¶ 169-179.

316. The CMS 416 report is not the only report that shows children enrolled in Florida Medicaid do not receive the primary care to which they are entitled under federal law and sometimes do not receive any primary care. AHCA requires its Medicaid HMOS, in accordance with 42 C.F.R. Section 438.358, to collect and report on certain performance measures to the state on an annual basis. PX 733 at 1-1. AHCA chose to use Healthcare Effectiveness Data and Information Set ("HEDIS") measures, a set of performance data that is broadly accepted in the managed care environment as the industry standard to compare and measure health plan performances. *Id.* "AHCA expects its contracted HMOs to support health care claims systems, membership data, provider files, and hardware/software management tools, which facilitate accurate and reliable reporting of HEDIS measures." *Id.* The agency contracts with Health Services Advisory Group, its external quality review organization, to evaluate how Florida Medicaid's HMOS perform against certain HEDIS measures. Brown-Woofter on 11/8/2011 Rough Tr. at 12; PX 733 at 1-1.

317. All Florida HMOs were required to have their results confirmed by a HEDIS compliance audit. PX 733 at 2-4. The results are within a plus or minus 5 points sampling error at the 95 percent confidence level. *Id.* HEDIS measures track the care provided to beneficiaries who are continuously enrolled in Medicaid

for a certain period of time – typically eleven months in a year. Crall on 2/7/2011 Final Tr. at 5213:2-6.

318. For all the HEDIS measures at issue in this action, AHCA allowed HMOs to determine their results using the hybrid method where claims records and administrative data is supplemented by a chart review for beneficiaries for whom encounter data is missing. Brown-Woofter on 11/8/2001 Rough Tr. at 24-26. Thus, the hybrid method does not depend on the completeness of the encounter data. *Id.*

319. All the HEDIS measures involve an apples-to-apples comparison because Florida Medicaid HMOs are compared to Medicaid HMOs nationally. Brown-Woofter on 11/8/2001 Rough Tr. at 20-21. One HEDIS measure tracks the number of children who do not receive any well child screens in the first fifteen months of their lives.

320. Of the 12 Florida HMOs operating in non-Reform counties, 11 HMOs scored below the national median, and six scored below the low performing level. Brown-Woofter on 11/8/2011 Rough Tr. at 19. For Healthy Palm Beaches, 5.9 percent of the infants received no well child screens in the first 15 months of their lives; for Preferred Medical Plan, Inc. percent; for Humana Family c/o Human Medical Plan, Inc. 6.7 percent; for Vista Health Plan Inc. – Vista South Florida 7.6 percent; for Vista Health Plan, Inc. – Buena Vista Medicaid 7.7 percent; and for

Jackson Memorial Health Plan 9.2 percent. PX 733 at 3-4. For the following year, 2007, for six of the HMOs, 5 percent or more of the infants received no well child checkups in the first fifteen months of life. DX 361 at DEFENDANTS022774. These figures are extremely troubling as they indicate that many infants received no preventative care at all.

321. While well child check-ups are important for children of all ages, "[t]he need for appropriate immunizations and health checkups has ever greater importance and significance at younger ages. If undetected in toddlers, abnormalities in growth, hearing, and vision impact future learning opportunities and experiences. Early detection of developmental difficulties provides the greatest opportunity for intervention and resolution so that children continue to grow and learn free from any health-related limitations." PX 733 at 3-1.

322. Other HEDIS measures also show that in both reform and non-reform counties children on Medicaid HMOs receive less primary care than children enrolled in the average HMO nationally. All 13 Medicaid HMOs operating in non-reform counties fell below that national mean in 2007. DX 361 at DEFENDANTS022775. Five of them had results that clustered around the 25th percentile, and eight of them had results around the 10th percentile. *Id.* In Reform counties, for the same year, seven of nine Florida Medicaid HMOs fell below the national mean. DX 334 at DEFENDANTS021293.

323. As for adolescent preventative care, the percentage of enrolled members 12 to 21 years of age who had at least one well child visit with a primary care provider or an OB/GYN practitioner during the measurement year, Florida Medicaid HMOs again generally ranked below the national mean of 43.6 percent. DX 361 at Defendants 022757. Five of the 13 HMOs in Florida operating in non-Reform counties were at or above the mean, eight were below it, with six clustered near the 25th percentile and two near the tenth percentile. *Id.* In Reform counties, the results were similar. Six Medicaid HMOs scored above the national mean; nine were below it. DX334 at DEFENDANTS021277.

324. Another HEDIS study looked at the well care provided to children between 11 to 20 years of age and found that only 19.6 percent of the children overall received even one well child visit during the study period; PX 689 at Summary of Findings; Brown-Woofter on 11/9/2011 Rough Tr. at 14.

325. Florida Medicaid HMOs also scored extremely low in terms of the percentage of pregnant women who received prenatal care. Some percentage of those women are teenage mothers on Medicaid, and for them prenatal care is a type of primary care. For seven Medicaid HMOs, more than one-third of the women did not receive even a single prenatal visit during the study period. DX 361at DEFENDANTS022772.

326. The HEDIS data show that on a number of measures of preventative child care, Florida's HMOs, both in reform and non-reform counties, rank below and often far below the national mean for Medicaid HMOs.

3. Primary Care Providers Participation in Medicaid.

327. There is a shortage of pediatricians in Florida. *See* DX 290c at 1. As a matter of supply and demand, that shortage means pediatricians have a greater ability, if they chose to do so, to treat higher paying patients and either not treat Medicaid patients at all or limit the number of Medicaid patients they treat. The shortage of pediatricians in rural areas is especially acute. There are 10 Florida counties with no pediatricians, and seven more counties with only one pediatrician. DX 290c at 2-7; Swanon Rivenbark on 11/15/2011 Rough Tr. at 50. Again, as a matter of economics, that shortage, disadvantages children on Medicaid who must compete with higher paying patients for the services of pediatricians in other counties.

328. The number of children on the Medicaid rolls has grown sharply, but the number of pediatricians willing to treat them has not. The number of Florida children enrolled in Medicaid increased from 713,540 as of October 1998 to about 1.2 million as of October 2005, then dipped slightly as of October 2007 only to rise again to 1,272,342 as of December 2008, and then jumped to 1,517,606 as of October 2009, as more children came on the Medicaid rolls as a result of the

economic downturn. PX 682 at FL-MED 07816; DX 262; Snipes on 1/8/2010 Final Tr. at 1274:15 – 1275:5. As of 2011, the enrollment had soared again, this time rising to 1.7 million children. Lewis on 11/29/2011 Rough Tr. at 48-49. Thus, the percentage of children on Medicaid has increased by more than 33% in just under three years, from December 2008 to November 2011. There is no indication that the number of primary care providers has increased at all, let alone proportionately, thus placing an increased demand on existing providers. *See* PX 682 at FL-MED 07816; DX 262. In fact, Florida has an overall shortage of physicians per 100,000 residents, compared to the United States as a whole, PX 742 at DEFENDANTS026980, and a shortage of pediatricians, DX 290c; PX 742 at DEFENDANTS026979 thereby placing more demand on Florida physicians to treat children on Medicaid, even though Medicaid pays far less than other payors.

329. More than twenty percent of pediatricians in Florida were accepting no new Medicaid patients, according to a 2009 physician workforce survey. PX 742 at DEFENDANTS027039; Swanson Rivenbark on 11/15/2011 Rough Tr. at 40-41. For family practitioners, more than 60 percent were not accepting a single new Medicaid patient. *Id.* That is significant because family medicine

practitioners provide well care for older children. St. Petery on 2/9/2010 at 1514:9-13.[29]

330. In addition, numerous pediatricians limit the number of children on Medicaid they will accept. *See* Cosgrove on 5/19/2010 Final Tr. at 2553:15 – 2557:12 (limiting practice for financial reasons to about 20 percent children on Medicaid)[30]; Silva on 5/20/2010 Final Tr. at 2768:23 – 2775:23 (only two of the non-for-profit company's seven pediatric sites accept new children on Medicaid, and for Dr. Silva's site, the company has limited the number of new Medicaid patients by (1) not accepting Medicaid HMOs; (2) only accepting new patients under 5; and (3) further limiting new patients to newborns, siblings of existing patients, or existing patients who go on Medicaid; about 20% of her patients are on Medicaid compared to 50% in 2001); Isaac on 8/11/2010 Final Tr. at 3855:13-17; 3856:4-12; 3861:5-25 (limits number of Medicaid patients he accepts; doesn't take any Medicaid HMOs; approves new MediPass patients on a case by case basis;

[29] The contrast between the percentage of physicians who accept no new Medicaid patients (46%) and the percentage who accept no new Medicare patients (only 22%) is stark and illustrates the inadequacy of the Medicaid reimbursement rates. PX 742 at DEFENDANTS027033, DEFENDANTS027037.

[30] In 2012, Dr. Cosgrove's practice had about 29 to 32% Medicaid patients, and she had loosened some of the restrictions on taking new Medicaid patients because the practice had hired a new nurse practitioner and because, as a result of the end of the space shuttle program at the Kennedy Space station and the ensuing loss of jobs, a number of existing patients went from having private insurance to being on Medicaid, and Dr. Cosgrove and her partner tried to accommodate them. Cosgrove on 1/31/2012 Final Tr. at 158-160, 171.

about one-third of his patients are on Medicaid); Ritrowski on 11/10/2008 Depo. Desig. at 8:13 – 9:12; 11:1-11 (to remain economically "viable" practice limited number of Medicaid patients by only accepting as new Medicaid patients (1) siblings of existing patients; (2) existing patients who lose private insurances; and (3) limited number of newborns); Orellana on 11/23/2008 Depo. Desig. at 99:24 – 100:11 (had to stop accepting Medicaid patients in his Gainesville but not his Lake City location).

331. The principal reason pediatricians do not participate in or limit their participation is Medicaid's low reimbursement rates. Flint on 8/3/2010 Final Tr. at 2949:21 – 2950:5("The fundamental issue that drives participation, that determines physician, physicians' decisions to participate in the program at all, or to limit their participation, is the rate of reimbursement."); Cosgrove on 5/19/2010 Final Tr. at 2554:19 – 2555:2; Ritrowski on 11/10/2008 Depo. Desig. at 11:1-11 (limited number of Medicaid patients to remain economically "viable"). I make further findings on this issue in Section VI. F, *infra*.

332. Defendants have pointed to the availability of care at county health departments and federal qualified health centers. County health departments, while they provide some primary care, are not an alternative to private pediatricians. The county health departments (CHDs) collectively only employed 27 pediatricians and no pediatric subspecialist as of 2009. Swanson Rivenbark on

11/15/2011 Rough Tr. at 57-58. Federal qualified health centers (FQHCs) had just 32 pediatricians collectively and one pediatric subspecialist. *Id.* Moreover, all well child visits provided by CHDs and FQHCs are included on the CMS 416 report. Crall on 2/8/2011 Rough Tr. at 83-84. There is no reason to believe CHDs will provide increasing care in the future. Indeed, the Florida Legislature sliced $30 million from the budget for the CHDs as of July 2011, leading to 300-400 positions being cut at the CHDs. Sentman on 10/6/2011 Rough Tr. at 11-13.

4. Child Health Check-Up Rate Increases

333. An increase in the reimbursement rate for well child check-up examinations translated directly into an increase in the number of children receiving well child check-ups. In 1995, AHCA increased the reimbursement rate for well child check-ups "from $30 to $64.82, and the participation rates increased from 32 percent to 64 percent." PX 734. AHCA has made that same assertion repeatedly in formal budget submissions to the governor and Legislature, *see* PX 734, PX 92, PX 93, PX 95, and in internal legislative budget requests, PX 94, PX 96, PX 702, PX 703. *See also* DX 600.

334. AHCA highlighted the effect of the 1995 well child check-up rate increase on the participation rate in proposing a child health check-up rate increase from $71.59 to $90.97 for the 2007-2008 budget year. Williams on 10/13/2011 Rough Tr. at 88-89; PX 734. AHCA predicted that same pattern would hold in the

future. "Increasing the Child Health Check-up reimbursement rate will increase access to service, which will increase the early identification of medication conditions before they become serious and disabling, thereby decreasing future costly treatment services." PX 734. AHCA noted that since 1995 provider fees for well child check-ups "have increased only a few dollars due to the Resource Based Relative Value System" and said, "An increase will also more accurately reflect the cost of providing and documenting this comprehensive, preventive service and will encourage provider participation and retention in the Child Heath Check-Up Program." *Id.*

335. In 2007, that same proposal was one of AHCA's top three priorities. PX 720; *see* also PX 92; Snipes on 12/9/2009 Final Tr. at 387:10 – 388:12; Snipes on 1/7/2010 Final Tr. at 1094:24 – 1095:10. Again, the agency told the Governor and Legislature that increasing the Child Health Check-Up "**will increase access to service**, which will increase the early identification of medical conditions before they become serious and disabling, thereby decreasing future costly treatment." PX 92 (emphasis added); Kidder on 5/19/2010 Final Tr. at 2512:4 – 2514:13; Kidder on 10/3/2011 Rough Tr. at 28.

336. While continuing to support legislative budget requests to increase the child heath check-up fee, AHCA subsequently changed the language to indicate that a fee increase "may," not will "increase access to services, which may increase

the early identification of medical conditions." PX 96; *see also* DX 600. That change was made during the course of this litigation and was not based on any study or formal analysis. Kidder on 5/19/2010 Final Tr. at 2519:21 to 2520:5. Dyke Snipes, who was head of the Medicaid program for AHCA from February 2008 through September of 2009, never reached a different conclusion as Medicaid director than that set forth in the "will increase" language. Snipes on 12/9/2009 Final Tr. at 351:3-9; 382:11-24.

337. Even with the modified language, however, the LBRs continued to say: "In 1995, there was a fee increase from $30 to $64.82 and the CHCUP participation rate increased from 32 percent to 64 percent." PX 96; *see also* DX 600. The Agency used that same language in LBRs for five consecutive years. Kidder on 10/3/2011 Rough Tr. at 33-35. Two senior level agency administrators testified in deposition that the statements in the 2007 final agency legislative budget request regarding a proposed increase in reimbursement for child health check-ups were true and correct. One was Beth Kidder, who testified in 2008, three years after this action began. Kidder on 10/3/2011 Rough Tr. at 28-30. Kidder acknowledged her prior testimony at trial, including her testimony that the language in the LBR was meant to indicate "causation, a causative effect here, that if you increase the rates, you will increase physician participation and in turn that will result in more kids receiving checkups." *Id.* at 29.

338. The second witness was Melanie Brown Woofter who testified in November of 2008, again as an agency designee under FED. R. CIV. P. 30(b)(6), at the very close of discovery, that the following statement was true and correct: "In 1995, there was a fee increase from $32 to $64.82 and the CHCUP participation rate increased from 32 percent to 64 percent." Brown-Woofter on 11/9/2011 Rough Tr. at 2-3; PX 96.

339. At trial, Ms. Kidder changed her testimony when she was called in defense's case in chief, but not when she was called as an adverse witness in plaintiffs' case, and suggested that the 1995 fee increase from $32 to $64.82 did not cause the increase in the participation rate from 32 percent to 64 percent because the fee increase did not lead to an immediate increase in the participation rate and because she asserted that the increased participation rate might have resulted from other factors, such as better reporting by Medicaid HMOs. Kidder on 6/1/2011 Rough Tr. at 118-19. She amended her views based on information she was provided by defense counsel after testifying in May of 2010 as an adverse witness in plaintiff's case. Kidder on 10/3/2011 Rough Tr. at 39-43. Ms. Brown-Woofter similarly changed her views and on redirect examination provided an

amended answer similar to Ms. Kidder's; Brown-Woofter on 11/9/2011 Rough Tr. at 122-26.[31]

340. While a 30(b)(6) witness may modify his or her testimony because it does not constitute a judicial admission, a court may consider any such change in assessing the credibility of the testimony. *See, e.g., R & B Appliance Parts, Inc. v. Amana Co., L.P.*, 258 F.3d 783, 786-87 (8th Cir. 2001); *Cont'l Cas. Co. v. First Fin. Emp. Leasing, Inc.*, 716 F. Supp. 2d 1176, 1190 (M.D. Fla. 2010); Considerable authority holds that "[u]nless it can prove that the information was not known or was inaccessible, a corporation cannot later proffer new or different allegations that could have been made at the time of the 30(b)(6) deposition." *Rainey v. Am. Forest and Paper Ass'n, Inc.*, 26 F. Supp. 2d 82, 94 (D.D.C. 1998); *see also Imperial Trading Co., Inc. v. Travelers Prop. Cas. Co. of Am.*, No. 06-4262, 2009 WL 2242380, at *9 (E.D. La. July 24, 2009) ("Numerous district courts have held that a party cannot adduce additional evidence to rebut the testimony of its Rule 30(b)(6) witness when, as here, the opposing party has relied on the Rule 30(b)(6) testimony, and there is no explanation for the difference.").

341. Defendants' only explanation to support admission of Ms. Kidder and Ms. Brown-Woofter's undisclosed and untimely decision to contradict their prior

[31] On cross examination, she said the increase in the participation rate may have been due to increased outreach, Brown-Woofter on 11/9/2011 Rough Tr. at 4, a wholly different answer than that elicited by her counsel on redirect.

testimony is that they had further time to scrutinize certain legislative budget requests. However, Ms. Kidder was deposed on August 27, 2008, more than two and one half years after this action commenced, and Ms. Brown-Woofter was not deposed until November 24, 2008. Defendants had adequate time and a duty to prepare these witnesses on the designated topics prior to their 30(b)(6) deposition.

342. I find the statements in AHCA's LBRs, repeated over five years with different secretaries and staff in place and repeatedly reported to the Governor and Florida Legislature, to be credible and demonstrate that AHCA believed there was a cause and effect relationship between a significant increase in the reimbursement rates for well child check-ups and the percentage of children eligible for Medicaid who received a well child checkup. I find Ms. Kidder and Ms. Brown-Woofter's trial testimony, while it may call into question whether ACHA believed there was a direct linear relationship, does not credibly call into question whether AHCA believes there is a cause and effect relationship.

5. AHCA's Reports and Defendants' Lay Opinion Testimony

343. Several defenses witnesses – especially Ms. Sreckovich, Ms. Kidder, and Ms. Brown-Woofter – testified regarding the various processes AHCA has in place to monitor and evaluate primary care providers enrolled in Medipass and managed care organizations.

344. While AHCA devotes considerable resources to monitoring, that monitoring does not demonstrate that children are receiving the care to which they are entitled under federal law for three fundamental reasons. First, though there is extensive testimony regarding the monitoring process in the record, there is very little in the record about the substantive results of that monitoring process. The mere fact that AHCA does monitoring is hardly probative as to whether children are receiving care. Indeed, much of this monitoring took place during the very time that AHCA's own documents demonstrate that children were not receiving care. Second, there is virtually no evidence and certainly no systematic evidence in the record that any PCPs or MCOs were fined, sanctioned, or expelled from the Medicaid program for failure to provide care to children on Medicaid or meet any contractual requirements relating to the provision of care. Thus, the contractual authority to levy sanctions is largely irrelevant. Third, and more fundamentally, the process oriented monitoring cannot show children receive care. For instance, the fact that a PCP does not have more than 1,500 children on Medicaid as patients and does not work more than 30 miles from where his or her patients live does not demonstrate that those children are able to see that PCP on a timely basis. AHCA's monitoring shows the system could work on paper, not that it works in practice.

345. There is no evidence in Ms. Sreckovich's testimony to establish that timely care and access to an appropriate array of pediatric doctors was actually provided rather than theoretically being available, if PCPs affiliated with MediPass or an HMO chose to treat a large number of children on Medicaid, despite the low Medicaid reimbursement rates. Flint on 1/24/2012 Rough Tr. at 153. Further, Ms. Sreckovich's general opinion that she has not seen evidence of a systematic problem, Screckovich on 1/12/2012 Rough Tr. at 54-55, appears to be based on discounting of every source of evidence—agency admissions in legislative budget requests, 416 reports, Plaintiff's expert testimony—as being subject to some question or not having been "verified." *Id.* at 54-56. While this may be consistent with Ms. Sreckovich in twenty years of testifying as an expert in never having found an element of a State Medicaid program to be noncompliant with federal law, Screckovich on 1/10/2012 Rough Tr. at 14, it also suggests she may be viewing these issues through the lens of the state agencies, including AHCA, with whom she does regular work. *Id.* at 5-9. In any event, I do not find her opinions persuasive.

346. A number of AHCA witnesses, especially Ms. Brown-Woofter and Ms. Kidder offered lay opinions regarding access.

347. Ms. Brown-Woofter offered a lay opinion that there are enough primary care providers enrolled in MediPass to comply with the contractual

requirement that no provider have more than 1,500 children on MediPass. Brown-Woofter on 10/24/2011 Rough Tr. at 67-69. That testimony does not even purport to indicate whether children are actually receiving care from PCPs, who are not obligated to accept any children on Medicaid, let alone all children on Medicaid who seek their services, merely because they enrolled as a MediPass provider, let alone whether that care is timely and comparable to care provided to children on private insurance. Moreover, Defendants failed to show that 1,500 to one ratio has any bearing in reality. Ms. Brown-Woofter did not know the average number of Medicaid patients that a typical PCP enrolled in MediPass accepts, Brown-Woofter on 11/8/2011 Rough Tr. at 81, but if that number is substantially smaller than 1,500, then the 1,500 to one ratio is meaningless.

348. Ms. Kidder offered a lay opinion to the effect that AHCA is able to deliver for children on Medicaid the care they need, when they need, close to where they need it (with limited exceptions), for both primary care and specialty care and that the increase in the number of children enrolled in Medicaid has not impacted AHCA's ability provide such care. Kidder on 10/3/2011 Rough Tr. at 122-123, 150. That sweeping opinion is based largely on hearsay – what Ms. Kidder is told by others, and is contradicted by AHCA's own statements in numerous legislative budget requests; Ms. Kidder's own testimony in her deposition; the testimony of various other AHCA witnesses, including then-

Secretary Andrew Agwunobi, former Medicaid Directors Mr. Snipes and Mr. Sharpe; the testimony of pediatricians; and numerous ACHA documents. Accordingly, I find her lay opinion is entitled to little if any weight.

6. Childrens' Medical Services ("CMS")

349. The problems experienced by CMS, a branch of the Department of Health, dedicated to helping children with special health care needs – and not to be confused with federal CMS – has had in finding primary care providers to treat CMS children on Medicaid is consistent with the problems experienced by other children on Medicaid in accessing primary care which they have legal rights to receive under the Medicaid Act.

350. In 2004, CMS conducted a Provider Access Survey. PX 319. That survey conducted by DOH showed that "[e]very CMS area office or regional office reported that some CMS-enrolled private primary care practices were closed to new CMS patients during calendar year 2003." PX 319 at DOH00077968; St. Petery on 12/8/2009 Final Tr. at 228:5 – 229:12.

351. The 2004 Provider Access Survey showed that "[l]ow reimbursement rates and lack of capacity were the top two reasons cited for the closure of primary care practices to new CMS patients, followed by CMS patients' health conditions being considered too complex for primary care practice and administrative burden/paperwork." *Id.*

352. The 2004 Provider Access Survey conducted by DOH in 2004 showed: "Every CMS provider recruitment office attempted to recruit primary care practitioners to become CMS-enrolled providers during calendar year 2003. Almost three-fourths (72%) of the contacted private primary care providers declined to enroll as CMS providers. Low reimbursement rates and lack of capacity were the main reasons cited for declining to participate." *Id.* There is no indication in the record that these problems have disappeared or even substantially ameliorated.

7. Blood Lead Screening

353. Under federal law, as part of an EPSDT exam, children on Medicaid must be screened for blood lead poisoning at 12 and 24 months, and if they did not have a test earlier, they must be screened for lead blood poisoning between 36 and 72 months. PX 71 at AHCA00148486. Doctors can comply with the lead blood screening requirements by either doing the testing themselves or referring their patients to a laboratory for testing. Snipes on 12/9/2009 Final Tr. at 391:12 – 393:2.

354. There is no safe level of lead in the blood. PX 77 at FL-MED 07068. The higher the blood level, the more severe the consequences. *Id.* Higher levels have even greater impact on the health and cognitive development of a child,

including lowered IQ, behavioral problems, hearing loss, neurological impairments, and death. *Id.*

355. Screening children for blood-lead poisoning at an early age is important. As Defendants have stated, "Screening for blood lead can lead to effective early interventions, decreasing overall treatment costs later." PX 98.

356. According to CDC, Florida ranks 8th in the nation for the number of estimated children with elevated blood lead levels. PX 71 at AHCA00148485; Snipes on 12/9/2009 Final Tr. at 399:12-16. The cities of Jacksonville and Miami rank 21st and 32nd respectively among large cities in the United States with an estimated 1,900 lead poisoned children. PX 71 at AHCA00148485.

357. A primary source of lead exposure in children is lead-based paint. Many home built prior to 1978 contain lead. PX 77 at FL-MED 07070. Homes built prior to 1950 pose the greatest risk for children since the amount of lead in paints from that time is generally greater and the structural condition of the homes often facilities greater risk of lead exposure. *Id.* The portion of pre-1950 housing by county in Florida varies from 3 percent to just over 15 percent. *Id.*

358. Florida's diverse population of immigrants, refugees and foreign born children are further at-risk groups for lead poisoning because of specific high risk behaviors and customary use of foreign products containing unsafe levels of lead. PX 71 at AHCA00148485; Snipes on 12/9/2009 Final Tr. at 399:8-11.

359. The CMS-416 Report submitted in April 2008 showed that only 60,000 blood-lead screens had been conducted for 250,000 eligible children between the ages of 1 and 2. PX 8 at AHCA0000087-88. Mr. Snipes testified, "I would say personally to me that's not acceptable." Snipes on 12/9/2009 Final Tr. at 372:5-11.[32]

360. In 2006, the most recent year for which there are figures in the record, there were 389 new reported cases of blood lead poisoning in Florida, with twenty or more new cases reported in Broward, Duval, Hillsborough, Miami-Dade, Orange, Pinellas, and Polk counties. PX 77 at FL-MED07073.

361. For FY 2005-06, 2006-07, 2007-08, and 2009-10, AHCA requested an increase in reimbursement rates for blood-lead screenings for children, stating: "Because physicians are not reimbursed for the collection and handling of lab specimens during an office visit, Medicaid children are being referred to a laboratory for the required blood lead test rather than the physician collecting the specimen and forwarding it to the laboratory for analysis. Lack of reimbursement has fragmented care, due to the fact that many recipients do not follow through with the lab trip." PX 704; PX 705; PX 97; PX 98; Snipes on 12/9/2009 Final Tr. at 391:12 – 397:8.

[32] One of the named plaintiffs, S.M., has not been testified for blood lead exposure because the first time his mother took him to the laboratory the lab was closed and she subsequently was not able to take her son to the lab because of difficulties securing transportation. *See supra* at ¶¶ 121-28.

362. Mr. Snipes supported the agency's request for an increase in fees for handling blood and believed that it would improve beneficiaries' ability to get blood-lead tests done. Snipes on 2/9/2009 Final Tr. at 397:2-8. In fact, he consistently proposed increases in reimbursement rates for blood-lead testing because he believed that there was a problem that had to be addressed. *Id.* at 399:22 – 400:2.

8. Legal Conclusions re Access to Primary Care

363. Defendants responsible for Florida's Medicaid program have failed to assure that the plaintiff class receive the preventative health care required under the EPSDT Requirements. I find, similar to other courts facing such evidence *see Health Care for All, Inc. v. Romney*, No. Civ.A. 00-10833RWZ, 2005 WL 1660677, *10-11 (D. Mass. July 14, 2005) (finding violation of EPSDT requirements as to dental care)*; Memisovski ex. rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *50-*56 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions) that the EPSDT Requirements that children receive such care have not been met when, as shown above, approximately one-third of Florida children on Medicaid are not receiving any of the preventative medical care they are supposed to receive. This is true both for children on fee-for-service as well as in managed care, where screening rates are, if anything, lower. In addition, an

unacceptable percentage of infants do not receive even a single well child visit in the first 18 months of their lives.

364. Because one-third of the enrolled children are not receiving any of their expected preventative care each year, I also find that they have not received care in accordance with the Reasonable Promptness requirements of the Medicaid Act. *See OKAAP v. Fogarty*, 366 F. Supp.2d 1050, 1109 (N.D. Okla. 2005) (finding violation of reasonable promptness provision as to medical care); *Health Care For All, Inc.*, 2005 WL 1660677, at *10-11 (D. Mass. July 14, 2005) (finding violation of reasonable promptness provision as to dental care); *Clark v. Kizer*, 758 F. Supp. 572, 575-579 (E.D. Cal. 1990) (finding violation of reasonable promptness provision as to dental care), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 585 (9th Cir. 1992). I also find a violation of Section 30(a) because Medicaid children lack equal access to primary care.

365. I also find that many pediatricians (and more family practitioners) refuse to take any new Medicaid patients, and other pediatricians sharply limit the number of new Medicaid patients they will accept. I also find that the percentage of children in Florida who receive blood lead screens is extremely low, notwithstanding the fact that part of Florida have an aging housing stock, which means children are likely exposed to lead-based paint.

366. I agree with AHCA's statement in repeated legislative budget submissions that if the AHCA increased the Medicaid reimbursement rates for well child check-ups, more children will receive well child check-ups.

**D. Provision/Utilization/Timeliness Of Specialist Care**

367. The EPSDT Requirements grant children on Medicaid the right not just to preventative care screens but to treatment for the conditions identified. 42 U.S.C. § 1396a(a)(43)(C). Often the care of a specialist is required. Brown Woofter on 10/18/2011 Rough Tr. at 135.

368. The problem of access to specialists for the Florida Medicaid population, including children, was acknowledged at the highest level by the official responsible for the Florida Medicaid program. Dr. Andrew Agwunobi, in 2007, speaking as Secretary of AHCA stated as follows:

> "I personally have traveled to all of our different areas – our 11 area offices, and I found that by far, the single biggest problem facing AHCA today is access to specialty care for Medicaid recipients. The single biggest problem. We have many problems, but that's the biggest" PX. 126A at 5.

Dr. Agwunobi later in the same speech referred to the problem as "a crisis in access to specialty coverage for this population." *Id* at 6.

369. Defendants objected to these statements on the grounds that they are not applicable to children. This is wrong. Dr. Agwunobi expressly stated in his speech that he was speaking about access for specialty care for children as well as

adults: "We have children and people right now that need access to specialty care." PX 126A. He illustrated the point thusly,

> So what this means is that when a child goes to the emergency room with a broken arm, they can't find an orthopedic surgeon to follow up with. Abscess teeth, can't get care. Usually through many hours of work and basically pleading on bended knee, we have actually found care for that patient. However, there are unacceptable delays which translate into poor quality and sometimes patients have to travel for miles. So all of that is to say yes, the service indicates and our experience confirms that we have a serious access to healthcare problem in the state of Florida and, we have to address it.

PX 126A at 5.

370. As to the cause of the problem, Dr. Agwunobi said that while there are many reasons for the problem of access to specialists, "one thing is very clear. Providers are in general underpaid in contrast to commercial insurance and Medicare." P X 126a at 6; *see also* PX 305 at L-STP 012841.

371. I find Dr. Agwunobi's admissions regarding the problem of access to specialty care to be highly probative. Secretary Agwunobi was a cabinet level officer, the highest individual in the agency primarily responsible for Medicaid, – and the only agency Secretary to testify in his case.[33] He was speaking as

[33] While they did not testify as witnesses, other AHCA secretaries presented similar views in documents. Secretary Arnold observed that "we have a system that is growing by double digits, where providers are paid less and less each year, access is limited, outcomes are not measured, racial disparities in health access continue, and participants are stigmatized. I'd say that's a bad system." PX 277A. *See also* PX 195 (email of Tom Arnold, then deputy secretary for Medicaid and

Secretary and could not be clearer as to the seriousness of the issue, characterizing it as a "crisis." An admission such as this could, standing alone, be taken as sufficient evidence of an access problem with respect to specialists. *See also Cockrum v. Califano*, 475 F. Supp. 1222, 1227 n. 1 (D.D.C. 1979) (Secretary of Health, Education and Welfare estopped from asserting claimants' responsibility for delays in administrative hearings by his admissions elsewhere that the delay problem was nationwide in scope.)

372. Sec. Agwunobi's views are reinforced by a 2007 survey of the AHCA regional offices. The results of this survey were that a majority of regional area offices reported an "acute shortage" of specialists for most specialty types. The following is the chart prepared by AHCA summarizing the results:

later Secretary of AHCA, asking "can we do anything that may reduce the reluctance of specialists in participating in Medicaid?")

**AREA OFFICES – List of Most Common Specialty Shortages** *

● = *Acute Shortage of Medicaid Providers Accepting Medicaid Patients*

| Specialty | AREAS One | Two | Three | Four | Five | Six | Seven | Eight | Nine | Ten | Eleven | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Otolaryngology | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | 11 |
| Neurology/Neurosurgery (Adults & Pediatric) | ● | ● | ● | ● | ● | ● | ● | ● | ● | | ● | 10 |
| Orthopedists/Orthopedic Surgery | ● | ● | ● | ● | ● | ● | ● | ● | ● | | ● | 10 |
| Dermatology | ● | ● | ● | ● | ● | ● | | ● | ● | | ● | 9 |
| Rheumatology | ● | ● | ● | ● | ● | ● | ● | ● | | ● | | 9 |
| Pain Management | ● | | ● | | ● | ● | ● | ● | ● | | ● | 8 |
| Endocrinology | | ● | ● | ● | | | ● | ● | ● | | ● | 7 |
| Urology | ● | | ● | ● | ● | | ● | | ● | | | 6 |
| Surgery, General (Including Bariatric) | ● | ● | ● | ● | | | | ● | | | ● | 6 |
| Orthodontists | | | | | ● | | ● | ● | ● | ● | ● | 6 |
| Dentistry, General | ● | | | | ● | ● | | | ● | | ● | 5 |
| Gynecology | | | ● | ● | ● | ● | | ● | | | | 5 |
| Oral Surgery (Dentist) | ● | | | | ● | ● | ● | ● | | | | 5 |
| Allergy | | ● | | ● | ● | | | ● | | | | 4 |
| Surgery, Plastic | ● | | | ● | | | | ● | | | ● | 4 |
| Pedodontist | | | | | | | ● | ● | ● | | ● | 4 |
| Gastroenterology | | | | | | | | | ● | ● | ● | 3 |
| Cardiovascular Medicine | | ● | | ● | | ● | | | | | | 3 |

PX 205.

373. AHCA sought to make the survey as accurate as possible, Nieves on 5/17/2010 Final Tr. at 2032:14-17, and did not subsequently update the survey. *Id.* at 2030:17-24; Snipes on 12/9/2009 Final Tr. at 431:8-16 (quoting deposition testimony that he has no reason to disagree with PX 205). While certain AHCA witnesses sought to diminish the term "acute shortage of Medicaid providers accepting Medicaid patients," that term was used by AHCA, never changed or challenged until trial, and is consistent with Secretary Agwunobi's public statements.

374. The survey responses from a number of the AHCA area offices confirm, and in certain instances, go beyond the statewide summary. *See* PX 200

(Area 10; Broward County); PX 201 (Area 1 shortages – Pensacola); PX 202 (Area 9 specialist shortages – Palm Beach county); PX 203 (Area 6 specialist shortages – Tampa); PX 204 (Area 7; Central Florida); PX 722 (Area 2; Florida panhandle counties); PX 708 (Area 8; Southwest Florida). For example, the response for Area 11, including Miami-Dade and Monroe counties, states that there is a shortage of "pediatric specialists of every kind" and that "there are no specialists of any kind willing to treat Medicaid recipients" in Monroe county. PX 199. AHCA through two agency representative's deposition testimony admitted that there was no reason to believe that the problems identified in the survey were problems for adults, but not for children. Kidder on 5/19/2010 Final Tr. at 2529:20 – 2530:10 (quoting deposition testimony); Brown-Woofter on 10/25/2010 Final Tr. at 83-96 (quoting deposition testimony).

375. AHCA proceeded to create a ranking of the different specialty practices by different geographical areas that were experiencing shortages. PX 710. These top five "priority rankings" of shortages, were applicable to children as well as adults. Nieves on 5/17/2010 Final Tr. at 2068:9-11.

376. Other internal AHCA documents and communications are consistent with the existence of difficulty in accessing specialists for the Medicaid population throughout the state. *See e.g.*, PX 210 (October 2007 letter from Secretary Agwunobi inviting providers to a Medicaid Access to Specialty Care Summit,

noting he had traveled the state, speaking about Florida Medicaid with providers, community-based organizations, and AHCA staff, and stating: "With rare exception, when asked what the most critical issue facing the program was, they identified the increasing lack of access to specialty medical care for Medicaid beneficiaries."); PX 181 (shortage of dermatologists, neurologists and neurosurgeons for kids and adults in Jacksonville); PX 182A (documenting access problems for children seeking orthopedics gastroenterologists, neurologists, and cardiology in Area 2); PX 188 (2006 survey of AHCA offices showing lack of readily available specialist care); PX 211 at 7-11 (relative number of specialists providing Medicaid services to total specialists); PX 221 (2000 survey of access to care shows relative lack of access for Medicaid population and also geographic differences in access); PX 187 (Area 3B Ocala area services not readily available in number of specialty types); PX 319 (no or very limited access to certain specialty care for Medicaid children in CMS); PX 338 ("significant crisis in Panama City area with orthopedic coverage").

377. The difficulty in access to specialist care found in the 2007 survey corroborated an earlier AHCA study entitled "Access to Medicaid physician Specialists." PX 563. This study measured access by dividing the total number of Medicaid annual visits in 2003-2004 by the national average of visits per specialist physician and then compared this "estimated Medicaid access" figure to lowest and

highest estimate of needs based on the literature. Each physician specialty was then given an access score from 1 to 5, with the following services receiving ranks of either "1 (indicating access is less than 50% of the lowest estimate of need); or "2" (access less than the low estimate of need"): Allergy, Dentists, dermatology, endocrinology, hematology, infectious disease, nephrology, neurology, oncology, orthopedic surgery, pulmonary disease, rheumatology, and urological surgery. PX 563 at Flint 01131, 01135. This study also shows the comparative lack of access per county.

378. Several AHCA witnesses who serve as area administrators nonetheless testified that they either never had or no longer were facing difficulties with respect to access to specialty care for Medicaid recipients in their areas. *See e.g.*, Nieves on 5/18/2010 Final Tr. at 2260:5-18; Albury on 11/15/2011 Rough Tr. at 107; Kimbley-Campanaro on 10/6/2011 Rough Tr. at 98-103. I find this testimony unpersuasive for a number of reasons.

379. First, certain of this testimony directly contradicted sworn deposition testimony from the same witness or prior written statements from the witness. Thus, Ms. Kidder testified in trial that she did not believe the shortages noted in the AHCA survey "were as systematic as they appear on that chart [PX 205]." Kidder on 5/20/2010 Final Tr. at 2751:1-6. At deposition, however, Ms Kidder testifying as the AHCA-designated agency representative on these issues, acknowledged that

the agency believed "there was a critical access to care problem in these specialty types" as to which a legislative budget proposal was made, and that remained true at the time of her deposition. *Id.* at 2751:7 – 2752:5. As discussed above, there are serious credibility issues raised when a witness changes her testimony from that given as a sworn 30(b)(6) witness. Similarly, Ms. Kimbley-Campanaro's testimony was directly in the face of her email, PX 203, which found "challenges" in her area for ten different areas of specialists. It is not credible that the use of the term "challenge" did not connote an understanding of difficulty in finding sufficient specialist providers.

380. Second, certain of this testimony was based on patently unreasonable assumptions as to what constituted reasonable access to care. Thus, Ms. Nieves based her opinion that there was no difficulty in securing access to any specialists in area 8, despite the fact that 14 areas of shortage were identified in 2007 for her area, *see* PX 205, on the assumption that if a single specialist was available for Medicaid recipients in that area or an adjoining area, then there was sufficient access. Nieves on 5/18/2010 Final Tr. at 2264:7-15; *id.* at 2265:1-5 (stating that "if dermatologist in downtown Miami was accepting some children on Medicaid, that would mean for purposes of Area 8 over in Sarasota you would have an available dermatologist").

381. Third, the testimony of AHCA area administrators is based on complaints they receive about difficulties in accessing care. If they do not receive such complaints, because beneficiaries or providers have not contacted the area office, the area administrator would not know that. Gray on 11/28/2011 at Rough Tr. 29; Nieves on 5/18/2010 Final Tr. at 2268:6-22; Kidder on 5/20/2010 Final Tr. at 2753:2-19. The area office also doesn't follow up and know whether care was received, or if received, whether it was unduly delayed or involved extensive travel. *See, e.g.*, Gray on 11/28/2011 Rough Tr. at 30-32; Albury on 11/16/2011 Rough Tr. at 48; Fuller on 11/29/2011 Rough Tr. at 87, 119-120. [Moreover, the volume of calls to area offices concerning specialty care is itself indicative of a problem in beneficiaries' access to such care. *See, e.g.*, Fuller on 11/29/2011 Rough Tr. at 130 (9100 calls for specialists in Area 5 in one year period).] Similarly, the inability of an AHCA employee to "recall a child going without specialty care being discussed," Albury on 11/15/2011 Rough Tr. at 121, in the office is weak evidence at best of the lack of a specialty access problem, especially in the face of documentary evidence from the same area office attesting to a shortage of specialists. *See, e.g.*, PX 202 (specialist needs in Area 9 where Mr. Albury works); PX 198 (shortage of pediatric specialists of every kind in area 11 where Ms. Gray works). As one such AHCA witness acknowledged, he could not

say whether or not children were actually denied care – just that he was not made aware of such problems or issues. Albury on 11/16/2011 Rough Tr. at 46.

382. Fourth, when pressed, these same witnesses often conceded the existence of a specialist care problem. For example, Rhea Gray, the Area 11 administrator, had testified she personally was not aware of complaints about access problems and that an adequate number of specialists were enrolled in the Medicaid program. But Ms. Gray admitted on cross-examination that she had correctly written that the real issues were the willingness of those specialists to see Medicaid patients, and that low pay and billing difficulties were the reported reasons they were not. Gray on 11/28/2011 Rough Tr. at 43-44. Further, while in her personal experience she had not faced more than a two-week delay in having patients seen at Miami Children's Hospital or Jackson Memorial Hospital in Miami, she acknowledged that frequently the wait time for Medicaid children to be seen by a specialist at one of those hospitals was from six to nine months. *Id.* at 45. Finally, Ms. Gray asked others in the office to comment on her draft report, PX 198, before she submitted the final report. PX 199. Gray on 11/28/2011 Rough Tr. at 50. That report indicated there were no specialists "of any kind" willing to see Medicaid recipients in Monroe County, that the Area 11 office has had difficulty in finding specialty care in eleven different fields, including "pediatric specialists of every kind." PX 199.

383. Fifth, none of the testimony provides a persuasive explanation for why a situation of "acute shortages" through most specialty areas throughout most of the state has suddenly disappeared. There have been no changes in reimbursement rates for specialists during this time period, Nieves on 5/18/2010 Final Tr. at 2262:7-16, while demand has continued to increase for services.

384. For all of these same reasons, I place little weight on the conclusory "lay opinion" offered by Beth Kidder and other AHCA witnesses that there were no problems in providing care to children through the state Medicaid program.

385. The existence of a severe problem in access to specialists is also reflected in the legislative budget requests prepared by AHCA and submitted by the governor to the legislature to increase the reimbursement rates for dermatology, neurology, neurosurgery and orthopedic surgery – each of which are specialists that children utilize. Kidder on 5/19/2010 Final Tr. at 2528:12-17. The given reason for the request was a critical access to care problem in those areas. PX 89; PX 90, PX 10; Kidder on 5/19/2010 Final Tr. at 2527:8 – 2528:7. One AHCA legislative budget request stated: "The Medicaid area offices have identified a physician specialty provider shortage and *critical access to care* problem" in these specialty areas. Ex. 727 (emphasis added). These areas were selected not because they were the only ones in which there was a need but rather because a modest proposal was believed to have the best chance politically for passage, Snipes on

12/9/2009 Final Tr. at 405:6-13; Isaac on 8/11/2010 Final Tr. at 3883:4-24 (testifying to statement of Sec. Agwunobi).

386. Carlton Snipes, the former Deputy Secretary of Medicaid and Medicaid director, who was the second highest ranking AHCA official to testify at trial, confirmed that these legislative budget requests reflected the views of the agency. Carlton Snipes on 12/9/2009 Final Tr. at 403:11-22. He testified that "we supported the issues, we felt the issues were important, even critical." *Id.* at 459:1-10.

387. These legislative budget requests for an increase in specialist reimbursement were presented again and again for a number of years. AHCA says that they take the statements in those requests "extremely seriously" and "do their best to give [the Legislature] accurate information." Kidder on 5/20/2010 Final Tr. at 2741:4-6. The requests went through a review process by a number of individuals and bureaus inside AHCA, including the secretary. They were then reviewed by the Governor's office and, indeed, were listed as one of the priorities for legislative action. PX 719 (For 2009-2010 fiscal year, physician specialty fee increase was number one AHCA priority in Governor Crist's recommendations). I find the agency's consistent position expressed in these legislative budget proposals persuasive evidence as to the conditions in Medicaid relating to access to specialty care.

388. Evidence from the DOH demonstrates that CMS children on Medicaid also lack access to specialty care. CMS reported widespread problems accessing specialty care, and said the pediatric specialties for which no access was most frequently encountered were dermatology, neurological surgery, orthopedics, psychiatry and urology, according to a 2004 CMS survey of the 17 CMS area and regional offices. PX 319. In October of 208, Vickie Posner, testifying as a designee of DOH was asked whether DOH was aware of any difference in the ability of children on Medicaid to access specialty care as compared to children with other types of insurance. She replied: "Anecdotally we know that some – if you are going to include all of insurances in that question, private paying, private insurance children have access to services that Medicaid children do not have. I think that's fairly widely recognized in the State of Florida." Posner on 10/28/2008 Depo. Design. at 83:20 – 84:12 (limited by Court ruling to CMS children only).

389. A number of pediatricians throughout the state also gave consistent and persuasive testimony as to the difficulties they faced in referral of children on Medicaid to specialty care. Dr. Lisa Cosgrove, a Brevard county pediatrician whose practice consists of approximately 20 percent Medicaid patients, has difficulty referring Medicaid children to dermatologists, allergists, orthopedic surgeons, neurologists and endocrinologists. Cosgrove on 5/19/2010 Final Tr. at 2563:12-17, difficulties not faced with commercial patients, *id.* at 2566:11-15,

2569:11 – 2571:14, 2573:1-6. These difficulties have continued, as testified by Dr. Cosgrove in her rebuttal testimony on January 31, 2012, with recent and continuing problems in referring Medicaid children to rheumatologists, orthopedics, dermatologists; Cosgrove on 1/31/2012 Rough Tr. at 149-152.[34]

390. Dr. Nancy Silva, a pediatrician in Hillsborough and Pasco counties, who had approximately 20 percent of her practice with Medicaid patients, also testified that she has trouble referring Medicaid patients to dermatologists, ENTs, ophthalmologists, orthopedists, endocrinologists, general surgeons, rheumatologists, and infectious disease specialists, among others. Silva on 5/20/2010 Final Tr. at 2779:6-15. Medicaid children have to wait three to five months in Brandon and one to three months in Tampa whereas commercial-insurance patients can be seen within one to two weeks. *Id.* at 2779:17 – 2780:8. In rebuttal testimony, Dr. Silva confirmed recent difficulties and travel times

[34] Defendants' hearsay objections to this rebuttal testimony by Dr. Cosgrove concerning referrals were overruled at trial, and I adhere to that ruling. Dr. Cosgrove's knowledge of these referral issues is obtained as part of her discussions with patients' parents or guardians in the course of treating their children and is then noted in the medical records as relevant to their treatment. Cosgrove on 1/31/2012 Rough Tr. at 145-146. *See* FED. R. EVID. 803(4); *see also U.S. v. Belfast*, 611 F.3d 783, 818-19 (11th Cir. 2010) (finding no error in admission of doctor's statement that patient reported he had been tortured over hearsay objection); *In re Moore*, 165 B.R. 495, 498-99 (M.D. Ala. 1993) (overruling objection to admission of counselor's statement relaying victim's identification of sexual assailant); *Portis v. Wal-Mart Stores East, L.P.*, Case No. No. 07-0557-WS-C, 2008 WL 3929672, at *3 (S.D. Ala. Aug. 22, 2008) (overruling hearsay objection to physician's statement including medical history relayed by patient).

experienced by Medicaid patients she refers to specialists, such as allergists, dermatologists, and endocrinologists, not experienced by her private patients. Silva on 1/19/2010 Rough Tr. at 140.[35]

391. Dr. Tommy Schechtman, a pediatrician in Palm Beach County, whose practice consists of 23 percent Medicaid children, similarly testified that it is "much more difficult to find a specialist who is willing or has an open panel to see Medicaid patients." Schechtman on 5/20/2010 Final Tr. at 2836:1-5. Examples included a child with a potentially precancerous mole who could not see a dermatologist for at least a six month period. *Id.* at 2838:2-13. Orthopedic surgeons would only see Medicaid patients with limited diagnoses, *id.* at 2839:3-11. By contrast, there are "no barriers" with respect to commercially insured patients. *Id.* There were no pediatric neurologists in Palm Beach County willing to accept Medicaid patients, leaving the only option for those patients to be travel to Miami. *Id.* at 2840:16 – 2841:12. On one occasion. Dr. Schechtman had to admit a Medicaid child into the hospital to receive a cardiac care that could have been managed in a low-cost out-patient setting if the child's Medicaid HMO plan had been accepted by pediatric cardiologists. *Id.* at 2842:25 – 2844:14. Access for Medicaid patients to ENT specialists is also "extremely limited," although

[35] As with Dr. Cosgrove, the rebuttal testimony on these points – although not the similar testimony given during plaintiff's case in chief – was objected to as based on hearsay. As with Dr. Cosgrove, I find the testimony admissible on the basis of 803(4).

commercial patients have "no problem" being seen. *Id.* at 2844:15 – 2845:17. Dr. Schechtman's rebuttal testimony showed that the obstacles in providing access to specialty care for Medicaid children are continuing. Schechtman on 1/26/2012 Rough Tr. at 14-21, 30-33.

392. Dr. Jerome Isaac, a pediatrician in Sarasota and Bradenton, testified that orthopedic care is not available to children on Medicaid in the "reasonable area' around his practice and that consequently he has seen children whose broken limb was only put in a splint and not a cast, which Dr. Isaac characterized as "medical neglect." Isaac on 8/11/2010 Final Tr. at 3869:10-20. Over the past few years, Dr. Isaac has been unable to refer Medicaid patients to specialists in orthopedics, neurosurgery, dermatology or psychiatry. *Id.* at 3873:3-23.

393. Other PCPs have also experienced trouble referring children on Medicaid, but not children with private insurance, to specialists. Seay Depo. Desig. on 11/14/2008 at 15:9 – 16:24, 20:2-9, 57:7-21; J. St. Petery Depo. Desig. on 11/11/2008 at 191:1-4, 195:7 – 196:11, 197:15-25; J. Ritrosky, J. Depo. Desig. on11/10/2008 at 27:18-22, 50:8-23; Seay Depo. Desig. on 11/14/2008 at 103:7-10; J. St. Petery Depo. Desig. on 11/11/2008 at 198:21 – 199:10; J. Ritrosky, J. Depo. Desig. on 11/10/2008 at 39:9 – 40:3, 45:2 – 47:7, 50:8 – 51:1; Curran Depo. Desig. on 10/7/2008 at 30:4 – 31:8, 32:16 – 34:14, 37:13 – 38:11, 55:8 – 56:4; T. Chiu Depo. Desig. on 11/25/2008 at 103:19 – 106:1; Knappenberger Depo. Desig. on

11/20/2008 at 32:9 – 33:5, 99:12 – 100-8; J. Ritrosky, J. Depo. Desig. on 11/10/2008 at 17:17 – 18:14.

394. The barriers to access to specialist care were confirmed by testimony from the specialists. Dr. Duncan Postma, who is the supervising partner of an ENT specialty practice in Tallahassee, Tallahassee ENT, testified that their practice limits the geographical area from which they accept Medicaid patients, declining to accept patients from outside the 7 county area, and also limits the number of new Medicaid patients to two new Medicaid patients per week per doctor. Postma on 8/4/2010 Final Tr. at 3152:2-19. As a result, Medicaid patients requiring ENT care face a two-month delay as opposed to a delay of two weeks. *Id.* at 3153:7-23, 3155:7-16. These limitations are imposed because Tallahassee ENT "lose[s] money on Medicaid patients and can only afford to lose so much." *Id.* In 2006, the average cost of an ENT patient encounter was $138, but Medicaid paid approximately $88 per encounter; in 2007, the average encounter cost was $135, and Medicaid paid approximately $85 per encounter. *Id.* at 3187-89. For a Medicaid child patient, Tallahassee ENT lost an average of $45-$50 per patient in 2006 and 2007. *Id.* at 3190:5-17.

395. Dr. Brett Baynham, an orthopedic surgeon in Palm Beach County, whose practice is 95 percent children, 25 to 30 percent of which used to be children on Medicaid. In 2004 he limited the number of Medicaid patients he

would see with the low reimbursement rates being the primary driving force for the change. Baynham on 1/24/2012 Rough Tr. at 8-9, 12; *see also* PX 770 (March 2010 email from pediatric otolaryngologist, stating he is the only pediatric ENT in the West Palm Beach area seeing Medicaid patients in an office setting and that he is presently scheduling Medicaid patients more than 2-3 months out.)

396. Dr. Adam Fenichel, an orthopedic surgeon in the Orlando area, testified similarly. While 80 percent of his patients are children, only five percent are on Medicaid. While Dr. Fenichel sees 2,000 new patients a year, he limits his practice to at most only a couple of hundred Medicaid patients, because "the reimbursement for Medicaid is lower than our cost to care for patients." Fenichel on 10/18/2010 Final Tr. at 4301:20 – 4302:4, 4306:2-24; *see also* Phillips Depo. Desig. on 11/24/2008 at 14:9-17, 83:8-18; J. Phillips Depo. Desig. on 11/24/2008 at 33:2-10, 34:2-16.

397. Dr. Ricardo Ayala, a specialist in pediatric neurology, limits the number of new Medicaid patients from straight Medicaid and Medipass he sees in his Tallahassee practice, he loses money on treating these children, and such children face a four to five month wait as opposed to a two week wait for commercial patients. Ayala on 8/9/2010 Final Tr. at 3569:21 – 3570:1, 3580:4-16, 3589:2-11. Furthermore, when he needs to refer children on Medicaid to other specialists, such as orthopedists, psychiatrists, sleep disorder specialists, and

rheumatologists, the referrals are not accepted. *Id.* at 3594:1-14; 3615:6 – 3620:24.

398. Plaintiffs also presented the testimony of Dr. Rex Northup, who in addition to being a critical care pediatrician, served as the regional medical director for Northwest Florida in the CMS program that treats Medicaid children with special medical needs. There are a number of areas within that region where there is "an inability to obtain access to care without augmenting or supplementing the Medicaid rate." Northup on 2/10/2010 Final Tr. at 1598:13-21. CMS has supplemented the Medicaid rate so as to obtain dermatology care, because there are no providers that will routinely see children for the Medicaid rate. Northup on 2/10/2010 Final Tr. at 1617:8-25; *see also* J. Curran Depo. Desig. on 10/7/2008 at 45:1 – 46:9; Knappenberger Depo. Designation on 11/20/2008 at 22:17-25; Seay on 11/12/2008 Depo. Desig. at 106:14 – 108:6. There is no orthopedist to treat children, except in the emergency department of the hospital, on Medicaid in the Panama City area. *Id.* at 1620:17-20, 1622:6-22. Children requiring orthopedic specialty care must travel to other areas, such as Jacksonville or Gainesville while there are orthopedists who will see private pay patients in the area. *Id.* at 1630:19 – 1631:23.[36] ENTs in the area limit the number of Medicaid children they will see,

[36] Dr. Northup's testimony on these points is not dependent on the residual exception to the hearsay rule, as to which another aspects of Dr. Northup's testimony concerning rates was admitted, Tr. at 1636:22 – 1637:9.

and have to drive three hours or more for care. *Id.* at 1638:2-12. For pediatric neurology care, the wait for Medicaid patients is two to three months as opposed to a couple of weeks for other patients. *Id.* at 1643:23 – 1645:18.

399. I find the testimony of these pediatricians and specialists to be credible. They are testifying based on their own personal experience and actions. I note that the Defendants did not call a single primary physician or specialist that offered contrary testimony. The testimony of Plaintiffs' medical witnesses is consistent with the survey evidence and AHCA admissions that there is a serious problem faced by Medicaid children in receiving prompt, let alone equal access, to medical specialists.

400. Based on the combination of AHCA surveys showing serious shortages of specialist care for Medicaid, admissions of AHCA officials, including the Secretary of AHCA, the legislative budget requests submitted repeatedly by AHCA acknowledging a serious access to specialty care problem, and the testimony of a number of medical doctors practicing throughout the state, I find that the EPSDT guarantee of access to care for treatment of conditions identified in children on Medicaid has not been afforded. Children on Medicaid have to travel to other areas of the state and/or wait for several months to obtain care. While there are certain specialists and certain locations, where issues of access – and reasonably prompt access – may not be a problem, the evidence presented

leads me to find that the issue extends throughout the state and across many specialty types. Moreover, the evidence reflects that while a particular specialty problem in a given area may improve with the arrival of a new doctor, that situation may change or another problem may occur because of the dependency of the Medicaid population on a relatively small number of providers, and among that number, many limit the number of patients they are willing to see. Accordingly, I find with respect to specialty care that during the time covered by this case, Florida has not met the obligations of the EPSDT Requirements in Section a(10) or the reasonable promptness requirements in Section (a)(8). *See OKAAP v. Fogarty*, 366 F.Supp.2d 1050, 1109 (N.D. Okla. 2005) (finding violation of reasonable promptness provision as to medical care); *Memisovski ex. rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *50-*56 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions); *Clark v. Kizer*, 758 F. Supp. 572, 575-579 (E.D. Cal. 1990) (finding violation of reasonable promptness provision as to dental care), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 585 (9th Cir. 1992). I similarly find that children seeking specialist care have not received that care as required under Sections 43(B) and 43(C) of the Medicaid Act. *Memisovski*, 2004 WL 1878332, at *50-*56 (finding violation of 42 U.S.C. 1396a(a)(43)(C) relating to the provision of EPSDT corrective services).

401. There is also extensive record evidence that leads me to find that children on Medicaid do not receive equal access to specialist care, compared to insured children in their geographical areas. *See, e.g.*, PX 583; *see Memisovski v. Maram*, 2004 WL 1878332, *42 -*47 (finding violation of equal access provision as to medical care); *OKAAP v. Fogarty*, 366 F.Supp.2d 1050, 1107 (finding violation of equal access provision as to medical services); *Ark. Med. Soc'y, Inc. v. Reynolds*, 819 F. Supp. 816, 825-826 (E.D. Ark. 1993) (finding violation of equal access provision as to medical care); *Health Care for All, Inc. v. Romney*, No. Civ.A.00-10833RWZ, 2005 WL 1660677 at *10-*11 (D. Mass. July 14, 2005) (finding violation of equal access provision as to dental care); *Clark v. Kizer*, 758 F. Supp. at 575-579 (finding violation of equal access provision as to dental care). As discussed elsewhere in these findings, rates are not set with any consideration of the level needed so as to provide such equal access, consistent with the other requirements of Section (30)(A) as required under the Medicaid Act.

**E. Provision/Utilization/Timeliness Of Dental Care**

402. Dental care is especially important for children on Medicaid because poor children are at substantially higher risk for dental disease, primary tooth decay, and its sequellae, and have higher levels of untreated dental disease. PX 85, PX 707.

403. As noted above, 42 U.S.C. § 1396d(r) requires states to provide eligible children with "Dental services including relief of pain and infections, restoration of teeth and maintenance of dental health." Moreover, 42 U.S.C. § 1396a(a)(43)(D)(iii) requires reporting on the number of children receiving dental services. The CMS form 416 is required by CMS to fulfill that reporting requirement.

404. For FFY 2007, of the approximately 1.6 million children enrolled in Florida Medicaid for at least part of the year and so eligible for dental services, only 343,000 received any dental care, according to the CMS-416 Report that AHCA submitted in April of 2008. *See* PX 8 (compare lines 1 and 12a). Dyke Snipes, former Medicaid Director acknowledged, "[T]hat's not acceptable." Snipes on 12/9/2009 Final Tr. at 373:1-8; *see id.* at 442:17-23. That equates to a dental utilization of 21% based on Florida's CMS 416 report (343,529/1,611,397). PX 440 at 52-53. That tied Florida for the lowest Medicaid dental utilization rate in the nation. PX 440 at 52-53. That means 79% of the children on Medicaid in Florida were not receiving any dental care. PX 440 at 52-53. FFY 2008 was not an aberration. For FFY 2006, Florida's Medicaid dental utilization rate was also 21%, which tied it for second lowest in the nation. PX 440 at 52-53; *see also* PX 418 at p. 9.

405. The percentage of children on private insurance who receive dental care is far higher than the percentage of children in Florida on Medicaid who receive dental care. Nationally, 55% of children with private insurance had visited a dentist within a given year, and 37% of the children on Medicaid had dental visit over the same time period, according to a 2008 GAO report. PX 452 at Crall01734; Crall on 11/17/2010 at Tr. 5093:20 – 5094:9; 5161:9 – 5162:25. Of children under 18 from families with incomes above 100% of the poverty line, 49% had a dental visit at least once during a 12-month period, and for children from families with incomes above 200% of the poverty line, the figure rose to at least 56% and perhaps as high as 73%, according to a 2001 report by the federal DHHS. PX 447 at Crall000750.

406. ACHA, through a series of legislative budget requests ("LBRs") and other documents has acknowledged for nearly a decade that Medicaid children's access to dental care is inadequate and that rates must be raised. LBRs go through multiple layers of review; the agency seeks to make them as accurate as possible. Kidder on 5/19/2010 Final Tr. at 2506:24 – 2508:13, 2741:4-6; Cerasoli on 8/11/2010 Final Tr. at 3931:4 – 3932:6. AHCA, through its LBRs, acknowledged that:

- Dental participation in the Florida Medicaid program is declining, *e.g.*, PX 82, PX 83, PX 84, PX 85, PX 88, PX 109, PX 726; *see also* Sharpe on 11/16/2010 Final Tr. at 4947:1-8; Cerasoli on 8/11/2010 Final Tr. at 3934:18-25;

- Florida's Medicaid reimburses dentists at less than 40% of their usual and customary costs, *e.g.*, PX 80, PX 81, PX 82, PX 83, PX 109, PX 715, PX 718, PX 726; *see also* Cerasoli on 8/11/2010 Final Tr. at 3935:12 – 3939:14;

- Florida's Medicaid reimbursement rates are very low compared to other states, *e.g.*, PX 80, PX 85; PX 88, PX 155; PX 718; *see also* Cerasoli on 8/11/2010 Final Tr. at 3957:16 – 3961:18; Sharpe on 11/16/2010 Final Tr. at 4954:8-21; and

- Florida dentists say the state's Medicaid rates do not cover their costs. PX 80, PX 81, PX 82, PX 83, PX 84, PX 88, PX 109.

407. The LBRs repeatedly called for a rate increase. Most striking, the LBRs repeatedly say in almost the exact same language, year after year: "A fee increase for children's dental services is needed if service is to be available." PX 78; *see also* PX 80 (same), PX 82 (same), PX 83, PX 109 (same). The LBRs also state, "An increase of fees is expected to increase provider participation, and subsequently, increase access to dental care." PX 80. The testimony about these LBRs is equally forceful. *See*, *e.g.*, Sharpe on 11/16/2010 Final Tr. at 4945:18 – 4949:8; 4952:16 – 4953:19; 4956:16 – 4963:19; at 4964:19 – 4966:19; 4968:5 – 4970:25; Snipes on 12/9/2009 at 411:15 – 414:10; at 415:10 – 416:8; Kidder on 5/19/2010 Final Tr. at 2534:12-24.

408. None of the above recommendations to increase dental fees was adopted by the legislature. Snipes on 12/9/2009 Final Tr. 423: 20-22. For every year since 2005-2006, the KidCare Coordinating Council has recognized the inadequacy of Florida's dental rates and recommended, in vain, increases in dental

reimbursement rates. PX 697, 698, 699, 349, 350, 682. From 1987 through 2010, Florida Medicaid dental rates were increased once, by 13 percent in 1998. Cerasoli on 8/11/10 Final Tr. at 3951:10-25. Meanwhile, children's enrollment in the Florida Medicaid program rose by about 78% from 1998 to 2008, thus widening the gap between the services needed and those available. PX 682 at 12; Kidder on 5/19/2010 Final Tr. at 2485:4 – 2486:4.

409. Defendants claim that some of those numbers in the LBRs showing a decline in the number of dentists participating in Medicaid were simply copied without verification from one year to the next. While that might be true, in part, it is clear that the percentage of licensed dentists enrolled in and participating in Florida Medicaid has declined. AHCA's own interrogatory response demonstrates that the number of general dentists with 100 or more paid claims for treating children declined from 616 to 377, a drop of more than 38%, from FFY 2003 to FFY 2007. PX 739 at Table 2. During the same time period, the number of oral surgeons with 100 or more paid claims for children fell more than 30% and the catchall category of other dentists plummeted from 130 to 42, a decline of 67%. *Id.*

410. It is clear that the reason for the declining participation is Florida's woefully inadequate dental reimbursement rates. A 2004 study by the American Dental Association, which AHCA relied upon in putting together its LBRs, showed

that Florida ranked 48th in the nation among state Medicaid program in its rates for preventative services and 49th in the nation in its rates for treatment services rates. PX 155 at 13-14; Cerasoli on 8/10/10 Final Tr. at 3960:22 – 3961:18. The same study showed that 15 dental procedures Florida's Medicaid reimbursement rates ranked no higher than the 5th percentile nationally, and for ten procedures, Florida's reimbursement rates were below the first percentile nationally. PX 155 at 6; PX 109 at AHCA00719087 to 88 (showing reimbursement rates were below dentists' costs for 6 of 7 procedures analyzed); Cerasoli on 8/10/11 Final Tr. at 3957:3 – 3959:24.

411. In 2001, the Health Care Financing Agency, the predecessor to federal CMS, stated: "In general, HCFA believes that significant shortfalls in beneficiary receipt of dental services, together with evidence that Medicaid reimbursement falls below the 50th percentile of providers' fees in the marketplace, create a presumption of noncompliance with both these statutory requirements. Lack of access due to low rates is not consistent with making services available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at CRALL 00751. Ms. Kidder admitted that if Medicaid reimbursements for dentists are below the 50th percentile (which they are), then

Florida is presumptively out of compliance with the Medicaid Act. Kidder Testimony on 5/20/2010 Final Tr. at 2733:5-11.

412. Numerous other agency officials from the Secretary on down have acknowledged substantial problems with Florida's Medicaid dental program. Alan Levine, a former AHCA Secretary, sent an email lamenting that "only 16 percent of our children in Medicaid fee-for-service got any preventative dental care last year." PX 277A. Then-Deputy Secretary and later Secretary of AHCA, Tom Arnold, gave a speech at the 2007 Medicaid Access to Specialty Care Summit, in which he presented charts showing that a small fraction of dentists participated in Medicaid and even fewer actually billed for Medicaid services. St. Petery on 12/8/2009 Final Tr. at 240:3 – 245:15. Summit related documents show that only 7.8 % of the 9,021 licensed dentists in Florida were enrolled in Medicaid, and only 502 or 5.6%, actually billed Medicaid. PX 218 at 4; *see also* PX 211 at p. 9.

413. Robert Sharpe, ACHA's Medicaid Director from 2000 to 2004, testified personally he did not believe that AHCA was in compliance with the reasonable promptness standard as to dental care. *Id.* at 4976:15 – 4977:9. He testified "Well, we're acknowledging that for a federally required service, at least for the children's portion of dental care, that the state is not even meeting federal requirements for the provision of that care." *Id.* at 4970: 20-25; PX 108. He said

he could not have made a stronger statement without being fired. *Id.* at 4962:11 – 4963:19; 4941: 8-25.

414. As recently as last year, AHCA recognized that even excluding the children enrolled in prepaid dental plans and Medicaid HMOs and PSNs that provided dental care, an astonishing figure of 834,651 children enrolled in Florida Medicaid had not received any dental care in at least six months, even though the periodicity schedule calls for them to have a dental check-up every six months. PX 150, PX 790.

415. Ms. Kidder acknowledged "a significant shortfall in beneficiary receipt of dental services." Kidder on 5/20/2010 Final Tr. at 2756:21 – 2757:5; 2728:20-22; 2730:6-9. In a November 2006 email, she wrote Medicaid reimbursement rates were "extremely low" and stated: "This is a serious barrier to dental care and is causing problems with access to dental care across much of the state…" PX 167; *see also* Cerasoli on 8/11/2010 Final Tr. at 3966:13-24. Ms. Cerasoli, AHCA's agency witness on deposition dental issues, acknowledged that Florida's Medicaid reimbursement rates "are among the lowest in the United States." Cerasoli on 8/11/2011 Final Tr. at 3932:13-15. The main reason many Florida dentists won't provide services to Medicaid recipients is because of its low reimbursement rates. *Id.* at 3933:7-11. Fewer and fewer dentists are enrolling in Florida Medicaid and treating Medicaid beneficiaries. *Id.* at 3934:18-25.

416. The Department of Health also acknowledged "a common barrier to access to services is a lack of specialty and dental providers, primarily attributable to the low Medicaid reimbursement rates." PX 315 at DOH00079770.

417. Florida Medicaid HMOs in Reform and non-Reform counties must report their HEDIS results for annual dental visits for members 2-21. Florida Medicaid HMOs in both programs score poorly compared to Medicaid HMOs nationally. The weighed measure of the Florida Reform MCOs is 15.1955% and the national measure for HMOs is 42.5%, according to a 2007 report, the most recent in the record. DX 334 at 2; Brown-Woofter on 11/8/2011 Rough Tr. at 32-33.

418. The first large MCO to provide dental care to Medicaid beneficiaries was Atlantic Dental Inc. ("ADI"). From FFY 2003 through FFY 2007, the most recent year for which there is data in the record, ADI never provided more than 23.12% of eligible recipients with any dental services. PX 14, PX 15, PX 16, PX 22. The dental participation rate peaked at 18.09% for this period. *Id.* Many ADI dentists provided even less care. Reports from individual dental providers, covering 2007 and 2008 in six month blocks, show that for each period, the majority of providers treated fewer than 15% of the children assigned to them; several provided no dental care whatsoever for the numerous children assigned to them. DX 519.

419. Testimony from providers underscores the lack of access to dental care. In the Tallahassee area, dental care is readily available to children with private insurance, but not children on Medicaid. Patients with cardiac issues must be sent to the University of Florida dental clinic in Gainesville where there is a six-month wait. St. Petery on 12/8/2009 Final Tr. at 260:19 – 261:17; 263:5 – 266:13.

420. Dr. Lisa Cosgrove, a pediatrician who practices in Merritt Island, Brevard County, Florida (Cosgrove on 5/19/2010 Final Tr. at 2550:8-9; 2525:15-25) finds that it takes six months to refer a Medicaid child enrolled in Medipass or a child enrolled in the Wellcare HMO to a dentist. Cosgrove on 5/19/2010 Final Tr. at 2573:7 – 2574:2. She had a Medicaid child with an abscess who could not get an appointment with a dentist for three months. *Id.* at 2574:3-23. In rebuttal testimony, she testified to continuing recent problems. Cosgrove on 1/31/2012 Rough Tr. at 147-152.

421. Nancy Silva, a Brandon pediatrician, does not know any dentists who will see Medicaid kids for bottle rot or deep cavities. Silva on 5/20/2010 Final Tr. at 2768:1-2; 2794:16 – 2796:9. Nor does she know of any dentists in Hillsborough County accepting new Medicaid patients. *Id.* at 2819:20-24; 2820:1-18.

422. Dr. Tommy Schechtman is a pediatrician who practices out of three offices in Palm Beach County. Schechtman on 5/20/2010 Final Tr. at 2832:6-9,

2833:7-14. Most of his Medicaid patients do not see a dentist. *Id.* at 2845:18 – 2846:5; 2846:6-18.

423. Rex Northup is a pediatric critical care physician, regional director for Children's Medical Services for Northwest Florida, and Co-Medical Director of Sacred Heart Children's Hospital in Pensacola. Northup on 2/10/2010 Final Tr. at 1585:5-8; 1588:23 – 1589:5; 1585:17-24. There are waiting lists of "several months' time" for CMS children to receive specialized dental care at Sacred Heart's dental clinic. *Id.* at 1600:9 – 1601:6; 1602:19 – 1603:9. At the time Dr. Northup testified, the clinic had just become operable again after a "several months' period of seeing no patients" because there was no dentist available. *Id.* There is high demand for services at the clinic because it "is the only dental clinic or dental provider in the four-county area specifically seeing pediatric patients that will take Medicaid[.]" *Id.* at 1603:12-18. Other dentists in the area accept private paying children. *Id.* at 1603:19-21.

424. Dr. Northup sometimes pays dentists rates above the Medicaid rates to treat CMS children because that "is essentially the only way we've been able to obtain access to dental care for those children." *Id.* at 1605:20-22; 1606:1-4. Dr. Northup supplements the Medicaid rates paid to dentists when a child needs urgent care and cannot wait the two to three months it otherwise would take to see a dentist. *Id.* at 1607:18 – 1608:1.

425. Other PCPs also have trouble referring children on Medicaid to dentists. J. St. Petery Depo. Desig. on 11/11/2008 at 197:15-25; Testimony Dr. John Curran Depo. Desig. on 10/7/2008 at 39:21 – 41:1, 41:22 – 42:3, 42:16 – 43:5; T. Chiu Depo. Desig. on 11/25/2008 at 87:21 – 89:1; J. Ritrosky, J. Depo. Desig. on 11/10/2008 at 49:9 – 50:7.

426. Dr. Natalie Carr is a pediatric dentist who practices outside of Tampa. Carr on 8/10/2010 Final Tr. at 3787:10-13. She practiced in Texas, where 99 percent of her patients were on Medicaid. In Florida, she did not accept Medicaid because "the reimbursement in Florida was much lower than it was in Texas at the time." *Id*. at 3789:25 – 3790:2. Sometimes, parents of Medicaid children come to her offering to pay her to render services to their child because they cannot find a Medicaid dentist. *Id*. at 3791:24 – 3792:8. She has difficulty making referrals because there are so few dentists in the area who accept Medicaid, and most of those do not accept new patients. *Id.* at 3793:3-20; 3808:17-24. Dr. Carr testified that she would not accept Medicaid patients in her new practice because even with a 48% increase the gap between the fees she charges is too great. Carr on 1/23/2012 Rough Tr. at 7:2-19.

427. Dr. Robert Primosch is a Professor of Pediatric Dentistry and Associate Dean of Education at the College of Dentistry of the University of Florida in Gainesville. As Chairman of the Department of Pediatric Dentistry, Dr.

Primosch ran the dental clinic for children, 80% of whom were on Medicaid. Primosch on 8/10/2010 Final Tr. at 3721:15-20; 3722:24 – 3723:4; 3725:9-16. The clinic saw about 14,000 patients a year, and the demand for its services exceeded its capacity. *Id.* at 3732:25 – 3733:4; 3725:17 – 3726:20. When Dr. Primosch ran the clinic, there was a six-month wait for children whose dental needs required hospitalization and that waiting period has not shortened since for children whose care he has supervised. *Id.* at 3731:4 – 3732:1.

428. Dr. James Crall is a professor of pediatric dentistry at UCLA, and a former chair of UCLA's pediatric dentistry section. Crall on 11/17/2010 Final Tr. at 5069:21-23, 5070:2-3; 5071:1-13. He was director from 2000-2008 of the National Oral Health Policy Center, which is funded by the Health Services and Resources Administration (HRSA). *Id.* at 5070:11-21. Over the last 25 years, Dr. Crall has held a variety of positions with numerous national and federal government bodies dealing with oral health policy. *Id.* at 5072:21 – 5073:20. Dr. Crall has twice testified before Congressional committees and twice before state legislatures. *Id.* at 5073:22 – 5074:7. He has published 60-65 articles in peer reviewed journals, *id.* at 5075:14-19, including many on the relationship between rates and participants by dentists in Medicaid programs. I accept Dr. Crall as an expert on public policy with respect to the provision of dental care to low-income children.

429. Dr. Crall testified: (a) Children's access to dental care in Florida Medicaid program is quite low, declining and inadequate; (b) Dentists' participation in this Florida Medicaid program is low, inadequate and declining; (c) Florida Medicaid rates are low compared to market based fees charged by dentists and far below the average overhead cost of providing dental services; and (d) Medicaid rates need to be increased at least to the 50th percentile of prevailing fees charged by Florida dentists to significantly improve access. Crall on 11/17/2010 Final Tr. at 5078:15 – 5079:5; 5079:12 – 5081:14; 5081:15-23; PX 418.

430. Dr. Crall's conclusion regarding access was based on Florida's CMS 416 reports showing that only 21-23% of eligible children received any dental care, and even fewer children received preventative care or treatment. PX 418 at p. 9; Crall on 11/17/2010 Final Tr. at 5082:8 – 5084:3; PX 447. By contrast, more than half of privately insured children receive dental care in the course of a year. Crall on 11/17/2010 Final Tr. at 5093:20 – 5094:9; 5161:9 – 5162:24; PX 452 at 13.

431. Despite Defendants' multiple attacks on the use of the form 416 data to measure access to dental care, the 416 remains the method which CMS uses to measure state performance. Crall on 2/7/2011 Final Tr. at 5208:1-22; PX 440 at 3; Crall on 1/26/2012 Rough Tr. at 155. HEDIS data are available only for managed care companies (Crall on 2/7/2011 Final Tr. at 5243:12-14) and are based on survey data while the CMS – 416 relies on all the data. Crall on 2/7/2011 Final Tr.

at 5243:12-22. Defendants touted the role of County Health Departments and Federally Qualified Health Centers in providing dental care for children on Medicaid, and suggested those institutions were sufficient to compensate for the paucity of private dental providers. However, based on the instructions for the CMS 416, all dental care provided to children by CHDs and FQHCs are counted on the CMS 416. Crall on 2/8/2011 Rough Tr. at 82-83. So I find that the number of children receiving dental care at either CHDs or FQHCs, which ranged from about 65,000 children in FFY 2003 to about 103,00 children in FFY 2007, as shown on PX739 (last page, table 3), are included in the total number of children receiving dental care as shown on the CMS 416s for those years. And the numbers on the CMS 416 demonstrate, that notwithstanding the important role played by CHDs and FQHCs, 79% of the children on Medicaid in Florida did not receive any dental care in FFY 2007.

432. Defendants' expert Ms. Sreckovich confused dental procedures with dental visits, in an error that undercuts her credibility, as even her own back-up materials clearly showed she was counting procedures. Sreckovich 1/10/2012 Rough Tr. at 23-24, 26-27. This had a significant effect on her analysis because dentists often perform several procedures during one visit, *id.* at 23, and made it appear as if children in Medicaid were receiving twice as much care, or more, than they really were. *Id.* at 31-34.

433. Even after Ms. Sreckovich corrected that error, she computed an average number of dental visits among all patients that completely obscures the fact that the vast majority of children received no dental visits. 2/8/2011 Rough Tr. at 102-103. I conclude that Dr. Crall is justified in relying upon the CMS 416 reports, and that the figures in those reports, are more telling that Ms. Sreckovich's average dental visit analysis.

434. Dr. Crall determined that Florida Medicaid rates were far below market rates and far below dentists' costs. He compared Florida Medicaid payment rates in each of the 14 procedure codes to the 51st and 70th percentiles of 2008 charge data provided to him by Met Life, a very large commercial dental insurer. Crall on 11/17/2010 Final Tr. at 5119:24 – 5120:13, 5122:5-22; 5126:3-4. Dr. Crall also obtained charge data from the "2008 National Dental Advisory Service Comprehensive Fee Report" (the NDAS report), which uses a system like Medicare's RBRVS system to make geographical adjustments. *Id.* at 5126:9 – 5127:20. Florida Medicaid rates equal only 22% to 41% of the 50th percentile NDAS charges and 22% to 45% of the 51st percentile of Met Life charges. *Id.* at 5131:7 – 5132:20; PX 418 (Table 5 and page E11 of the Appendix).

435. In reaching his opinion about the adequacy of Florida's Medicaid dental rates, Dr. Crall considered the dental service component of the Consumer Price Index, and determined that since 2003, inflation had run about 40%, at a

compound rate, *Id.* at 5138:19 – 5139:15), and that the literature shows that 60-68% of dental office revenues, exclusive of any compensation to the dentists, are spent on overhead. *Id.* at 5139:17 – 5140:6.

436. Dr. Call examined not only the 50th percentile of dentists' charges, but also 70th-75th percentile of dentists' charges because of the use of that percentile as a benchmark for Medicaid rates in Indiana, South Carolina, Connecticut, and Tennessee and in connection with settlement of litigation. *Id.* at 5140:15 – 5141:20; PX 418 at 11. A sizeable increase in dentists' participation followed Medicaid dental rate increases to at least the 75th percentile of charges. *Id.* at 5141:11 – 5144:19; PX 418 at 11. Dr. Crall knows of no state which had an increase of 58% or more in dental participation without a contemporaneous increase in Medicaid rates to at least market levels. *Id.* at 5145:6-12.

437. Defendants criticize Dr. Crall's charge data. Dr. Crall used charge data rather than payment data because, among other things, reports in the literature, including a GAO report, is that dentists' collection rates are close to 95%. *Id.* at 5121:2-22; *id.* on 2/8/2011 Rough Tr. at 75:21 – 76:14. Moreover, making comparisons using payment data from commercial insurers (if it were readily available) would be problematic because co-pays and deductibles are also paid. Crall on 2/8/2011 Rough Tr. at 82:7-17.

438. Michigan had a 300% increase in dental participation within 12 months in the counties where the rates were increased. *Id.* at 5147:1-7. In those Michigan counties where the increase in dental rates was implemented, the number of children receiving a dental service increased about 32.3 % the first year, *id.* at 5148:23-25; Crall on 1/26/2012 Rough Tr. at 106-107.

439. Dr. Crall also examined the effect of the rate increases from 1998 to 2003 in Alabama, Delaware, Indiana, South Carolina and Tennessee on the number of children reported as receiving dental care on the respective states' CMS 416 reports. Crall on 11/17/2010 Final Tr. at 5147:12 – 5148:2; PX 418 at 11. The number of Medicaid children receiving any dental service over the period 1998 - 2003for these five states increased by 168% to 446%, according to these states' respective CMS-416 reports. Crall on 2/8/2011 Rough Tr. at 70-74. Those results are illustrated by the following chart in his report:

| | FY1998 CMS 416 % with Dental Visits | FY2001 CMS 416 % with Dental Visits | 2001 vs. 1998 CMS 416 % with Dental Visits | FY2003 CMS 416 % with Dental Visits | 2003 vs. 1998 CMS 416 % with Dental Visits |
|---|---|---|---|---|---|
| AL | 41,659 | 105,522 | 253% | 151,581 | 364% |
| DE | 8,428 | 15,430 | 183% | 18,269 | 217% |
| IN | 47,730 | 160,627 | 337% | 212,909 | 446% |
| SC | 96,590 | 88,523 | 92% | 245,297 | 254% |
| TN | 148,028 | 141,140 | 95% | 249,252 | 168% |

PX 418 at 12. (The first, second and fourth columns should read "number with Dental Visits," not "% with Dental Visits.). The 2007 Connecticut settlement lead to an increase to the 70th percentile of dentists' charges and that in turn resulted in

a tripling of dentists participating in Medicaid and an increase of 38-45% in utilization in the most recent two year period. Crall on 11/17/2010 Final Tr. at 5140:15 – 5141:10, 5150:12-24.

440. Dr. Crall concluded that in order to increase the number of dentists who participate in the Medicaid program in an amount comparable to the increases achieved in these states, it would be necessary to increase the rates Florida Medicaid pays dentists at least to the 50th percentile of dentists' charges in Florida. *Id.* at 5149:15 – 5150:7. CMS has also used the 50$^{th}$ percentile as a benchmark of the adequacy of dental fees. PX 447 at CRALL00751.

441. Ms. Sreckovich's contention that increases in dental rates do not increase dentists' participation is belied by the numerous examples Dr. Crall cited in his initial report. PX 418. Crall on 1/26/2012 Rough Tr. at 104. As Dr. Crall opines, a significant increase will induce more dentists to participate in Medicaid.

442. The most important factor in inducing dentists to participate in Medicaid is the adequacy of the reimbursement rates. Crall on 2/7/2011 Final Tr. at 5341:3-13; 5380:15-16; PX 450 at CRALL01638 ("Dentists cite as the primary reason for their not treating more Medicaid patients that payment rates are too low.") If anything, factors such as high rates of broken appointments and higher rates of dental disease militate in favor of dentists being given financial incentives

to see Medicaid children equal to or greater than the rest of the population. Crall on 2/8/2011 Rough Tr. at 77-78.

443. Dr. Crall also considered the trend line of the number of dentists participating in Medicaid. Crall on 2/8/2011 Rough Tr. at 81; PX 418 at 8-9. He concluded, based on data from the CDC and from a State of Florida website that about 1,000 active Medicaid dentists was insufficient to serve a Medicaid population of 1,600,000. Crall on 11/17/2010 Final Tr. at 5089:13 – 5099:18. In rebuttal report, Dr. Crall amplified his analysis, using the 700 Medicaid children per active Medicaid dentist benchmark developed in Tennessee Medicaid Litigation Settlement. Crall on 2/8/2011 Rough Tr. at 63; PX 439 at pp. 7-8; Crall on 1/26/2012 Rough Tr. at 188.

444. In vast majority of the counties of Florida, there are a considerable number of dentists not actively participating in Medicaid. Even if only half the dentists in each Florida county participated in Medicaid, there would 35 counties, including those with the largest population of Medicaid children, with fewer than 700 Medicaid children per participating dentist. PX 439 (Appendix A, far right column showing number of Medicaid kids per active dentist is less than 350).

445. Defense counsel suggested that Dr. Crall failed to take into account that a number of Florida counties are designated health shortage areas. Crall's analysis is consistent with the Federal Health Resources Services Administration

(HRSA), which considers as dental shortage areas those areas where population per dentist ratio exceeds 3,000 to 1. Crall on 2/7/2011 Final Tr. at 5348:21 – 5349:17. Based on the data on HRSA's website, only 15 % of Florida population lives in an area considered underserved. Crall on 2/7/2011 Final Tr. at 5349:10-22.

446. Defense counsel also suggested Dr. Crall he should have included adults seeking dental care in his workforce analysis. Crall on 1/31/2012 Rough Tr. at 121-122. I agree with Dr. Crall that the appropriate comparison for a workforce survey is between the access for children on Medicaid and the access for children in general because he was analyzing children's access to dental care. Crall on 2/8/2011 Rough Tr. at 59.

447. Effective July 1, 2011, following an appropriation by the Florida Legislature, AHCA increased the rates paid by Florida's Medicaid Program for dental services by 48%. D.E. 962, p. 2. Dr. Crall prepared a supplemental report dated May 24, 2011, in which he assessed the impact of Florida's 48% increase in rates, PX 786, Crall on 1/26/2012 Rough Tr. at 87, and concluded that "the increase of 48% still leaves Florida dental Medicaid rates severely below adequate market-based rates" and so he continues to believe these rates must be increased. *Id.* at 88. Dr. Crall took the increased rates and compared them to two of the three measures which he used to evaluate the charges in his initial expert report *i.e.*, the 2008 NDAS comprehensive fee survey and the 2008 data he obtained from the

commercial dental plan. *Id.* at 88. The following chart shows after considering the 48% increase, Florida's dental reimbursement is still very low as compared to normal dentistry charges, even without accounting for inflation since 2001.

| Procedure Code | FL Medicaid Rates | FL Medicaid Rates vs. 2001 ADA S Atlantic %-iles | FL Medicaid Rates Based on Proposed 48% Inc | FL Medicaid Rates w/ 48% Inc vs. 2001 ADA S Atlantic %-iles |
|---|---|---|---|---|
| D0120 | $15 | 5th | $22 | 33rd |
| D0150 | $16 | <1st | $24 | 5th |
| D0210 | $32 | <1st | $47 | 4th |
| D0272 | $9 | <1st | $13 | 2nd |
| D0330 | $30 | 1st | $44 | 4th |
| D1120 | $14 | <1st | $21 | <1st |
| D1203 | $11 | 4th | $16 | 20th |
| D1351 | $13 | <1st | $19 | 3rd |
| D2150 | $41 | <1st | $61 | 4th |
| D2331 | $39 | <1st | $58 | 1st |
| D2751 | N/A | | | |
| D2930 | $68 | 2nd | $101 | 10th |
| D3220 | $50 | 3rd | $74 | 18th |
| D3310 | $148 | 1st | $219 | 3rd |
| D7140 | $27 | <1st | $40 | 1st |

D.E. 964-6. Comparing the Florida rates with the 48% increase to Southeast Atlantic Region percentiles from the American Dental Survey in 2001 shows all 14 of those new Florida Medicaid enhanced rates below the 33rd percentile and 11 of the new rates in the 10th percentile or lower. *Id.* at 92-93. PX 786, Exhibit E.

448. From 2001 to 2010 the dental component of the Consumer Price Index increased 51%. *Id.* at 93. PX 786, par. 15. Dr. Crall in his supplemental declaration therefore concluded that: "given the woeful inadequacy of the current rates, a 48% increase in Florida's Medicaid dental reimbursement rates might slow

the exodus of providers from Florida's Medicaid program, but is not sufficient to induce a significant number of providers to enter or re-enter the program, or to stimulate current providers to substantially increase the number of children on Medicaid that they are willing to treat. As I previously indicated, doing so would require raising reimbursement rates to a least the 50th percentile of dentists' prevailing charges." *Id.* at 93. PX 786 par. 16.

449. In his initial report, Dr. Crall also analyzed capitation rates. He considered three actuarial studies done in 1998, 1999 and 2004 of per member, per month (PMPM) amount necessary to cover dental care for children on Medicaid. These studies, which on average are more than a decade old, found that from about $17 to $26 PMPM was necessary. Crall on 11/17/2010 Final Tr. at 5133:7 – 5160:10, PX 418 at 6-8. By contrast, AHCA's 2009 contract with the company that acquired ADI called for a PMPM amount for children from 1-20 of between $5.53 and $7.86, depending on age and status. DX 355 at 88. Even with the 48% dental fee increase, effective as of July 1, 2011, MCNA's blended capitation rate was $11.88, Brown-Woofter on 11/10/2011 Rough Tr. at 66-67, still far below the amount necessary to provide adequate dental care for children on Medicaid, according to the three studies cited by Dr. Crall, the only such studies in the record.

450. Ms. Sreckovich has not done any analysis on the effect of the 48% increase in dental rates which Florida instituted in 2011, either for fee for service

providers or for providers enrolled with dental managed care organizations. Sreckovich on 1/17/2012 Rough Tr. at 45-46. Ms. Sreckovich's analysis of whether Florida's Medicaid rates may be sufficient to cover the variable costs of treating a Medicaid patient is largely irrelevant because: (1) she did not address the dentists' opportunity cost; and (2) did not consider whether in the real world rates above variable costs but below average costs would motive dentists to see Medicaid patients. Crall on 2/7/2011 Final Tr. at 5334:19 – 5337:6; 5342:4-6. In her analysis of the dental rates in Florida, Ms. Sreckovich reached no conclusion that the rates paid dentists by the Florida Medicaid program were adequate to ensure children had access to care. Sreckovich on 1/17/2012 Rough Tr. at 33-34.

451. The Florida legislature has authorized ACHA to expand Medicaid prepaid dental plans statewide. Brown-Woofter on 10/25/2011 Rough Tr. at 50-52. The prepaid dental plans in Miami-Dade County as well as statewide will be required to pass along to providers the 48% increase in dental fees which took effect July 1, 2011. Brown-Woofter on 11/8/2011 Rough Tr. at 126-127. Ms. Sreckovich knows of no evidence and offered no opinion regarding the likely effects of the prepaid dental plan, which Florida is putting into effect in 2012 . Sreckovich on 1/17/2012 Rough Tr. at 48. Defendants did not submit any evidence by Ms. Sreckovich or otherwise that the 48% increase in dental rates or the statewide prepaid dental plan will be sufficient (a) to raise Florida's Medicaid

dental rates to private market rates; (b) induce substantial additional numbers of Florida dentists actually to offer services to children enrolled in Medicaid or (c) increase the percentage of children enrolled in Medicaid to the 30% level, which CMS has considered a minimum threshold for compliance. *See* PX 447 at 3. Defendants did not call any dentists to testify.

452. After reviewing the evidence and weighing the expert opinions, I find that until the recent July 1, 2011 increase, Florida's Medicaid reimbursement rate was among the lowest in the nation, and not surprisingly, Florida's Medicaid dental utilization rate was also among the very lowest if not the lowest in the country.

453. I find that while a number of different factors affect dentists' decisions as to whether to participate in Medicaid, the adequacy of reimbursement rates is the most important of those factors., and that with a significant increase in rates, will come a significant increase in provider participation, which, in turn, will lead to a substantial improvement in children's access to care.

454. Defendants have offered no evidence or opinion to contest Dr. Crall's opinion that even with a 48% increase Florida's Medicaid reimbursement rates are woefully inadequate. I find his opinion credible and accept it, especially given the utter lack of any contradictory evidence.

455. I agree with Dr. Crall's opinion, based inter alia on the fact 79% of the children enrolled in Medicaid are getting no dental services at all, that Medicaid children in Florida are not receiving dental services with reasonable promptness. Crall on 1/26/2012 Rough Tr. at 96-97. *See Health Care for All, Inc.*, 2005 WL 1660677, at *10-11 (D. Mass. July 14, 2005) (finding violation of EPSDT requirements and the reasonable promptness provision as to dental care); *Memisovski,* 2004 WL 1878332, at *50 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions); *Clark v. Kizer*, 758 F. Supp. at 575-579 (finding violation of reasonable promptness provision as to dental care).

456. It also means Florida is not in compliance with the EPSDT requirements. *See Health Care for All, Inc. v. Romney*, 2005 WL 1660677, *14 (D. Mass. July 14, 2005) (finding a violation of 43(B) and (C) as to dental care); *Memisovski,* 2004 WL 1878332, at*50-*56 (finding violation of EPSDT provisions).

457. I also agree with Dr. Crall's opinion that Florida's Medicaid dental rates failed to provide equal access in violation of 42 U.S.C. § 1396a(a)(30)(A) for Florida's Medicaid children in each of AHCA 11 regional areas, based on how few dentists participate in Florida Medicaid and on the 79% of children who get no dental service. *Id.* at 98:6-20. *See Health Care For All, Inc.,* 2005 WL 1660677, at *10-*11 (finding violation of equal access provision as to dental care); *Clark v.*

*Kizer*, 758 F. Supp. at 575-579 (finding violation of equal access provision as to dental care).

**F. Provider Enrollment**

458. I have discussed above the issues surrounding the adequacy of the number of providers of primary, specialty and dental care for Medicaid children, and whether such providers even if enrolled limit the number of Medicaid patients they will see. I consider here the issue of whether increased reimbursement levels would likely result in increased provider participation, and hence access to care for the plaintiff class. I note that this issue already has been discussed expressly with respect to dental care. *See* Section VI. E, *supra*, and indirectly inasmuch as AHCA and others have discussed primary and specialist care problems in terms of the inadequacy of reimbursement rates.

459. While it is recipients and not providers who hold the rights provided by federal law, any analysis of their ability to access that care at all, or with the Reasonable Promptness and Equal Access, required by the Medicaid Act, must take into account the relationship between the rates at which provider reimbursement and participation by providers in the program, which reflects access to care.

460. The relationship between provider reimbursement and participation in Medicaid has been studied by academic researches, and analyzed by policymakers

at the state and federal level. There also have been certain empirical tests where reimbursement has been increased, and finally, there are legislative judgments that have been made in this area. For example, Section 30(A) itself reflects an understanding that reimbursement is directly related to access to medical care by directing that rates be set, *inter alia*, so as to insure equal access to care for Medicaid children – a statutory provision which would make no sense in the absence of a relationship between the two.

461. Plaintiff's expert, Dr. Samuel Flint, opined that "the fundamental issue that drives participation, that determines physician's decisions to participate in the program, or to limit their participation is the rate of reimbursement." Flint on 8/3/2010 Final Tr. at 2949:21 – 2950:5. Dr. Flint testified that 27 of 30 peer-reviewed studies that he reviewed supported this view. *Id*. This academic research came from different parts of the country, using different research methods, different time frames and different populations. *Id.* at 2951:5-7. While this academic research did not deny the presence of other factors, in Dr. Flint's view, the professional literature supports his opinion that doctors will "put up" with administrative hassles, patient difficulties and other concerns if they are paid a satisfactory fee. *Id.* at 2951:2-4.

462. Considerable time was spent at trial by both sides on reviewing specific studies in this rich academic literature. Defendants, to be sure can quote

certain passages from certain studies that might cast doubt on the strength or the universality of the causal relationship between fee levels and provider participation. Nonetheless, there is no question that the consensus of the academic literature reflects a causal relationship between reimbursement levels and physician participation. *See e.g.*, PX 498, PX 501, PX 504,PX 505, PX512, PX 513 and PX 524. Ms. Sreckovich admitted that she had identified no professional literature not considered by Dr. Flint. Sreckovich on 1/10/2012 Rough Tr. at 116. Reliance on peer-reviewed studies, especially from multiple studies, is the gold standard and far more reliable than non-peer reviewed work commissioned for litigation.

463. I note, as one example, the work done by Peter Cunningham, which both sides treated as authoritative. In addition to reporting that 84% of physicians surveyed identified low Medicaid reimbursement as a moderate or very important reason for not accepting new Medicaid patients, PX 512 at Flint 01123, Flint 8/3/2010 Final Tr. at 2960:4 – 2961:2. Cunningham also conducted a regression analysis that "showed that higher Medicaid fees relative to Medicare were associated with a higher probability of accepting new Medicaid patients." PX 513 at Flint 00152; Flint at 2961:16-25. A third study by Cunningham considering community norms, professional attitudes and other factors, nonetheless identified physician fees as the "driving force" in physician decision-making. PX 514, Flint on 8/3/2010 Final Tr. at 2963:3-21, 3514:11 – 3515:23. Cunningham studied a

projected 20% increase in Medicaid reimbursement relative to Medicare, and found a significant relationship among all communities studied, one of which was Miami, where he projected an increase of 11.8 percentage points in provider participation. PX 514 at Flint 00155 Flint, Flint on 1/24/2012 Rough Tr. at 173. The Cunningham study of 12,000 physicians and 60 communities also showed a statistically significant reduction in unmet medical needs of Medicaid population, increased satisfaction with choice of specialist and reduced use of emergency care, associated with higher reimbursement rates. PX 513; Flint on 1/24/12 Rough Tr. at 174-75.

464. These results are consistent with surveys and empirical relied upon by Dr. Flint. A survey of Florida physicians who were members of the American Academy of Pediatrics reported a significant number of physicians surveyed would increased their willingness to take Medicaid patients with higher reimbursement. PX 535. While this survey is methodologically limited by a small sample, it is consistent with the other evidence presented. The more providers who participate in Medicaid, the more access children on Medicaid will have to care. Flint on 8/4/2010 Final Tr. at 3348:17 – 3350:13; Crall on 11/17/2010 Final Tr. at 5106:23 – 5107:15.

465. The relationship between fees and provider participation is also illustrated by Defendants' own 2009 survey of half of Florida's physicians.

According to that survey, 46% of Florida physicians were accepting no new Medicaid patients, while only 22% were accepting no new Medicare patients, PX 742 at pp 62, 66, which pays significantly more than Medicaid.

466. In Polk County, Florida, physician reimbursement for treating uninsured patients was increased to Medicare levels during 2007-2008. The result was a substantial increase in access to care. Flint on 1/24/2012 Rough Tr. at 182-184. While this occurred among a population of uninsured individuals, I do not see that as undermining the example's relevance. Similarly, Polk County was shown to be a rather typical Florida county. Flint, Rough Tr. 1/3012 at 113-114. *Id*.

467. Even Ms Sreckovich did not opine there was no association between rates and provider participation, a point that would have been counter to common sense. Instead, she pointed to the other factors – including physician attitudes toward Medicaid patients and administrative issues – as undermining that association. Sreckovich on 1/6/2012 Rough Tr. at 83-84. Ms Sreckovich, however, could not counter that for a significant number of physicians, although clearly not all, those obstacles can be overcome by higher reimbursement levels. Indeed, she admitted as much. Sreckovich on 1/9/2012 Rough Tr. at 119-120.

468. These studies are confirmed by AHCA's own budget requests, which seek increased reimbursement for both physicians and dentists grounded in the

causal relationship between increased reimbursement rates and increased provider participation on the one hand, and increased provider participation and increased access on the other hand. *See* PX 92 ("Increasing the Child Health Check-Up reimbursement rate will increase access to services"); PX 93 (same); PX 94 (same). AHCA repeatedly observed that when AHCA doubled the reimbursement rates for child health check-ups in 1995, the participation rate doubled as well. *See* PX 734, PX 92, PX 93,PX 94, PX 95, PX 96, PX 702, and PX 703.[37]

469. In addition, AHCA, in multiple legislative budget requests over a number of years, proposed as a solution for that "specialty provider shortage" and "critical access to care problem" a fee increase for certain specialist to the Governor and Legislature. *Id.* This, too, recognizes the obvious existence of a relationship among rates, participation and access.

470. Federal CMS also recognizes the relationship between reimbursement rates, provider participation and access, declaring in a Dear State Medical Director letter: "Lack of access due to low rates is not consistent with making services

[37] At trial, defendants sought to question this relationship, even though it was repeatedly submitted to the legislature and acknowledged as correct under oath in depositions. Defendants claim there was a certain time lag before the higher rates had the observed effect. Such a time lag between raising rates and an effect on participation and rate of check-ups is not surprising. Defendants also claim that certain other steps may have contributed to increased participation rates, but no one suggests those other factors, such as educational efforts, were the principal case. *See* PX 524 and Flint on 1/24/2012 Rough Tr. at 186-193, GAO Report citing increase as example of effect of increased reimbursement rates.

available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at CRALL 00751.

471. Based on the evidence in this case, I conclude that while reimbursement rates are not the only factor determining whether providers participate in Medicaid, they are by far the most important factor, and that a sufficient increase in reimbursement rates will lead to a substantial increase in provider participation and a corresponding increase in access to care.

472. There was also substantial support at trial that the point at which physician reimbursement rates needed to be increased to have a significant effect was the level paid under the Medicare program. This was Dr. Flint's opinion and it was the level in the Polk county experience. Flint Testimony on 1/24/2012 Rough Tr. at 182-186. An increasing number of other states have pegged Medicaid compensation to, at or very near the Medicare rate *Id.* at 191-192. Moreover, Congress, in recent legislation, has required for a two-year period that primary care providers receive compensation at least at the Medicaid rate. Sreckovich on 1/12/2012 Rough Tr. at 49. It is also logical that the Medicare rate – the rate at which compensation is paid under the other large government health care program in this country – is a good indication of a competitive market price. Flint on 1/24/2012 Rough Tr. at 191-192. There was no evidence presented by the

Defendants of any different rate level. Given the record, I find that Plaintiffs have shown that achieving adequate provider enrollment in Medicaid – and for those providers to meaningfully open their practices to Medicaid children – requires compensation to be set at least at the Medicare level.

**G. Managed Care**

473. As of October 2009, there were just over 1.5 million children on Medicaid in Florida, and about 650,000 were assigned to an HMO in a non-Reform County and another 120,000 of so were assigned to an HMO in a Reform county. DX 262a.

474. Whether AHCA chooses to provide care for children on Medicaid through a fee-for-service arrangement or through a Medicaid HMO, AHCA is still ultimately responsible, as the designated agency that administers Florida's Medicaid program, to ensure children on Medicaid receive the care to which they are entitled under federal law.

475. AHCA pays HMOs on a capitated basis, and determines how much to pay Medicaid HMOs on an annual basis. Because of the formula AHCA uses to determine per capita payments for Medicaid HMOs, the amount of those payments is driven in substantial part by the amount AHCA pays providers on a fee-for-service basis through the MediPass system and historical rates of utilization. Williams on 10/12/2011 Rough Tr. at 101-103; Brown-Woofter on 11/8/2011

Rough Tr. at 124-26; *id.* at 11/9/2011 at 25. AHCA discounts aggregate payments to HMOs to account for the presumed efficiencies of HMOs.[38] Williams on 10/17/2011 Rough Tr. at 171-173.

476. "[T]he rates of capitation and the rates of physician reimbursement under capitation are a reflection of the fee-for-service rates." Flint on 8/3/2010 Final Tr. 2975:13 – 2976:2. Florida is one of the lowest paying states in terms of its managed care compensation. *Id.* at 2999:20 – 3000:4.

477. In 2005 AHCA obtained federal and state approval for a Medicaid pilot project, known as Medicaid reform, pursuant to a 1115 research and demonstration waiver. Brown-Woofter on 10/20/2011 Rough Tr. at 96-98. Medicaid Reform was instituted in July 2006 in Broward and Duval counties and expanded in 2007 to Baker, Clay and Nassau counties. *Id.* at 97. Medicaid Reform allows ACHA to use managed care almost exclusively for service provision to Medicaid recipients. Brown-Woofter on 10/18/2011 Rough Tr. at 9.

478. The Medicaid Reform pilot must be budget neutral, meaning that it does not cost more to operate with the waiver than it would have without the waiver. Brown-Woofter on 10/18/2011 Rough Tr. at 9-10.

479. Florida's Office of Program Policy Analysis & Governmental Accountability (OPPAGA) in June 2009 reported on the progress of Medicaid

[38] Typically the discount has been about 8 percent. Testimony of Mr. Williams on 10/7/2008 Depo. Desig. at 59:13 – 61:17.

Reform through December 2008 and found the data did not show Medicaid Reform had improved access, or quality of care, or saved the state money. PX 683, page 1. OPPAGA recommended the Legislature not expand Medicaid Reform until more data was available to evaluate claims of its success. *Id.* That is the most recent OPPAGA report concerning Medicaid Reform. Copa on 4/5/2011 Rough Tr. at 127-129. In September 2007, the Office of the Inspector General of AHCA made a similar recommendation, after what then-Secretary of AHCA Andrew Agwunobi called in "independent, objective and through analysis," to delay the expansion of Medicaid Reform; the Agency adopted that recommendation; Agwunobi 2/13/2009 Depo. Desig. at 183:7 – 187:1.

480. The three largest Medicaid HMO's operating through Medicaid Reform in Broad County in 2008, had approximately 50% of the Medicaid enrollment in Broward, but two years later, none of those three plans were still operating in the county. *Id.* at 182-85.

481. AHCA's application to extend the waiver for Medicaid Reform in the five counties in which it is currently operating was recently granted for three years, Sreckovich on 1/18/2012 Rough Tr. at 51-52, but Florida's application to expand Medicaid Reform statewide has not at the present time been approved by the federal government. Copa on 4/5/2011 Rough Tr. at 128.

482. Children enrolled in Medicaid HMOs suffer from the same lack of access to care as children in MediPass or fee for service Medicaid. *See* Section VI.C., *supra*. As discussed above, HEDIS reports show that children in both reform and non-reform counties on managed care do not receive adequate preventative health care. PX 689, PX 733, DX 361, DX 334.

483. Certain medical providers do not take any Medicaid HMOs; Isaac on 8/11/2010 Final Tr. at 3856:4-12; Ayala on 8/9/2010 Final Tr. at 3570:2-17; Fenichel on 10/18/2011 Final Tr. at 4301:22 – 4302:1. Others limit which HMOs they will accept. Postma on 8/4/2010 Final Tr. at 3149:1-3; J. St. Petery on 11/11/2008 Depo. Desig. at 176:8-23; Donaldson on 10/15/2008 Depo. Desig. at 78:18 – 80:18; 206: 21-25.

484. AHCA's monitoring of HMOs does not demonstrate that children are receiving the care to which they are entitled under federal law for three fundamental reasons. First, though there is extensive testimony regarding the monitoring process in the record, there is very little in the record about the substantive results of that monitoring, and nothing to indicate children are receiving timely or adequate care. Flint on 1/24/2012 Rough Tr. at 153.

485. Second, most of the monitoring focuses on process, and even if the results were in the record, they would not demonstrate the children were getting the requisite care. For instance, the fact that an HMO has no more than 1,500

children per PCP, or has a number of specialists on its panel does not demonstrate that the doctors will see the children at all, let alone promptly.

486. Third, there is virtually no evidence and certainly no systematic evidence in the record that any MCOs were hit with a substantial fine, or expelled from the Medicaid program for failure to provide care to children on Medicaid or meet any contractual requirements relating to the provision of care. Thus, there is virtually no evidence that AHCA has used its power to sanction HMOs to ensure children receive adequate and prompt care.

487. Ms. Brown-Woofter, acting assistant deputy secretary for Medicaid operations, who testified for *ten* days did not even know, for instance, whether AHCA had *ever* issued any financial sanctions to Medicaid HMOs for having a low percentage of enrollees who received a lead blood screening exam. Brown-Woofter on 10/18/2011 Rough Tr. at 116-118; Brown-Woofter on 11/8/2011 Rough Tr. at 131-132. While she testified AHCA had issued some fines against HMOs for failing to meet a state requirement for a 60 percent screening ratio for children continuously enrolled in the HMO for six months, but had no information regarding the size of the fines. *Id.* at 118. AHCA did not issue any fines against HMOs for low child health check-up screening rates until 2008, years after this action began. Brown-Woofter on 10/18/2011 Rough Tr. at 131-32. Ms. Brown-Woofter testified that a financial sanction was levied against Universal in 2011, but

was not even sure what the sanction was for. Brown-Woofter on 10/20/2011 Rough Tr. at 60.

488. Ms. Brown-Woofter offered a lay opinion that children on Medicaid HMOs do not have trouble accessing primary care and that they do not have difficult accessing specialty care and that any trouble with specialty care are limited to a few individuals. Brown-Woofter on 10/19/2011 Rough Tr. at 38-40, 74-77. I find her sweeping conclusions unpersuasive. They conflict with testimony that she gave as a 30(b)(6) witness at the end of the discovery period and in rendering her opinion, she did not consider numerous AHCA documents regarding shortages of providers.[39] *See* Brown-Woofter on 10/25/2011 Rough Tr. at 88-97; 95-97, 100, 103-07, 109-22; 126-38; PX 205, PX 188; PX 186; PX 90; PX 101; PX 199.

489. Based on applicable statutes and case law, I find that AHCA, as the agency that administers Florida Medicaid, is legally responsible to ensure that children who obtain their care through a Medicaid HMO (or through a Provider Service Network) receive the care to which they are entitled under federal law.

[39] While her deposition testimony focused on the fee-for-service component of Medicaid, not the HMO component, there is overlap between the providers enrolled in fee-for-service Medicaid and Medicaid HMOs, testimony of Ms. Brown-Woofter on 10/25/2011 Rough Tr. at 100, and no testimony as to why Medicaid HMOs, whose per capita compensation rate is driven by the fee-for-service rates, would be able to provide better care than the MediPass program.

490. I further find that the fee-for-service reimbursement rates AHCA sets for providers is a key factor in determining the capitation rate paid to HMOs and so for determining how much HMOs can, in turn, pay their providers. Accordingly, inadequate fee-for-service reimbursement rates result in inadequate compensation by Medicaid HMOs to their providers.

491. Based on the HEDIS reports, the mini-CMS 416 reports, as well as other documents and testimony from providers, I also find that same problems that plague fee-for-service Medicaid – failure to provide well child check-ups, a paucity of specialists, excessive wait times and travel distances for specialty care, lack of dental care – infect the Medicaid HMOs, which, accordingly, fail to meet the federal requirements for providing EPSDT care, in violation of a(10); do not provide care with reasonable promptness, as required by (a)(8); do not provide care with equal access under Section 30(A); and have not complied with the obligation to provide care as established by sections 43(b) and 43(c) of the Medicaid Act.

492. There is also extensive record evidence that leads me to find that children on Medicaid HMOs do not receive equal access to specialist care, and, as discussed in these findings, capitation rates paid to Medicaid HMOs are not set with consideration of the level needed so as to provide such equal access, consistent with the other requirements of (30)(a) as required under the Medicaid Act.

### H. Outreach And Medicaid Application Process

493. Undisputed evidence at trial established that an estimated 268,000 Florida children are eligible for but not enrolled in the Medicaid program. 2009 Florida KidCare Coordinating Council Report. PX 682 at 2. Twenty percent of Florida children are uninsured, compared to a national average of 10 percent. *Id.*

494. Between 2004 and 2006, Florida moved to a largely on-line system of applications, eliminating most of the office locations at which individuals can apply in person for Medicaid coverage. PX 238. 57% of the DCF services centers were eliminated between 2004 and 2006. Nieves on 5/17/2010 Final Tr. at 2098:20 – 2099:1. These changes, accompanied by cuts in personnel, were enacted not because they were viewed as improvements but rather due to budget cuts. Lewis on 10/20/2010 Final Tr. at 4602:25 – 4603:14.

495. In 2007, an analysis by AHCA of the revised application system reported: (a) that the on-line system will time out in 20 minutes leading to 350 lost sessions each day; (b) 25% of applicant are unable to complete their application on first attempt; (c) "often, for numerous reasons, applicants are unaware that they have not submitted the required additional information and their case is closed;" (d) that 17 to 20 percent of the applicant population due to language barriers and other factors cannot successfully complete one or all steps in the new ACCESS

Medicaid eligibility process. PX 238; Nieves on 5/17/2010 Final Tr. at 2106:9 – 2111:20.

496. If assistance is required, it is difficult to obtain with the Tampa regional center reporting 40% of incoming calls abandoned or receiving busy signals in 2007. The rate in the other two regional centers is 20% in Miami and for Jacksonville it is 19%. PX 238 at 3. At trial, Mr. Lewis testified that he believed that 40% of the incoming calls at the Tampa regional call center are *still* either abandoned or receive a busy signal. Lewis on 10/20/2010 Final Tr. at 4638:3 – 4634:8.

497. In addition, DCF data indicate that between June 1, 2004 and March 1, 2005, applications were consistently processed above the designated time standard." PX 238 at 7.

498. The Access Medicaid application, which is the principal means by which Medicaid applicants apply, purportedly has been simplified, but remains a highly formidable challenge to complete. The application, reprinted as part of the application guide (DX 160), runs for over 50 pages of screens that Medicaid applicants must navigate. Nieves on 5/17/2010 Final Tr. at 2105:2 – 2106:4. Because it is a combined application in which families may apply for multiple cash and in-kind assistance programs, there are lengthy sections requiring answers on assets and expenses not needed for determination of children's Medicaid

eligibility. Complex terms, for example, are found in questions asking about "liquid assets" and "life estates." A significant amount of records must be gathered to complete the application. And, by virtue of being an on-line application, basic computer literacy is required.

499. By contrast, the Florida KidCare application (DX 181) is a two-page application for children seeking Medicaid or SCHIP assistance, but provides sufficient information for DCF to make a Medicaid eligibility determination. Lewis on11/29/2011 Rough Tr. at 31. Although AHCA added an on-line link to the KidCare application during the course of the trial in this action, the KidCare application is an alternative to the primary ACCESS application which individuals must first find on-line – a feat that even Ms. Sreckovich, Defendant's expert witness, had difficulty accomplishing unassisted by counsel. Sreckovich on 1/17/2012 Rough Tr. at 4-18. Applicants must then indicate they want to apply solely for Medicaid for children and not other potential programs. *Id.*

500. There is no reason established why the simple KidCare application could not serve as the default application for children seeking Medicaid. St. Petery on 2/2/2012 Rough Tr. at 86-87.

501. Even though DCF's on-line application is the primary vehicle by which applicants are encouraged to apply for Medicaid, DCF does not attempt to identify individuals who start the on-line application but do not complete it, collect

demographic information on them, or determine why they do not complete the application. Poirier 10/5/2011 Rough Tr. at 3-7, 6-7 33. DCF does not even know how many people start but do not finish the application. *Id.* at 12.

502. In addition to the complex application and the difficulties in obtaining help to completing the application, Florida has eliminated its primary outreach program for Medicaid. Until 2003 Florida "had an award-winning outreach program" recognized by federal CMS as a model for other states. PX 700 at DOH10000478. Before funding was terminated in 2003 approximately $4 million a year was spent on outreach programs, more than half of which came from the federal government. *Id.* The outreach program included: Statewide multi-media campaigns in English, Spanish and Creole covering television, radio, bus cards, and billboards; free distribution of applications and promotional brochures, postures and booklets; 17 regional outreach projects charged with recruiting and training community partners; data driven market research, county level enrollment data reporting and tracking; assistance for families with enrollment and coverage issues, and statewide training and technical assistance. *Id.* at DOH10000478-479; Louis St. Petery on 12/10/2009 Final Tr. at 526:3 – 531:9. In 2003 there was $4 million in funding, more than half of which came from the federal government. In 2003, the Florida legislature eliminated funding for the program. PX 682 at 20. Mr. Snipes on 12/9/2009 Final Tr. at 452:17-22 (Less outreach now for getting

eligible individuals enrolled). Since 2003 direct outreach funding has been limited to a one-time non-recurring $1 million authorization in 2006. PX 700 at DOH10000479. As AHCA acknowledged in its 2007-2008 budget request, this level of funding "will probably not provide the amount needed to make an impact on significantly decreasing the rate of uninsurance for children[,]" even if it were recurring. PX 711 at AHCA01095027.

503. While a variety of outreach efforts exist, such as through community partners, AHCA does not even assess the effectiveness of its written materials. Boone on 10/21/2008 Depo. Desig. at 58:21 to 60:2 And there has been no showing that these ad hoc efforts are an adequate substitute for the organized statewide program that existed before funding was terminated. There are at least four strong indications that they are not.

504. First, the difference between the outreach done before the budget cuts and that performed now is stark. Before, there were statewide multi-media campaigns in English, Spanish and Creole including public service announcements (PSAs) on television and radio, as well as bus cards and billboards. PX 700 at DOH10000478-479. That is no longer the case. Anne Boone, who was AHCA's child health check-up coordinator for years when she was deposed in 2008, was not aware of any PSA being played recently anywhere in the state on either radio or television. Boone on 10/21/2008 Depo. Desig. at 65:3-67:8. Rather, all she

knew concerning whether any PSA had been aired in the last several years on radio or television is that a single PSA about lead blood poisoning "might have been on a radio station." *Id.* That is the only PSA in the voluminous record in this action. DX 492. Rather than running on the radio or television, AHCA's PSA are shown on a loop on television sets at booths at heath fairs. Boone on 8/28/2008 Depo. Desig. at 163:14-164:1; Boone on 10/21/2008 Depo. Desig. at 309:21-310:6, 311:18-312:2. Similarly, Ms. Boone knew of only one instance in recent years in which there was a child health bus billboard, and even then, the billboard was only on busses in one city. Boone on 10/21/2008 Depo. Desig. at 67: 9-20.

505. Second, the KidCare Coordinating council which has representatives drawn from a variety of governmental and private organizations interested in medical care for children stated as follows:

> Unless families learn about Florida KidCare, how to apply and where to seek assistance in they need it, the program will not fully reach the population it is intended to serve. Florida KidCare enrollment significantly declined in 2004 … Enrollment started to increase again in 2007 as a result of increased emphasis on outreach. However, except for a non-recurring $1 million appropriation to Healthy Kids for community based outreach and marketing matching grants in Fiscal Year 2007-08, other activities were undertaken within existing resources and with non-recurring funds, making a large scale and ongoing initiative unsustainable without additional resources.

The KidCare Coordinating council recommended by a unanimous vote of 22 to zero that outreach funding for programs for unenrolled children be restored. PX 682 at 20. The council has been making this recommendation for years. *See* PX

349 at DOH00078171; PX 350 at 19-20; PX 682 at 2; PX 697 at16; PX 699 at 18; and PX 700 at DOH10000478.

506. Third, the Agency for Health Care Administration has also urged that outreach funding be restored, in the form of a legislative budget request for that purpose. PX 711.

507. Fourth, the existence of over a quarter million children eligible for Medicaid but not enrolled as of 2008 is compelling evidence that outreach programs are required. Indeed, an AHCA staff analysis indicated that approximately 75% of children with incomes under 200% of the federal poverty level are "low hanging fruit" for being enrolled in existing programs by conducting outreach. PX 240. Before the outreach program was eliminated, for each kid enrolled in Healthy Kids as a result of outreach, 2 children were identified as Medicaid eligible. *Id.* at 2.

508. The convoluted history of AHCA's dental reminder letter – reminding parents who had not taken their Medicaid child to a dentist for some time to do so – is indicative of the Agency's inadequate commitment to outreach. AHCA once sent out such periodic reminder letters, but stopped doing so in 2000. Boone on 2/24/2012 Depo. Designation at 31:10-19, PX 441 at 6. It discontinued the practice because there were so few dentists participating in the program that it was hard for parents to find a dentist close to where they lived and they became upset

when they couldn't. Boone on 8/28/2008 Depo. Desig. at 33:3-12. AHCA even told federal CMS, while Mr. Sharpe who left the agency in 2004 was Medicaid Director, that AHCA had not actively marketed its dental program to recipients for four to five years because of the few numbers of dentists participating in Medicaid and because it was often difficult for those seeking treatment to find a provider close to them. Sharpe on 2/8/2011 Rough Tr. at 184.

509. Ms. Boone admitted that the letters did help increase utilization. Boone on 8/28/2008 Depo. Designation at 32: 14-19. But for years, AHCA did not send out dental reminder letters, despite its extremely low utilization rate, in what can only be viewed as in intentional effort to curtail outreach to avoid further straining an already overburdened system.

510. In February of 2008, federal CMS conducted an on-site visit in Florida as part of its decision to review states with a dental utilization rate of 30% or less on the CMS-416 report for the fiscal year 2006. PX 440 at 3. In its report on that visit, federal CMS noted that Florida had sent reminder letters until 2000 and recommended that Florida again send dental reminder letters to "parents of beneficiaries who have not received periodic dental services." PX 441 at 6-7. AHCA stated in its response that implementation of Medicaid's new fiscal agent began on July 1, 2008, but that in "the very near future" it "will work with the new fiscal agent" to send out dental reminder letters.

511. Several years later, however, when Ms. Kidder testified at trial on May 31, 2011, she acknowledged that AHCA had still not begun sending out dental reminder letters. Kidder on 5/31/2011 Rough Tr. at 107-108. She said the letter would likely go out soon. *Id.* Ms. Cerasoli, who had testified as AHCA's designated agency representative on dental issues at deposition, testified that the dental letters were not sent because the agency did not view this as a priority. Cerasoli on 8/11/2010 Final Tr. at 3980:12 – 3981:1.

512. When AHCA analyzed its claims data in May of 2011 to see how many children enrolled in Medicaid had not received any dental services in the last six months, the figure was a staggering 834,651 children. PX 790. And that did not include children enrolled in ADI, Reform HMOs, and non-reform HMOs that offered dental services.

513. Given the Defendants' limited outreach, it is, perhaps, not surprising that A.D. did not know until she became a next friend in this action that her son was entitled to dental care through Medicaid. *See supra* at ¶¶ 142-155. And S.B. did not know that she was entitled to free transportation to doctor's appointments and laboratory visits. *See supra* at ¶¶ 121-128.

514. Federal law requires states to effectively inform all EPSDT eligible individuals or their families about the availability of EPSDT services, how those services may be obtained, that those services may be obtained at no cost to the

child, and that transportation is available. *See* 42U.S.C. § 1396a(a)(43)(A); 42 C.F.R. § 441.56(a). Florida has delegated to DCF, among other agencies, certain outreach and informational responsibilities. *See* FLA. STAT. § 409.9122(2)(c) (DCF must provide "clear and easily understandable information" about Medipass and Medicaid HMOs, the plans through which most children are supposed to receive EPSDT services in Florida). I previously held and reaffirm here that "DCF, as well as AHCA and DOH, have outreach responsibilities; they are required to 'ensure that each Medicaid recipient receives clear and easily understandable information' about Medipass or managed care options. This requirement arises from the Medicaid Act's outreach provision." 9/30/2009 Order on Class Certification, D.E. 671 at 7 (citations omitted).

515. The defendants contend that 42 U.S.C. § 1396a(a)(43) does not require them to conduct outreach to children who are not enrolled but are eligible for Medicaid. The plain language of the regulations implementing this section state that "[t]he agency must [p]rovide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program." *See* 42 C.F.R. § 441.56(a)(1); *Friends of Everglades v. S. Fla. Water Mgt. Dist.*, 570 F.3d 1210, 1227-28 (11th Cir. 2009) (stating that an agency's promulgation of regulations interpreting ambiguous statutory language is entitled to deference as long as the interpretation is

reasonable). "Medicaid's implementing regulations [in specific, § 441.56(a)] . . . obligate participating States to 'effectively' inform all eligible individuals." *See Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006). The plain language of the regulations, combined with the case law supporting this interpretation, compel the conclusion that § 1396a(a)(43) and 42 C.F.R. § 441.56(a)(1) mandate that the state conduct outreach to all eligible individuals.

516. Defendants have failed to "[p]rovide for a combination of written and oral methods designed to inform effectively *all EPSDT eligible individuals* (or their families) about the EPSDT program," and to conduct outreach in "clear and nontechnical language" that provides information about the benefits of preventative care, the services available under the EPSDT program, how those services may be obtained, that the services are available at no cost to children, and that transportation services are available. *See* 42 C.F.R.441.56(a)(1), (a)(2) (emphasis added); *see also* § 1396a(a)(43)(A).

517. I further find that the use of the Florida Access application in the circumstances in which it currently is utilized constitutes an unnecessary and impermissible barrier to the provision of the EPSDT services to children required under the EPSDT Requirements of the Medicaid Act.

## VII. PROPOSED DECLARATORY RELIEF

518. Pursuant to 28 U.S.C. § 2202, a court may issue a declaratory judgment while retaining jurisdiction to grant supplemental relief. "The purpose of [28 U.S.C. § 2202] . . . is to allow the district court to retain jurisdiction in order to grant the relief necessary to effectuate its prior judgment." *Burford Equip. Co., Inc. v. Centennial Ins. Co.*, 857 F. Supp. 1499, 1502 (M.D. Ala. 1994); *see also In re Bicoastal Corp.*, 156 B.R. 327, 331 (Bankr. M.D. Fla. 1993) ("the further relief permitted by 28 U.S.C. § 2202 was designed to carry out the principle that every court, with few exceptions, has inherent power to enforce its own decrees and make such orders as may be necessary to render them effective.) Such supplemental relief includes the issuing of an injunction. *Powell v. McCormack*, 395 U.S. 486, 499 (1969) ("A declaratory judgment can then be used as a predicate to further relief, including an injunction.").

519. I have previously decided, with the agreement of all parties, that I would reserve the issue of what injunctive relief, if any, is appropriate on those claims on which I find Plaintiffs were entitled to relief. This process will allow the proper consideration of additional evidence regarding the need for and contours of appropriate injunctive relief.

520. The findings herein do not and are not intended to question the motivation of many dedicated public servants who work for AHCA, DCF and DOH. However, in our federal judicial system, when a state program is being

operated in such a manner that it denies individuals their federally assured rights, it is the agency heads responsible for those programs who must serve as defendants in litigation such as this and who are accountable, in their official capacity, for compliance with federal law. This is consistent with the long and well-established authority of federal courts in suits under Section 1983. *See supra* at Section II, *supra*.

521. I find that the named plaintiffs and the certified class of Florida children who are or will be eligible for Medicaid have been and are being denied their legally enforceable rights under the Medicaid Act, as set forth below.

522. First, the rate-setting of reimbursement under Florida's Medicaid program, directly for most codes under the fee-for-service program, and indirectly, because those codes then serve as the basis for much reimbursement of managed care, is done on the basis of a "conversion factor" required to achieve "budget neutrality" without consideration of whether such fees are (a) adequate to assure delivery of EPSDT services required under federal law Section (a)(10), or Sections 43(B) or (C) of the Medicaid Act; (b) adequate to assure access to such required care with reasonable promptness under Section (a)(8); or (c) sufficient to enlist enough providers so that care and services are available to Medicaid-eligible children to the extent that such care and services are available to the general

population in any of the geographic areas served by AHCA as required under 42 USC § 1396a(a)(30)(A).

523. Second, the wrongful termination of children from Medicaid eligibility, the subsequent reassignment of children whose eligibility is restored to physicians other than the provider which their parents previously chose, and the denial of prompt care to newborns presumptively eligible for Medicaid, violates (a) Plaintiffs' rights to EPSDT services under 42 U.S.C. § 1396a(a)(10); § 43(B) and 43(C) of the Medicaid Act, and (b) violates Plaintiffs' rights to receive care with "reasonable promptness" under 42 U.S.C. § 1396a (a)(8).

524. Third, defendants are not furnishing EPSDT screening services to all Medicaid-eligible Florida children in violation of (a) 42 U.S.C. § 1396a(a)(10); and § 43(B); (b) or with reasonable promptness in violation of 42 U.S.C. § 1396a(a)(8). The failure to provide blood lead screening services to that portion of the Plaintiff class required to receive such services also is in violation of these requirements. The failure to set provider reimbursement at levels sufficient to ensure equal access to care in any of the AHCA areas, which I find relevant geographical regions, also constitutes a violation of 42 USC § 1396a(a)(30)(A).

525. Fourth, defendants are not furnishing required specialty care to all Medicaid-eligible Florida children in violation of (a) 42 U.S.C. § 1396a(a)(10); and § 43(C); (b) or with reasonable promptness in violation of 42 U.S.C.

§ 1396a(a)(8). The failure to set provider reimbursement for specialists at levels sufficient to ensure equal access to care in any of the AHCA geographical areas also constitutes a violation of 42 USC § 1396a(a)(30)(A).

526. Fifth, defendants are not furnishing required dental care to all Medicaid-eligible Florida children in violation of (a) 42 U.S.C. § 1396a(a)(10); § 43(b) and (c) or with reasonable promptness in violation of 42 U.S.C. § 1396a(a)(8). The failure to set provider reimbursement for dental providers at levels sufficient to ensure equal access to dental care in any of the AHCA geographical areas also constitutes a violation of 42 USC § 1396a(a)(30)(A).

527. Sixth, the current ACCESS Florida application constitutes an obstacle to the receipt of EPSDT care for Florida's Medicaid eligible children, at least as currently administered. In addition, defendants are in violation of Section 43(A) by eliminating the Florida outreach program directed at providing notice of the availability of services to children eligible for Medicaid, and by not otherwise assuring such children are notified of the availability of care and services,

528. I recognize that AHCA is the principal agency responsible under Florida law for carrying out the requirements of the Medicaid Act. Defendant Dudek is thus declared, in her individual capacity, to be operating the Medicaid program in Florida in violation of the above requirements. Defendant Wilkins, secretary of DCF is declared to be in violation solely with respect to declarations

above related to eligibility determinations and the application outreach process. Defendant Farmer, secretary of DOH, is declared to be in violation solely with respect to the care provided to children in the CMS program, which operates under the authority of the Department of Health.

## VIII. CONCLUSION

I shall enter a final declaratory judgment pursuant to 28 U.S.C. § 2202, reserving jurisdiction for further proceedings with respect to injunctive relief, the scheduling of which shall be set by separate order.[40] The court will by separate order set a status conference to determine such briefing, discovery and evidentiary hearings that are appropriate in connection with injunctive relief.

Dated: March 23, 2012

Respectfully Submitted,

By: /s/ Stuart H. Singer

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[40] I also reserve jurisdiction to consider applications for attorneys fees and costs pursuant to 42 U.S.C. §1988.

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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on March 23, 2012, I electronically filed the foregoing document with the Clerk of the Court by using the CM/ECF system and that the foregoing document is being served this day on all counsel of record identified below via transmission of Notice of Electronic Filing generated by CM/ECF.

/s/ Stuart H. Singer
Stuart H. Singer

# SERVICE LIST

**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.**

**Case No. 05-23037-CIV-JORDAN/BANDSTRA**
**United States District Court, Southern District of Florida**

| | |
|---|---|
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# EXHIBIT A

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

**CASE NO. 05-23037-CIV-JORDAN/BANDSTRA**

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

**Plaintiffs,**

**vs.**

**LIZ DUDEK, et. al.,**

**Defendants.**
_____/

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# PLAINTIFFS' CORRECTED[1] PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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[1] Attached as Exhibit A is a redline version of the document, showing the corrections which have been made. The changes consist of corrections of typographical errors and record citationss.

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This is a class and representative action seeking declaratory and injunctive relief to require Florida officials responsible for the state's Medicaid program to operate that program so as to provide children the medical and dental care to which they are entitled under federal law.

**PROCEDURAL HISTORY OF THE ACTION**

This action was initiated in 2005 on behalf of the Florida Pediatric Society, the Florida Association of Pediatric Dentists, and a number of individual children on the Medicaid program through their parents or legal guardians. The complaint alleges violations of the Federal Medicaid statutory requirement that children receive medical and dental services known as the Early Periodic Screening Diagnosis and Treatment ("EPSDT") ("EPSDT Requirements"), and to do so with reasonable promptness as required under 42 U.S.C. § 1396a(a)(8) and (a)(10) (Count I) ("Reasonable Promptness"); violations of the Federal statutory requirement that rates for reimbursing medical and dental providers be set, *inter alia*, so as to secure access to care for children that is equal to that of other children in the same geographical area as required under 42 U.S.C. § 1396a(30)(A) (Count II) ("Equal Access"); violations of the federal Medicaid requirements regarding HMOs (Count III) under 42 U.S.C. § 1396u-2(b)(5); and violations of the Federal statutory requirements that the states conduct outreach programs to inform individuals determined to be eligible for Medicaid of the availability of services

and to insure such patients requesting those services are able to receive them. (Count IV) ("Outreach") 42 U.S.C. § 1396a(a)(43).

On January 11, 2007, I denied Defendants' motion to dismiss as to three of the four Counts. D.E. 40. Defendants argued that the Medicaid Act did not provide privately enforceable rights permitting such actions to be enforced under 42 USC § 1983. I found that such enforceable rights existed with respect to all but Count III, but dismissed Count III regarding HMO reporting requirements. On April 24, 2007, I denied Defendants' motion to reconsider. D.E. 58.

Prior to the completion of discovery, I permitted two of the defendants, the Secretaries of the Department of Health and the Department of Children and Families, to file motions for summary judgment on the grounds that the asserted claims did not relate to those officials' statutory authority. Following briefing and argument, I largely denied these motions on March 19, 2009. D.E. 541.

Following extensive discovery, the issue of class certification was referred to the U.S. Magistrate Judge for a report and recommendation. On July 30, 2008 the Magistrate Judge recommended that intervention by certain additional plaintiffs be permitted. I affirmed that ruling with respect to K.V., S.C., K.S., and S.B. but not all of the intervening plaintiffs. D.E. 268. The Magistrate Judge, following briefing and argument, found the requirements of Rule 23 satisfied in an extensive report and recommendation. D.E. 613. Following further briefing and argument,

I overruled objections and certified a class for declaratory and injunctive relief consisting of all Florida children eligible for EPSDT services under the Medicaid Act. D.E. 671. As part of that decision, I found that at least one named plaintiff had standing to advance each of the three remaining accounts with respect to each of the Defendants. *See* Class Certification Order. D.E. 671, p. 3-5. Defendants' request for interlocutory review by the Court of Appeals was denied on December 1, 2009.

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Prior to trial, Defendants filed an additional motion for summary judgment arguing that there was no private right of action, that "medical assistance" as used in the Medicaid Act did not provide an enforceable right to recipients to receive timely access to care, and that none of the Plaintiffs had standing. Following briefing and argument, this motion was denied in an order entered September 30, 2009. D.E. 672.

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The trial of this matter commenced on December 9, 2009, and proceeded for a total of 94 trial sessions throughout 2010, 2011, and January 2012.[2] Over this period, Plaintiffs called 32 live witnesses in their case-in-chief (and 14 witnesses testified during rebuttal). Defendants did not file a motion for involuntary

[2] I initially had limited the parties to 100 hours each for trial. Defendants objected to this as insufficient in light of the importance of the issues presented, and I subsequently removed the time limitation on the parties' presentation of evidence. 2/11/10 Final Tr. 1864:7-1865:22.

dismissal at the conclusion of Plaintiffs' case-in-chief.[3] Defendants presented live testimony from 19 witnesses in their case-in chief. Both parties presented additional testimony by deposition and numerous exhibits were received in evidence.

Following the close of the evidence, the parties submitted proposed findings of fact and conclusions of law and presented closing argument on March 26-27, 2012. These findings deal with liability and entitlement to declaratory relief, as with the agreement of all parties, I previously indicated that if liability is established, I will conduct an additional hearing on the issue of injunctive relief.

**SUMMARY OF PARTIES' POSITIONS ON ISSUES TRIED**

Plaintiffs contend that the Florida Medicaid program has failed to provide Florida children with access to medical and dental care in accordance with the EPSDT Requirements, the Reasonable Promptness requirements, the Equal Access requirements, or the Outreach requirements under the Medicaid Act. Plaintiffs allege that a number of structural, financial, and administrative barriers result in

[3] At the conclusion of their case in chief, Plaintiffs requested a preliminary injunction on two of their issues – the conversion ratio used by Florida to set Medicaid reimbursement rates and the level of dental reimbursement. Without deciding the novel issue of whether a preliminary injunction was allowed under FED. R. CIV. P. 65(a)(1)(2), I ruled that it would not be appropriate to consider such a motion until Defendants had a full chance to present their own case in chief, and denied the motion without prejudice. D.E. 1007.

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children not receiving the access to care Federal law has bestowed as an enforceable right, which they categorize into six areas:

First, Plaintiffs submit that Florida's Medicaid reimbursement structure is fundamentally inconsistent with the Federal Medicaid Act. Florida determines reimbursement by a "conversion ratio" with respect to the setting of reimbursement rates for most medical procedures so as to assure "budget neutrality," while failing to consider whether such rates are sufficient to meet federal requirements. Plaintiffs contend this is a *per se* structural violation of the guarantees of access to EPSDT services, to receive required care with reasonable promptness, and the right to equal access to care.

Second, Plaintiffs contend that Florida has violated the Medicaid Act by wrongly terminating thousands of young children from eligibility who in fact are entitled to "continuous eligibility." Moreover, when eligibility is restored, these children are often "switched" to a different primary provider than that which the parent initially selected. These issues allegedly affect tens of thousands of Medicaid children each year, who are thereby denied their rights to EPSDT services, as well as their right to receive such care with reasonable promptness.

Third, Plaintiffs argue that primary care to which they have entitlement under the EPSDT Requirements is not provided, as evidenced by the fact that hundreds of thousands of children do not receive any preventative health care

according to the official EPSDT reports submitted to the federal government. Moreover, the percentage of children receiving certain aspects of preventative health care, such as lead blood screens, is extremely low. Plaintiffs point to legislative budget requests that AHCA has submitted to the legislature calling for increases in reimbursement for child health checkups, for blood lead screening and for outreach, as needed to bring the program into compliance with federal law.

Fourth, Plaintiffs maintain that Medicaid children face long delays and unreasonable obstacles in receiving access to needed specialist care in many areas of the states, and for many important specialists. Such specialist care is also a federal right as part of the EPSDT Requirements under 42 U.S.C. § 1396d(r)(5), the reasonable promptness provisions, as well as under 42 U.S.C. § 1396a(a)(43) for children who request such services. Plaintiffs point to admissions made by high-level AHCA officials that Florida Medicaid recipients face a critical lack of access to specialist care, to surveys of area offices by AHCA reflecting acute shortage of specialists in many areas, and to the testimony of both primary care physicians and specialists with respect to the difficulties and delays in finding specialists to treat children on Medicaid.

Fifth, Plaintiffs contend that Florida fails to provide children with access to dental care, which is one of the EPSDT Requirements under the Medicaid Act, pointing to official government reports showing Florida the worst state in the

country with only 21% of children receiving any dental care. Plaintiffs point to low reimbursement rates for Florida dentists who accept Medicaid children as the principal reason for this failure, which results in many dentists refusing to treat Medicaid children.

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Sixth, Plaintiffs contend that Florida has violated Section 43(a) of the Medicaid Act by utilizing an application form that is unnecessarily complex and eliminating the statewide outreach program designed to inform children determined to be eligible for Medicaid of their rights to services. It is estimated that over 250,000 Florida children are eligible for but not enrolled in the Medicaid program.

Defendants' position, notwithstanding public statements by AHCA administrators and legislative budget requests to the contrary, is that there are no systemic problems in the Florida Medicaid program. Defendants maintain that every child who needs care is able to be provided for and that Plaintiffs' position is based on overstated statistical and unreliable anecdotal information. Defendants claim that AHCA's prior legislative budget requests relating to these issues were exaggerated and unreliable; they similarly claim that state surveys of problems in accessing specialist care are not accurate. In addition, Defendants argue that the state now does a better job through managed care and other initiatives in making sure children receive access to care, that improvements have occurred – such as a

recent increase in dental reimbursement – and that to the extent children do not receive care; that may reflect a personal or family choice not to seek care.

Defendants also argue that the named Plaintiffs lack standing because they did not have a problem receiving needed care and face no reasonable prospect of a future denial of care. Defendants object to the certification of a class on multiple legal grounds. Finally, Defendants renew their argument that the Medicaid statute is not enforceable by recipients, and that the promise of "medical assistance" relates to the expediency with which providers receive reimbursement and does not constitute an assurance that recipients will in fact receive adequate access to care.

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## FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Court makes the following findings of fact, and conclusions of law:

### I. JURISDICTION AND PARTIES

1. This is a class action brought on behalf of all children under the age of 21 who now, or in the future, will reside in Florida, and who are or will be eligible for Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") services as part of the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act. Plaintiffs seek declaratory and injunctive relief to require Florida officials responsible for the Medicaid program to provide the plaintiff class with the rights of access to medical care required by federal law. D.E. 220-2.

2. This Court has jurisdiction under 28 U.S.C. § 1331, § 1343(a)(3) and §1343(a)(4), this being a civil action under 42 U.S.C. § 1983 for declaratory and injunctive relief for deprivation of rights secured by Title XIX of the Social Security Act, 42 U.S.C. §§1396 et seq.

3. Pursuant to Section 409.902, Florida Statutes (2008), the Agency for Health Care Administration ("AHCA") is designated as the "single State agency" authorized to make payments for covered medical goods and services under Title XIX of the Social Security Act, to the extent that such services are provided to eligible individuals by qualified Medicaid providers. Defendant Holly Dudek is sued in her official capacity as the Secretary of AHCA.

4. The Department of Children and Families ("DCF") has been delegated the responsibility for making Medicaid eligibility determinations under Florida law. FLA. STAT. §409.963. Defendant David Wilkins is sued in his official capacity as the Secretary of DCF.

5. The Department of Health ("DOH") has been delegated the responsibility to administer the Children's Medical Services ("CMS") program, which is responsible for ensuring that Medicaid children with special health care needs receive Medicaid services. FLA. STAT. §391.016, §391.026. "Children with special health care needs" means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and

who also require health care and related services of a type or amount beyond that which is generally required by children. FLA. STAT. § 391.021(2) (2009). Defendant Harry Frank Farmer, Jr. is sued in his official capacity as the Surgeon General, and head of DOH.

6. Plaintiffs allege that Florida Medicaid is not in compliance with various provisions of Title XIX of the Social Security Act, including its EPSDT Requirements, 42 U.S.C. § 1396d(r), 42 U.S.C. §1396a(a)(43)(b) and (c); the Reasonable Promptness provision, 42 U.S.C. § 1396a(a)(10). 42 U.S.C. §1396a(a)(8) and (a)(10); the Equal Access provision, 42 U.S.C. §1396a(a)(30)(A); and the Outreach provision, 42 U.S.C. § 1396a(a)(43).

7. The Plaintiff Class, which I certified in my Order of September 20, 2009, consists of all children under the age of 21 who now, or in the future will, reside in Florida and who are, or will be, eligible under Title XIX of the Social Security Act for Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") services. As set forth in its findings below, I reaffirm this as an appropriate class action seeking declaratory and injunctive relief pursuant to FED. R. CIV. P. 23.

8. The Plaintiff Class is represented by Individual Plaintiffs J.S., N.G., J.W., N.A., L.C., K.K., N.V., and S.B. Each Individual Plaintiff is a Medicaid-eligible child. I find, as discussed in detail below, that these Individual Plaintiffs

face a realistic and immediate danger of sustaining a violation of their legal rights as a result of Defendants' non-compliance with the Medicaid Act, and accordingly, have standing to bring each of these claims against each of these Defendants.

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9. Two organizations also are plaintiffs. The Florida Pediatric Society ("FPS"), the Florida Chapter of the American Academy of Pediatricians, is an advocacy organization consisting of doctors, and its mission is to improve the health and welfare or infants, children, and young adults of Florida. The Florida Academy of Pediatric Dentistry ("FAPD") is an advocacy organization consisting of dentists, and its mission is to practice the art and science of pediatric dentistry and to promote optimal health care for infants, children, and persons with special health care needs. As discussed below, I find they also have standing to advance these claims.

## II. RELEVANT PRINCIPLES UNDER 42 U.S.C. § 1983

10. 42 U.S.C. § 1983, the Civil Rights Act, provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State…subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit or equity, or other proper proceeding for redress…

11. The Social Security Act in general, and Title XIX thereof (The Medicaid Act), is a "law" within the meaning of 42 U.S.C. § 1983 which creates a

right of action for people who, are deprived of a right secured by the Constitution and laws of the United States." *Neb. Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295 (8th Cir. 1985) (emphasis in original). Section 1983 provides a federal remedy for violations, not only of the U.S. Constitution, but also for federal statutes as well. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980); *31 Foster Children v. Bush*, 329 F. 3d 1255, 1268 (11th Cir. 2003); *see Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 508-23 (1990) (42 U.S.C. §1983 may be used to enforce section 13(A) of the Medicaid Act).

12. Civil rights litigation is a historically proven tool for bringing state institutions and programs into compliance with federal mandates. *See* 7 Newberg on Class Action § 23.11 (4th ed.) The Eleventh Amendment to the U.S. Constitution does not bar a federal district court from ordering injunctive relief requiring a defendant state official to make payments to a Medicaid provider which are required to fulfill an enforceable provision of the Medicaid law. *Doe v. Chiles*, 136 F.3d 709, 719-20 (11th Cir. 1998), relying in turn on *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 694-95 (11th Cir. 1997) (per curiam).

13. Defendants cite to cases involving the circumstances where a government official may be held liable for an employee's "randomized acts," typically under a theory of *respondeat superior*. *See, e.g., Ky. v. Graham*, 473 U.S. 159 (1985) (seeking damages against police commissioner for alleged

violation of constitutional rights committed by police officer.) This case, however, involves claims against state officials for direct liability based on state policies, not vicarious liability for the acts of state or local employees. *See, e.g, Shakhnes ex rel. Shakhnes v. Eggleston,* 740 F. Supp. 2d 602, 621 -22 (S.D.N.Y. 2010) (discussing distinction). To the extent certain of Plaintiffs' claims involve reimbursement rates and other actions taken by private parties such as managed care organizations, it is well-established that state officials cannot avoid liability for compliance with federal law based on a decision to rely on private entities to administer services. *See West v. Atkins,* 487 U.S. 42, 56 (1988); *Catanzano by Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995); *Tenn. Ass'n of Health Maint. Orgs., Inc. v. Grier*, 262 F.3d 559, 565 (6th Cir. 2001).

## III. RULE 23 CLASS ACTION REQUIREMENTS ARE SATISFIED

14. Rule 23(a)'s requirements for class certification are: (1) the class must be so numerous that joinder of all members is impracticable; (2) there must be a question of law or fact that is common to the class; (3) the class representatives must present claims or defenses typical of those of the class members; and (4) the class representatives must fairly and adequately protect the interests of the class. *See* FED. R. CIV. P. 23(a); *Pickett v. Iowa Beef Processors*, 209 F.3d 1276, 1279 (11th Cir. 2000). A court "must conduct a rigorous analysis of Rule 23 before certifying a class[.]" *Vega v. T-Mobile USA, Inc.*, 564 F.3d 1256, 1266 (11th Cir.

2009). "Rule 23 does not set forth a mere pleading standard. A party seeking class certification must affirmatively demonstrate his compliance with the Rule . . . ." *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011).

15. I previously found the requirements for class certification met and certified a class of "all children under the age of 21 who now, or in the future will reside in Florida and who are, or will be, eligible under Title XIX of the Social Security Act for Early Periodic Screening Diagnosis and Treatment Services." D.E. 671 at 8-9. I reaffirm that conclusion based on the lengthy trial record.

**A. Numerosity**

16. I find that the proposed class is "so numerous that joinder is impracticable." FED. R. CIV. P. 23(a)(1). Defendants' own statistics indicate that more than 1.5 million children were enrolled in Medicaid as of October 2009. DX 262. As of 2012, the enrollment had soared again, this time rising to 1.7 million children. Lewis on 11/29/2011 Rough Tr. at 48-49.

**B. Commonality**

17. Rule 23(a) requires a question of law or fact common to the class. FED. R. CIV. P. 23(a)(2). The commonality requirement "does not mandate that all questions of law or fact are common; a single common question of law or fact is sufficient to satisfy the commonality requirement, as long as it affects all class members alike." *Colomar v. Mercy Hosp., Inc.*, 242 F.R.D. 671, 676 (S.D. Fla.

2007). I find commonality is established in this case.

18. "What matters to class certification … is not the raising of common questions – even in droves – but, rather, the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation." *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011). The common contention "must be of such a nature that it is capable of class-wide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Id.*

19. Nothing in the *Wal-Mart* decision purports to hold class actions are not appropriate in institutional reform cases such as this one. Courts continue to certify classes in institutional reform cases as well as class actions after *Wal-Mart*. *See, e.g., Cronas v. Willis Group Holdings, Ltd.*, Case No. 06civ15295 (RMB), 2011 WL 6778490, *4 (S.D.N.Y Dec. 19, 2011) (certifying a settlement class in a Title VII gender discrimination case brought by women who all worked in one location and who all faced personnel actions by the same decision maker); *Carrera v. Bayer Corp. et al.*, Case No. 08-4716 (JLL), 2011 WL 5878376 (D. N.J. Nov. 22, 2011) (certifying class in consumer protection case brought by indirect purchasers alleging uniform, deceptive marketing practices by defendants); *Wilhoite v. Mo. Dept. of Social Serv.*, Case No. 2:10-cv-03026-NKL, 2011 WL 5025850 (W.D. Mo. Oct. 21, 2011) (certifying class of Medicaid beneficiaries who

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claim the state improperly deducted money from unrelated civil settlements or judgments to pay for part of their medical costs).

20. In litigation challenging a government program, all class members do not have to suffer the same injury simultaneously to meet the commonality requirement; it suffices if they are all subject to risk of deprivation of their legal rights. *See, e.g.*, *Baby Neal for and by Kanter v. Casey*, 43 F.3d 48, 60 (3d Cir. 1994). In a case challenging governmental policy, Rule 23(a)(2)'s commonality provision "does not require complete identity of legal claims." *Johnson v. Am. Credit Co. of Ga.*, 581 F.2d 526, 532 (5th Cir. 1978).

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21. I find a number of common questions of law and fact inform this action, and that those questions can be answered on a class-wide basis. Those questions include:

- Whether AHCA considers the requirements of federal law when it sets fee-for-service reimbursements rates for Medicaid providers or whether it simply sets rates to ensure budget neutrality;
- Whether reimbursement rates are sufficient to ensure that Class Members have reasonably prompt and equal access to primary providers, medical specialists, and dentists;
- Whether Defendants have failed to ensure compliance with a provision of Florida's state Medicaid plan, prohibiting terminating a child during a period of continuous eligibility;
- Whether Defendants have failed to conduct an effective statewide outreach program designed to inform children

determined to be eligible for Medicaid of their rights to services; and

- Whether Florida's uniform Medicaid application and process serve impose unnecessary obstacles to obtaining care.

22. The Class Members seek prospective relief to compel governmental entities to comply with their statutory mandates. The Eleventh Circuit has explicitly stated that the commonality requirement is satisfied in such cases. *See Haitian Refugee Ctr., Inc. v. Nelson*, 694 F. Supp. 864, 877 (S.D. Fla.1988), *aff'd*, 872 F.2d 1555 (11th Cir.1989) ("Class actions seeking injunctive or declaratory relief . . . by their very nature present common questions of law or fact."). This Court's rulings have been in accord. *See e.g.*, *Edmonds v. Levine*, 233 F.R.D. 638, 641 (S.D. Fla. 2006) (commonality satisfied in case challenging AHCA's criteria for denying Medicaid reimbursement for Neurontin); *Hernandez v. Medows*, 209 F.R.D. 665, 669 (S.D. Fla. 2002) (commonality met by "common issues of fact and law aris[ing] by virtue of the Federal Medicaid Program").

23. *Wal-Mart v. Dukes* is easily distinguished from these cases. In *Wal-Mart*, plaintiffs were claiming, in the face of a corporate policy explicitly prohibiting gender discrimination, that "a strong and uniform 'corporate culture' permits bias against women to infect, perhaps subconsciously, the discretionary decision making of each one of Wal-Mart's thousands of managers – thereby making every woman at the company the victim of one common discriminatory

practice." *Wal-Mart*, 131 S. Ct. at 2548. Here, by contrast, Plaintiffs are challenging Defendants' policies and practices, such as their policy for setting fee-for-service reimbursement rates for providers without considering whether those rates were sufficient to comply with federal requirements.

**C. Typicality**

24. Under Rule 23(a), Plaintiffs' claims must be typical of those of the Class Members. FED. R. CIV. P. 23(a)(3). "A sufficient nexus [to satisfy the typicality requirement] is established if the claims or defenses of the class and the class representative arise from the same event or pattern or practice and are based on the same legal theory." *Kornberg v. Carnival Cruise Lines, Inc.*, 741 F.2d 1332, 1337 (11th Cir.1984); *see also Andrews v. Am. Tel. & Tel. Co.*, 95 F.3d 1014, 1022 (11th Cir. 1996) (quoting *In re Am. Med. Syst., Inc.*, 75 F.3d 1069, 1082 (6th Cir.1996) ("'Typicality' exists when a plaintiff's injury arises from or is directly related to a wrong to a class and that wrong includes the wrong to the plaintiff.").

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25. I find that the typicality requirement is readily satisfied here. Each Plaintiff's inability to access care resulted from the same pattern or practice regarding Defendants' administration of the Florida Medicaid system. Factual variations amongst class members do not defeat typicality. *See Prado-Steiman*, 221 F.3d at 1279 n. 14 (typicality can "be satisfied even if some factual differences

exist between the claims of the named representatives and the claims of the class at large" because a "strong similarity of legal theories will satisfy the typicality requirement despite substantial factual differences"); *Appleyard v. Wallace*, 754 F.2d 955, 958 (11th Cir. 1985), *overruled on other grounds*, 474 U.S. 64 (1985) (stating, in case seeking to enforce rights under the Medicaid Act: "The similarity of the legal theories shared by the plaintiffs and the class at large is so strong as to override whatever factual differences might exist and dictate a determination that the named plaintiffs' claims are typical of those of the members of the putative class."); *see Edmonds v. Levine*, 233 F.R.D. 638 (S.D. Fla. 2006) (rejecting defendant's argument that named plaintiffs' claims were not typical because they had various medical conditions, and were prescribed Neurontin for different reasons, because defendants' actions in denying Neurontin coverage and underlying rationale for the denials were identical for all class members.); *Hernandez v. Medows*, 209 F.R.D. 665, 672 (S.D. Fla. 2002) ("[I]ncidental variations in Plaintiffs' factual situations do not defeat typicality because the basic nature of the injury and the legal theory of recovery is typical for the entire class."); *see also Baby Neal*, 43 F.3d at 58 ("Where an action challenges a policy or practice, the named plaintiffs suffering one specific injury from the practice can represent a class suffering other injuries, so long as all the injuries are shown to result from the same practice."); *Perdue*, 218 F.R.D. at 301 (N.D. Ga. 2003)

("Moreover, the named plaintiffs and putative class members all claim injuries arising from systemic deficiencies in the child welfare system, and all request the same system-wide declaratory and injunctive relief.)

**D. Adequacy**

26. Rule 23(a)'s last requirement is that Plaintiffs and their counsel will adequately protect the interests of the Class Members. FED. R. CIV. P. 23(a)(4). The "determining factor" for the adequacy of representation requirement "is the forthrightness and vigor with which the representative party can be expected to assert and defend the interests of the members of the class." *Veal v. Crown Auto Dealerships, Inc.*, 236 F.R.D. 572, 578 (M.D. Fla. 2006) (quoting *Lyons v. Georgia-Pacific Corp. Salaried Employees Ret. Plan*, 221 F.3d 1235, 1253 (11th Cir. 2000)). The adequacy of representation requirement has two components: "(1) the class representative has no interests antagonistic to the class and (2) class counsel possesses the competence to undertake the litigation." *Hammett*, 203 F.R.D. 695 (S.D. Fla. 2001); *see also Reese v. Miami-Dade County*, 209 F.R.D. 231, 233 (S.D. Fla. 2002).

27. Plaintiffs are represented by Boies, Schiller & Flexner, LLP, the Public Interest Law Center of Philadelphia, and Louis Bullock of Bullock, Bullock & Blakemore. I find that in the more than six years since this case was filed and during the 22-week trial, these attorneys have demonstrated their commitment to

the named Plaintiffs and to the Class Members and their ability to adequately represent their interests.

28. "[A] party's claim of representative status is defeated only if the conflict between the representative and the class is a fundamental one, going into the specific issues in controversy." *Pickett v. Iowa Beef Processors*, 209 F.3d 1276, 1280 (11th Cir. 2000). "A fundamental conflict exists where some party members claim to have been harmed by the same conduct that benefitted other members of the class." *Valley Drug Co. v. Geneva Pharm., Inc.*, 350 F.3d 1181, 1189 (11th Cir. 2003).

29. Far from being in conflict, Plaintiffs and the Class Members share an overriding interest in bringing Defendants into compliance with federal law. There is no evidence of any conflict between the Class Members, fundamental or otherwise. The Individual Plaintiffs and the Class Members will all benefit from the entry of the injunctive and declaratory relief sought in this case.

30. My finding that Plaintiffs' interests do not conflict with those of the class members is fully supported by precedent. *See, e.g., Hernandez v. Medows*, 209 F.R.D. 665, 667 (S.D. Fla. 2002) (class of current and future Medicaid recipients); *Chisholm v. Jindal*, No. Civ. A. 97-3274, 1998 WL 92272, at *5 (E.D. La. March 2, 1998) (plaintiffs challenging access to EPSDT care and services);

*Karen L. ex rel. Jane L. v. Physicians Health Servs., Inc.*, 202 F.R.D. 94, 102 (D. Conn. 2001) (Medicaid recipients).

**E. Certification Is Proper Under Rule 23(b)(2) Because Defendants Acted Or Failed To Act On Grounds Generally Applicable To The Class**

31. Certification is proper under Rule 23(b)(2) where Defendants have "acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." FED. R. CIV. P. 23(b)(2). "Requesting a declaration that Defendants presently are violating the law and an injunction forcing defendants to comply with the law is precisely the type of class appropriate for class certification under Rule 23(b)(2)." *Fabricant v. Sears Roebuck*, 202 F.R.D. 310, 316 (S.D. Fla. 2001); *see also Nat'l Law Ctr. on Homelessness and Poverty, R.I. v. New York*, 224 F.R.D. 314, 325 (E.D.N.Y. 2004) (Certification under Rule 23(b)(2) is "proper where a government entity refuses to comply with federal law.") (citation omitted). Rule 23(b)(2)'s requirements are "almost automatically satisfied in actions primarily seeking injunctive relief." *Baby Neal*, 43 F.3d at 58.

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32. A class action is appropriate when "the party opposing the class . . . has established a regulatory scheme Common to all class members . . . . What is necessary is that the challenged conduct or lack of conduct be premised on a

ground that is applicable to the Entire class." *Johnson v. Am. Credit Co. of Ga.*, 581 F.2d 526, 532 (5th Cir.1978). The key to the (b)(2) class is "the indivisible nature of the injunctive or declaratory remedy warranted – the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them." *Wal-Mart*, 131 S. Ct. at 2557 (internal quotation omitted).

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33. This is a paradigmatic example of a case in which certification under Rule 23(b)(2) is appropriate. 7 NEWBERG ON CLASS ACTIONS § 23:11 (4th ed.); *see e.g., Hawkins ex rel. Hawkins v. Comm'r of N.H. Dep't of Health and Human Servs.*, No. Civ. 99-143-JD, 2004 WL 166722, at *4 (D.N.H. Jan. 23, 2004) ("Classes certified under Rule 23(b)(2) frequently serve as the vehicle for civil rights actions and other institutional reform cases, including cases alleging deficiencies in government administered programs such as Medicaid.") (internal quotation omitted).

34. Many other courts have certified similar classes. *See Memisovski ex rel. Memisovski v. Maram*, No. 92 C1982, 2004 WL 1878332, at * 1 (N.D. Ill. Aug. 23, 2004) (noting certification of a class consisting of "[a]ll children… in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medicaid Assistance Program ('Medicaid') established under Title XIX of the Social Security Act"); *Okla. Chapter of Am. Acad. of Pediatrics v.*

*Fogarty*, 01-CV-0187 (N.D. Okla. May 30, 2003) (certifying class of "all children under the age of 21 who are now, or in the future will be, residing in Oklahoma and who have been, or will be, denied or deprived of Medical Assistance as required by law"), *overturned on other grounds*, 472 F.3d 1208 (10th Cir. 2007); *Hawkins ex rel. Hawkins v. Comm'r of N.H. Dep't. of Health and Human Servs.*, No. 99-CIV-143-JD, 2004 WL 166722, at *1 (D.N.H. Jan. 23, 2004) (certifying settlement class of "all persons under age 21 who are now enrolled, or who became enrolled during the term of this Decree, in the New Hampshire Medicaid program and are, or will become, entitled to receive EPSDT dental services"); *Thompson v. Raiford*, No. 3:92-CV-1539-R, 1993 WL 497232, at *1 (N.D. Tex. Sept. 24, 1993) (certifying nationwide class of "[a]ll Medicaid-eligible children under age 72 months who are eligible to receive Early and Periodic Screening, Diagnostic, and Treatment ('EPSDT') program services"); *McCree v. Odom*, No. 4:00-173(H)(4), slip op. at 37 (E.D.N.C. Nov. 26, 2002)[4] (certifying class of "all persons under age 21 who are or will be eligible for Medicaid in North Carolina" in suit challenging provision of dental care under Medicaid); *Salazar v. D.C.*, 954 F. Supp. 278, 281 (D.D.C. 1996) (noting previously certified class of "[a]ll persons who have applied, have attempted to apply, or will apply in the future during the pendency of this litigation, for medical assistance pursuant to Title 19 of the Social Security Act

[4] This is an unpublished opinion, previously submitted to the Court as D.E. 281-3.

('Medicaid'), and all persons who have received, are receiving, or will receive in the future during the pendency of this litigation, Medicaid in the District of Columbia"); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 68 (D. Conn. 2001) (certifying class of "all individuals in Connecticut who are or will be eligible for Medicaid managed care Husky A benefits, and are or will be seeking dental services" and a subclass of "children in Connecticut who are now or will be under the age of 21, are or will be seeking dental health services, and are or will be eligible for Medicaid managed care Husky A benefits"); *Sanders v. Lewis*, No. 2:92-CV-0353, 1995 WL 228308, at *1 (S.D. W.Va. March 1, 1995) (certifying class of "[a]ll children who are now, or will in the future be, under the age of 21, in out-of-home care in the legal or temporary legal custody of the West Virginia Department of Health and Human Resources, and eligible for Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services").

## IV. THE MEDICAID STATUTES

### A. The Plaintiffs' Ability To Sue Under §1983 For Alleged Violations Of The Statutes

35. To determine whether a federal statute creates an enforceable right against a state, a court must analyze three factors:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on

> the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

*Blessing v Freestone,* 520 U.S. 329, 340-41 (1997) (citations omitted). For statutory language to satisfy the first factor, it must be "rights-creating" and clearly impart an "individual entitlement" on the plaintiff with an "unmistakable focus on the benefitted class." *See Gonzaga Univ. v. Doe,* 536 U.S. 273, 274, 284 (2002). The provisions at issue in the case meet the three-prong test established in *Blessing*, as refined by *Gonzaga.*

36. The Eleventh Circuit in *Doe v. Chiles*, 136 F.3d 709, 719 (11th Cir. 1998), expressly held that 42 U.S.C. § 1396a(a)(8), which requires medical assistance be provided with "reasonable promptness," meets all three requirements of the *Blessing* test, and *Doe* has not been called into doubt by *Gonzaga. See Bryson v. Shumway*, 308 F. 3d 79, 89 (1st Cir. 2002); *Newark Parents Ass'n v. Newark Pub. Sch.,* 547 F.3d 199, 208 (3d Cir. 2008); *Sabree ex. rel. Sabree v. Richman*, 367 F.3d 180, 189-90 (3d Cir. 2004)*; Doe v. Kidd*, 501 F. 3d 348, 356 (4th Cir. 2007); *Westside Mothers v. Olszewski*, 454 F.3d 532, 536-37 (6th Cir. 2006).

37. 42 U.S.C. 1396a(a)(10) provides that a state plan for medical assistance must "provide for making medical assistance available." Medical assistance includes a guaranty that EPSDT services be provided to children, 42 U.S.C. § 1396 a(a)(10)(A), and confers enforceable rights. *See Newark Parents*

*Ass'n*, 547 F. 3d at 208; *Sabree*, 367 F.3d at 190; *S,D, ex rel Dickson v. Hood*, 391 F.3d 581, 607 (5th Cir. 2004); *Westside Mothers*, 454 F.3d 532, 536-37; *Katie A. ex rel Ludin v. L.A. County*, 481 F. 3d 1150, 1153 n 7 (9th Cir. 2007); *Watson v. Weeks*, 436 F. 3d 1152, 1154 (9th Cir. 2006).

38. 42 U.S.C. Section 1396a(a)(30)(A) requires a state program to:

> ["P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and *are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . .*"

(Emphasis supplied).

39. As I have previously held, the individual plaintiffs may bring an action under 1396a(a)(30)(A) in light of *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 519-20 (1990). In *Wilder*, the Supreme Court held that health care providers could sue to enforce the Boren Amendment because they were the "intended beneficiaries" of a provision that imposed a "binding obligation" on states to adopt reasonable rates. *See id*. at 509-510.

40. The Wilder Court's analysis was expressly preserved by *Gonzaga*, which stated that the language of the Boren Amendment "left no doubt of its intent for private enforcement . . . because the provision required States to pay an 'objective' monetary entitlement to individual health care providers." *See*

*Gonzaga*, 536 U.S. at 281. *Wilder*, then, remains good law. Indeed, *Wilder* has been cited this term with approval by the U.S. Supreme Court in *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, -- S. Ct. --, 2012 WL 555204 (Feb. 22, 2012).

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41. Section "1396(a)(30)(A) imposes a mandate on states that mimics the Boren Amendment and contains similar "rights-creating language." *See Gonzaga*, 536 U.S. at 290. The Boren Amendment required states to create programs that provided reasonable payment to provide access to adequate medical assistance, while 1396(a)(30)(A) requires states to create programs that provide sufficient payment to ensure that adequate access to medical assistance is "available under the plan."

42. The "structure and language of [the Boren Amendment and § 1396a(a)(30)(A)] are nearly identical, and each focuses on mandatory obligations [that] a state plan must meets" there is "no principled basis to say that a private right of action is unavailable in this case." *See Memisovski v. Maram*, 2004 WL 1878332, at *8 (N.D. Ill. 2004). *See Penn. Pharm. Ass'n v. Houston*, 283 F.3d 531, 538 (3d Cir. 2002) (*en banc*) (Alito, J) (holding that 1396(a)(30)(A)'s provision for quality of care and adequate access were draft[ed] . . . with an unmistakable focus on Medicaid beneficiaries"); *see also Clark v. Richman*, 339 F. Supp. 2d 631, 639-40 (M.D. Pa. 2004) (applying the reasoning of *Memisovski* to find that § 1396a(a)(30)(A) confers privately enforceable rights); *Pediatric*

*Specialty Care, Inc. v Ark. Dept. of Human Servs.*, 443 F.3d 1005, 1014-16 (8th Cir. 2006) (finding that § 1396a(a)(30)(A) confers a privately enforceable right to Medicaid recipients), *cert. granted and order vacated as to individual defendants only*, 551 U.S. 1142 (2007).

43. Post *Gonzaga* a number of Courts of Appeal other than the Eleventh Circuit have held Section 1396a(a)(30)(A) is not enforceable by Medicaid providers and/or recipients, *e.g.*, *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007); *Westside Mothers v. Olszewski*, 45 F. 3d 532, 542 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3rd 1051, 1060-61 (9th Cir. 2005); *OKAAP v. Fogarty*, 472 F.3rd 1208, 1210, 1215 (10th Cir. 2007); *Mandy R . ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Long Term Care Pharm Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004). Respectfully, I find these courts have not distinguished the U.S. Supreme Court's holding in *Wilder*. D.E. 672 p. 6.

44. On February 22, 2012, the United States Supreme Court decided *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, -- S. Ct. --, 2012 WL 555204 (Feb. 22, 2012). In that case, California Medicaid recipients and providers, in light of the holding in *Sanchez v. Johnson*, 416 F.3rd 1051, 1060 (9th Cir. 2005), that 1396a(a)(30)(A) was unenforceable under 42 U.S.C. § 1983, instead sought to enforce 1396a(30)(A) through the Supremacy Clause to the U.S. Constitution

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against a California statute cutting Medicaid reimbursement rates. In its opinion, the Supreme Court, in light of developments after certiorari was granted, remanded the case for further proceedings by the Ninth Circuit without deciding whether section 1396a(a)(30)(A) may be enforced through the Supremacy Clause. Significantly, the Opinion for the Court in *Douglas*: (a) did not contain any discussion of whether section 1396a(a)(30)(A) may or may not be enforced through 42 U.S.C. § 1983 and (b) cited to its opinion *Wilder v. Va. Hosp. Ass'n.*, 496 U.S. 498 (1990) without any intimation that *Wilder* is not still good law. Because I have found that Section (30)(A) is enforceable under 42 U.S.C. §1983, I have not had to reach the issue of whether jurisdiction to enforce Section (30)(A) would independently exist under the Supremacy Clause.

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45. Section 1396a(a)(43)(A), which provides a right to outreach and information, also confers enforceable rights on the plaintiffs.

> "First, the Eleventh Circuit in a pre- Gonzaga case, *31 Foster Children v. Bush*, 329 F.3d 1255 (11th Cir. 2003), held that this provision created enforceable rights. Second, I do not think *31 Foster Children* has been called into question by *Gonzaga*, and I concur with those other district courts that have addressed this issue post- *Gonzaga* and concluded that §1396a(a)(43)(A) confers enforceable rights on the plaintiffs. *See Clark v. Richman*, 339 F. Supp. 2d 631, 638-640 (M.D. Pa. 2004); *Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, *8-11 (N.D. Ill. 2004); *Health Care for All v. Romney*, 2005 WL 1660677, *13 (D. Mass. July 14, 2005); *Westside Mothers v. Olszewski*, 368 F. Supp. 2d 740, 769-770 (E.D. Mich. 2005); *A.M.H. v. Hayes*, 2004 U.S. Dist. Lexis 27387, *19 (S.D. Ohio 2004). The provision at issue requires the defendants to provide basic outreach and information to the plaintiff class. As a result, Congress must have

> intended that the provision in question benefit the plaintiffs, and the clear right that is protected by the provision is neither "vague" nor "amorphous."

Order denying Defendants Motion to Dismiss, January 11, 2007, D.E. 40. More recently, the enforceability of Section 1396a(a)(43)(A) has been reconfirmed in *John B. v. Goetz*, 626 F.3d 356, 362 (6th Cir. 2010).

46. 42 U.S.C. § 1396a(a)(43)(B) and 42 U.S.C. §1396a(a)(43)(C), which provide rights to treatment for children who request care, also satisfy all three *Blessing* factors, and contain private rights of action. This has been the conclusion of every court to consider this issue since *Gonzaga*. *See S.D. ex rel Dickson v. Hood*, 391 F.3d 581, 603-04 (5th Cir. 2004); *Hunter ex rel. Lynah v. Medows*, Case No. 08-2930, 2009 WL 5062451, at *2-3 (N.D. Ga. Dec. 16, 2009); *D.W. v. Walker*, No. 09- 00060, 2009 WL 1393818, at *6 (S.D. W. Va. May 15, 2009); *Parent League for Effective Autism Servs. v. Jones-Kelley*, 565 F. Supp. 2d 895, 904 (S.D. Ohio 2008); *Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050, 1111 (N.D. Okla. 2005), *reversed on other grounds*, 472 F. 3d 1208 (10th Cir. 2007); *Clark v. Richman*, 339 F. Supp. 2d 631, 640 (M.D. Pa. 2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92-1982, 2004 WL 1878332, at *8-11 (N.D. Ill. Aug. 23, 2004); *Health Care for All, Inc. v. Romney*, No. 00-10833, 2004 WL 3088654, at *2 (D. Mass. Oct. 1, 2004); *Kenny A. ex rel. Winn v. Perdue*, 218 F.R.D. 277, 293-94 (N.D. Ga. 2003); *John B. v. Emkes*, Civil Action

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No. 3:98- cv-0168 in the United States District Court for the Middle District of Tennessee, Memorandum Opinion and Order, Document Number 1572, pp. 5-8, filed February 14, 2012.

47. Defendants argue "medical assistance" as used in the statute does not allow anything more than payment for services and creates no right to actual receipt of medical assistance. I rejected this agreement previously and do so again. In *Doe v. Chiles*, 136 F.3d 709 (11th Cir 1998).

> "the Eleventh Circuit followed *Sobky v. Smoley*, 855 F. Supp. 1123, 1145 (E.D. Cal 1994), which held that "medical assistance under the plan…can only mean medical services." *See* 136 F.3d 709, 716 n.13. Based on this understanding *Doe* upheld a claim that the Florida Department of Health & Rehabilitative Services violated § 1396a (a)(8) by failing to provide medical assistance, which consisted of the "therapies, training and other active treatment to which [the plan participants were] entitled." *Id.* at 711. The Eleventh Circuit in *Doe*, then, considered and rejected the argument that the term "medical assistance" is limited to payment alone. Indeed, the state had argued that it had "no obligation to place individuals in facilities; but were obligated only to reimburse the ICF providers with reasonable promptness." *See* Brief of Appellee at 17-18, *Does v. Chiles*, No. 96-5144 (11th Cir. April 9, 1997)."

Order denying Defendants' Motion for Summary Judgment, September 30, 2009, D.E. 672 p. 7-8.

48. The Eleventh Circuit's broad interpretation of "medical assistance" as including medical services is supported by decisions of the First and Ninth Circuit, though there is admittedly a split in the circuits. *See Bryson v. Shumway*, 308 F.3d, 79, 89 (1st Cir. 2002); *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d at

1154. *But see Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724, 728-29 (5th Cir. 2009) (holding that medical assistance means payment for medical services); *Westside Mothers*, 454 F. 3d at 540-41 (same); *Bruggeman ex rel Bruggeman v. Blogojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (same); (dictum) OKAAP, 472 F.3d at 1214 (same).

49. The Medicaid Act defines "medical assistance" as "payment of part or all of the cost of the [listed] care and services." 42 U.S.C. 1396(a). Additionally, § 1396(a)(10) states that a plan must provide "for making medical assistance available, *including at least the care and services* listed" in 1396d(a), which specifies access to hospital services and physician services. *See §* 1396a(a)(10) (emphasis added); §§ 1396a(a)(10) (d)(l),(d)(5). Because the word "include" shows that the statute's drafters "intended to provide a non-exhaustive list of examples to clarify the meaning of a term," the structure of § 1396a(a)(10), read together with § 1396d(a) suggests that care and services contained within the definition of medical assistance. *See Jean v. Nelson*, 863 F.2d 759, 777 (11th Cir. 1988). Several other provisions in §1396a(a) also describe "medical assistance" as including care and services. *See, e.g.*, §§ 1396d(a)(43), 1396a(10)(C)(iii) and (C)(iv). Additionally, regulations enacted pursuant to the Medicaid Act require that a state plan "specify that" recipients are "furnished" listed "services," *see* 42 C.F.R. 440.210, 440.220, and require the state agency administering EPSDT

provide recipients "services" including dental care and immunizations. *See* 42 C.F.R. 441.56(c). These regulations are consistent with the plaintiffs' definition of "medical services." Even if the statutory language is ambiguous, the agency's interpretation is entitled to deference so long as it is reasonable. *See Friends of Everglades v. S. Fla. Water Mgt. Dist.*, 570- F.3d 1210, 1227-28 (11th Cir. 2009). *Id. a*t p. 8 §n 6.

50. Any issues previously created by the definition of medical assistance in 42 U.S.C. § 1396d(a) were resolved by the enactment on March 23, 2010 of the Patient Protection and Affordable Care Act" (hereafter referred to as" PPACA"). *See* Pub L. No. 111-148, 124 Stat. 119. Section 2304 of PPACA, which is headed "Clarification of Definition of Medical Assistance" and amends the Medicaid Act, 42 U.S.C. sec. 1396d(a) (Social Security Act sec. 1905d(a)) to add to the provision below the italicized language.

> The term medical assistance means payment of part or all of the cost of the following care or services, *or the care and services themselves, or both* if provided in or after the third month in which the recipient makes application for assistance…..

This change eliminated the legislative basis for Judge Posner's dictum in *Bruggeman* and those courts that have followed his view.

51. The legislative history of this amendment demonstrates that the Congress intended this amendment to resolve the split in the Circuit Court cases

and that Congress always had intended that medical assistance include care and/or services. H.R. Rep. No. 111-299 at 649-50.

> Section 1905(a) of the Social Security Act defines the term "medical assistance." The term is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. The Committee, which has legislative jurisdiction over Title XIX of the Social Security Act, has always understood the term to have this combined meaning. Four decades of regulations and guidance from the program's administering agency, the Department of Health and Human Services, have presumed such an understanding and the Congress has never given contrary indications.
>
> Some recent court opinions have, however, questioned the longstanding practice of using the term "medical assistance" to refer to both the payment for services and the provision of the services themselves. These opinions have read the term to refer only to payment; this reading makes some aspects of the rest of Title XIX difficult and, in at least one case, absurd. If the term meant only payments, the statutory requirement that medical assistance be furnished with reasonable promptness "to all eligible individuals" in a system in which virtually no beneficiaries receive direct payments from the state or federal governments would be nearly incomprehensible.
>
> Other courts have held the term to be payment as well as the actual provision of the care and services, as it has long been understood. The Circuit Courts are split on this issue and the Supreme Court has declined to review the question. To correct any misunderstandings as to the meaning of the term, and to avoid additional litigation, the bill would revise section 1905(a) to read, in relevant part: "The term 'medical assistance' means payment of part or all of the cost of the following care and services, or the care and services themselves, or both." This technical correction is made to conform this definition to the longstanding administrative use and understanding of the term. It is effective on enactment.

The Eleventh Circuit in a post-PPACA decision, *Moore ex rel Moore v. Reese*, 637

F.3d 1220, 1232 (11th Cir. 2011), recognized that "medical assistance" means provision of medical services," without citing PPACA. *See also Disability Rights New Jersey, Inc. v. Velez*, CIV-05 – 4723 (AET), 2010 WL 5055820 (D.N.J. Dec. 2, 2010) at *2; (taking account of PPACA).

**B. The Substantive Standards of the Medicaid Act**

52. Medicaid is a cooperative federal/state program through which the federal government grants funds to participating states to provide health care services to needy individuals. *See* 42 U.S.C. § 1396-1; *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 L. Ed. 2d 455, 110 S. Ct. 2510 (1990). State participation in Medicaid is voluntary, but if states choose to participate, they must comply with the requirements outlined in the Medicaid statute. *Wilder*, 496 U.S. at 502. Florida has elected to participate in the Medicaid program. To qualify for federal funds, a state must submit a plan to the Secretary of Health and Human Services (HHS) which complies with all fifty-eight subsections outlined in 42 U.S.C. § 1396a(a). *Id.*

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53. **EPSDT Services:** When Congress amended the Medicaid statutes in 1989, it made the provision of "early and periodic screening, diagnostic, and treatment services ("EPSDT" services) to Medicaid-eligible children mandatory for participating states. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2261-2265, 2268, 2269 (codified as amended at 42

U.S.C. § 1396d(r)(2005)); 42 U.S.C. § 1396d(a)(4)(B),-(r). 42 U.S.C. § 1396a(a)(10)(A) requires that states provide "for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5)…of Section 1396d(a) of this title, to … all individuals [who are eligible]."

54. 42 U.S.C. § 1396d(a)(4)(B), in turn, defines "medical assistance" to include "early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) [42 U.S.C. § 1396 d (r)] for individuals who are eligible under the plan and are under the age of 21." And 42 U.S.C. § 1396d(r) specifically sets out the mandatory EPSDT services that must be provided to all eligible individuals under the age of 21:

> (1) Screening services, which at a minimum must include (i) "a comprehensive health and developmental history (including assessment of both physical and mental health development)" (ii) "a comprehensive unclothed physical exam"; (iii) "appropriate immunizations… according to age and health history"; (iv) "laboratory tests (including lead blood level assessment appropriate for age risk factors)"; and (v) "health education";
>
> (2) Vision services, including diagnosis and treatment for vision defects;
>
> (3) Dental services, including "relief of pain and infections, restoration of teeth, and maintenance of dental health";
>
> (4) Hearing services, including diagnosis and treatment for defects in hearing; and
>
> (5) All medically necessary health care services "…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."

55. There are additional requirements concerning EPSDT services in 42 U.S.C. §1396a(a)(43), which states that a state plan must contain provisions:

> (B) providing or arranging for the provision of such screening services in all cases where they are requested; (C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services; and (D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:
>
> > (i) the number of children provided child health screening services,
> >
> > (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),
> >
> > (iii) the number of children receiving dental services and other information relating to the provision of dental services to such children described in section 2108(e) [42 USCS § 1397hh(e)], and
> >
> > (iv) the State's results in attaining the participation goals set for the State under section 1905(r) [42 USCS § 1396d(r))].

56. In connection with its duties under EPSDT, a state Medicaid agency must implement a periodicity a schedule for screening services that: "(a) meets reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations in child health care; (b) specifies screening services applicable at each state of the recipient's life,

beginning with a neo-natal examination, up to the age at which an individual is no longer eligible for EPSDT services." 42 CFR 441.58 (a) and (b).

57. These "EPSDT Requirements" differ from merely providing "coverage" for or "access" to services; the Medicaid statute places affirmative obligations on states to assure that these services are actually provided to children on Medicaid in a timely and effective manner. *See, e.g., Stanton v. Bond*, 504 F.2d 1246, 1251(7th Cir. 1974) ("EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose."); *Memisovski v. Maram*, 2004 U.S. Dist LEXIS 16772 (N.D. Ill. 2004) at 49-150.

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58. Indeed, the statute and regulations require states to make sure the screening services are delivered to the greatest number of children possible. "Congress' intent to ensure that Medicaid-eligible children actually receive services is underlined by provisions in the statute that place explicit duties on states to (a) mandate outreach, (b) provide or arrange for screening services in all cases where they are requested, (c) arrange for whatever corrective treatments are discovered to be needed; and (d) report on their results. *See* § 1396a(a)(43); 42 C.F.R. § 441.56(a)(1), – .61, -.62 (2005).

59. "When a state elects to provide an optional service [under Medicaid] that service becomes a part of the state Medicaid plan and is subject to the

requirements of federal law." *Doe v. Chiles*, 136 F.3d 709, 714, (11th Cir. 1998 (citing) *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F. 3d 693, 698 (11th Cir. 1997) (per curium). Because Florida has chosen to provide continuous eligibility as part of its state plan, PX 712 at FL-MED 08335, that requirement is enforceable as part of federal law. *Doe v. Chiles*, 136 F.3d at 714. Under continuous eligibility, children under the age of five cannot, with very limited exceptions, have their eligibility terminated until they have been on Medicaid for 12 months from the time of their last eligibility determination. Lewis on 10/20/2010 Final Tr. at 4654:10 – 4655:4; PX 712 at FL-MED 08335. For children between the ages of 5 and 18, the period of continuous eligibility is six months. *Id.*

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60. **Reasonable promptness:** 42 U.S.C. § 1396a(a)(8), frequently referred to as the "Reasonable Promptness" provision, requires that a participating state plan for medical assistance:

> …provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to *all eligible* individuals.

61. **Equal Access:** U.S.C. § 1396a(a)(30)(A), which is frequently referred to as the "Equal Access" provision, requires a state plan to:

> …provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan…as may be necessary…to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan

> at least to the extent that such care and services are available to the general population in the geographic area.

The term "general population" in 42 U.S.C. § 1396a(30)(A) means the population which has public or private insurance other than Medicaid; it does not include the uninsured population. *See Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F. 3d 519, 527 (8th Cir. 1993).

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62. There is no single approach that must be used for defining a relevant geographic medical care market. *See Methodist Hospitals, Inc. v. Sullivan*, 91 F. 3d 1026.1029 (7th Cir. 1996). Courts have in the face of significant statewide disparities in reimbursement rates, combined with multiple instances of disparities to access in multiple areas of the state found a Section 30(A) violation. *See OKAAP v. Fogarty*, 366 F. Supp. 1050, 1119 (N.D. Okla. 2005); *Ark. Med. Soc'y, Inc. v. Reynolds*, 834 F. Supp. 1097 (E.D. Ark. 1992) (focus on level of physician participation in program and level of reimbursement to determine compliance with equal access provision).

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63. **Effective Outreach:** 42 U.S.C. §1396a(a)(43) provides that a state plan must contain provisions (A)"Informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(r) [42 USCS § 1396d (r)], of the availability of early and periodic screening, diagnostic, and treatment services as

described in section 1905(r) [42 USCS § 1396d(r)] and the need for age-appropriate immunizations against vaccine-preventable diseases[.]"

64. **Paragraph 64, was deleted because it is a duplicate of paragraph 62.**.

65. The requirement that states inform eligible children of EPSDT services has both procedural and substantive implications. States must draft guidelines by which the information regarding EPSDT services is to be transmitted; they must also ensure that effective notice, in fact reaches children and their families. *See Stanton v. Bond*, 504 F.2d 1246, 1250 (7th Cir. 1974) ("The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the 1967 act and by the interpretative regulations and guidelines."); 42 C.F.S. § 441.56(a)(1) (2005). If a state's scheme for informing children of their rights is ineffective or conveys out-of-date or inaccurate information, the state is not in compliance with the law. *See Health Care for All v. Romney*, 2005 U.S. Dist. LEXIS 14187, Civ. No. 00-10833RWZ, 2005 WL 1660677, at *14 (D. Mass. July 14, 2005) (Zobel, J.) (concluding that the state violated its duty to inform children of EPSDT services where notices sent to children and their families contained "incorrect or outdated guidance on obtaining services"); *cf. Pediatric Specialty Care*, 29d F.3d at 481

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("The state may not shirk its responsibilities [under § 1396a(a)(43)] to Medicaid recipients by burying information about available services in a complex bureaucratic scheme.") *Rosie D. v. Romney*, supra, 410 F. Supp 2d at 26-27.

66. **Judicial & Administrative Requirements:** A state which chooses to have part or all of its Medicaid program delivered by HMOs may not thereby escape legal responsibility if the HMOs fail to make care and services available as required by federal law. *See John B v. Menke*, 176 F. Supp. 2d 786, 801 (M.D. Tenn. 2001). *See Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 997 (N.D. Calif. 2010); *McCartney by and through McCartney v. Cunsler*, 608 F. Supp. 2d 694 (E.D.N.C. 2009); *Salazar v. D.C.*, 596 F. Supp. 2d 67 (D.D.C. 2009).

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67. The United States Court of Appeals for the Eleventh Circuit has recently pointed out in language applicable to this case: "However pressing budgetary burdens may be, we have previously commented that cost considerations alone do not grant participating states to shirk their statutory duties under the Medicaid Act." *Moore v. Reese*, 637 F.3d 1220, 1259 (11th Cir. 2011) (citing *Tallahassee Mem.*, 109 F.3d at 704 (per curiam).

68. The fact that 42 U.S.C. 1396(c) gives the Secretary of federal HHS power to cut off federal funding of a state's Medicaid funding if the state doesn't comply substantially with the law does not preclude Medicaid recipients from maintaining an action under sections of the act which contain rights creating

language such as a(a)(8) and a(a) (10)for the state's violations affecting them. *See Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004).

69. Nor does the fact that a state's Medicaid Plan contains a fair hearing mechanism in compliance with 42 U.S.C. a(a)(3) demonstrate that the state has a comprehensive remedial scheme which causes a Medicaid recipients' claim under a(a)(8), a(a)(10), a(a)(30)(A) or a(a)(43)to fail the third prong of the test in *Blessing v. Freestone*, 520 U.S. 329(1997). *See Sabree v. Richman*, 367 F. 3d 180, 193 (2004).

70. Courts look to various factors in determining whether a state is in violation of provisions of the Medicaid Act. As one court noted:

> Two major factors used frequently by the Secretary of Health and Human Services and the courts are the level of physician participation in the Medicaid program and the level of reimbursement to participating physicians. As to the first factor, a longstanding criterion used by the Department of Health and Human Services and its predecessor agency, the Department of Health, Education and Welfare, for implementing the equal access requirement is a two-thirds participation ratio.

*Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D. Calif. 1990), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 985 (9th Cir. 1992). *Clark*, 758 F. Supp. at 576.

71. In addition, the court also considered: whether "providers [are] widely opting out of the Medicaid program or restricting their Medicaid caseloads"; "whether there is a steady stream of reports that recipients are having difficulty obtaining care"; and admissions by state agency personnel "that reimbursement

rates are inadequate and that the equal access provision is being violated." *Id.* at 577-78. Further, the court looked to the "utilization rate" as another relevant factor. *Id.* at 578.

72. These factors have been cited approvingly by other courts. *See Okla. Chapter of the Am. Acad. of Pediatrics (OKAAP) v. Fogarty*, 366 F. Supp. 1050, 1105-06 (N.D. Okl. 2005)[5]; *Clark v. Richman*, 339 F.Supp.2d 631, 644 (M.D.Pa.2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332 at *42 (N.D. Ill. Aug.23, 2004); and *Ark. Med. Soc'y, Inc. v. Reynolds*, 834 F. Supp. 1097, 1100 (E.D. Ark.1992). *Health Care for All, Inc. v. Romney*, 2005 U.S. Dist. LEXIS 14187 (D. Mass. 2005) at 32-33.

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73. In both OKAAP *v. Fogarty* and the *Memisovski* case, the court found the defendants in violation of the Medicaid Act. In *OKAAP v. Fogarty*, from 1995 to 2003, the state's fee-for-service schedule never exceeded 72 percent of Medicare. *OKAAP v. Fogarty*, 366 F. Supp. at 1059. Just before the trial, the state raised the rates for evaluation and management codes to 90% of Medicare; the rate for most codes was 71% of Medicare. *Id.* Specialists were paid approximately 72% of Medicaid for most services. *Id.* at 1060; *see also id.* at 1074. In *Memisovski*, expert testimony showed that Medicaid, at most, paid 55%

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[5] A subsequent order in this case was overturned by the Tenth Circuit on other grounds. *See Oklahoma Chapter of American Academy of Pediatrics v. Fogarty*, 472 F. 3d 1208 (10th Cir. 2007)), cert denied, 552 U.S. 813 (2007).

of the rate that Medicare paid for the same service, and that the Medicaid rate was a lower percentage of the rates paid by private insurance. *Memisovski*, 2004 WL 1878332 at *43.

74. The Department of Health and Human Services has taken a similar view. In 2001, the Department of Health and Human Services issued a Dear State Medicaid Director letter, providing guidance to states on what would constitute a violation of sections 1396a(a)(8) and (a)(30), and emphasized the importance of paying competitive rates. PX 447. The Department said, in an opinion consistent with the ruling in *Clark v. Kizer*, "Lack of access due to low rates is not consistent with making services available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at CRALL00751.

75. The Department further said: "[S]ignificant shortages in beneficiary receipt of dental services, together with evidence that the Medicaid reimbursement rates falls below the 50th percentile of providers fees in the marketplace, creates a presumption of noncompliance with both these statutory requirements." *Id.* While that statement concerned dental care, it is equally applicable to medical care, except that a different benchmark, in lieu of the 50th percentile of usual and customary fees, would apply to medical fees. As the above case law shows, the most appropriate benchmark is Medicare reimbursement rates.

76. Other facts that courts have placed weight upon, include: CMS 416 results; HEDIS reports; whether rates cover providers' average costs; promptness of payments; difficulty referring children on Medicaid to other providers, wait times and travel distances to see providers, comparative experience of children on private insurance, testimony of beneficiaries, admissions in legislative budget requests, and immunization rates. *See generally OKAAP* and *Fogarty*.

77. Congress' recognition of the importance of increasing reimbursement rates to ensure adequate access to care is reflected in section 1202(a)(1) of the Patient Protection and Affordable Care Act (PPACA) 42 U.S.C. § 1396 a(a)(13)(C), which provides that:

> Payment for primary care services…furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine or pediatric medicine at a rate not less than 100% of the payment rate that applies to such services under Part B of Title XVII.

(*i.e.*, Medicare) with respect to evaluation and management codes and services related to certain immunization administration for vaccine codes. Section 1202(a)(2) of PPACA, 42 U.S.C. § 1396a-2(f) requires that payments for such primary services in managed care plans be "consistent with" the said minimum payment rates.

## V. THE NAMED PLAINTIFFS AND ORGANIZATIONS

### A. Legal Requirements for Standing

1. The Named Plaintiffs Have Standing

78. In order to prosecute a case as a class action, "the named plaintiffs must have standing[.]" *See Vega v. T-Mobile USA Inc.*, 564 F.3d 1256, 1265 (11th Cir. 2009) (citations omitted). Standing requires a showing that:

> (1) the plaintiff . . . suffered an injury in fact--an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) there must be a causal connection between the injury and the conduct complained of-- the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court; and (3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

*Bloedorn v. Grube*, 631 F.3d 1218, 1228 (11th Cir. 2011) (citations omitted). "[T]he essence of [the] standing question is whether the plaintiff has alleged such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues[.]" *Harris v. Evans*, 20 F.3d 1118, 1121 (11th Cir. 1984) (internal quotation marks omitted).

79. Standing is determined as of the time of filing an action. *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167 (2000). Plaintiffs need show only a "minimal injury" to satisfy the threshold standing inquiry. *Council of Ins. Agents & Brokers v. Molasky-Arman*, 522 F.3d 925, 932 (9th Cir. 2008) (holding that "an identifiable trifle" is sufficient to establish

standing) (quoting *U.S. v. Students Challenging Regulatory Agency Procedures (SCRAP)*, 412 U.S. 669, 689 n.14 (1973)).

80. As this Court has explained, "In a case seeking prospective relief, the focus under the injury element is on prospective harm." (D.E. 541, Order on DCF/DOH Summ. J. Mot. at 5.) A child need not wait until he or she has been unable to access EPSDT services in order to obtain preventative relief. (*See id.* (citing *Fla. N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1161 (11th Cir. 2008)).) For an injury to satisfy this element it must be "immediate," which "requires only that the anticipated injury occur within some fixed period of time in the future, not that it happen in the colloquial sense of soon or precisely within a certain number of days, weeks, or months." (*Id.* at 6 (citing *Browning*, 522 F.3d at 1161).) The injury must also be "likely," which means that it "must pose a 'realistic danger' and cannot be merely hypothetical or conjectural." (*Id.* (citing *Browning*, 522 F.3d at 1161).) An injury can result from the "delay and denial of healthcare, and need not be accompanied by an adverse health consequence." (*Id.* at 7.)

81. A party's continued exposure to the policies or practices from which he seeks prospective relief is sufficient to confer standing upon the party. *See, e.g., 31 Foster Children v. Bush*, 329 F.3d 1255, 1266 (11th Cir. 2003) ("The alleged systemic deficiencies in the Florida foster care system are similar to an injurious policy, and different from the random act at issue in *Lyons*."); *Church v. City of*

*Huntsville*, 30 F.3d 1332, 1338 (11th Cir. 1994) ("Because of the allegedly involuntary nature of their condition [of poverty and illness], the plaintiffs cannot avoid future exposure to the challenged course of conduct in which the City allegedly engages.") (internal quotation marks and citation omitted); *see also Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008) (rate cut affecting "those individuals most directly affected by the administration of [a state welfare] program is sufficient to allow petitioners to seek injunctive relief in federal court") (internal quotation marks and citation omitted).

82. Applying *Lyons*, the Eleventh Circuit Court of Appeals has recognized a distinction between two types of future injuries: "[F]uture injury that depends on either the random or unauthorized acts of a third party is too speculative to satisfy standing requirements," but, "when the threatened acts that will cause injury are authorized or part of a policy, it is significantly more likely that the injury will occur again." *31 Foster Children v. Bush*, 329 F.3d 1255, 1266 (11th Cir. 2003); *see also Church v. City of Huntsville*, 30 F.3d 1332, 1339 (11th Cir. 1994) (holding that plaintiffs had standing where they "alleged that it is the custom, practice, and policy of the City to commit the constitutional deprivations of which they complain"). Quoting the foregoing passage from the *31 Foster Children* decision, I have applied that distinction in holding that plaintiffs had standing to challenge a county government's strip-search policy. *See Haney v. Miami-Dade County*, No.

04-20516, 2004 WL 2203481, at *3 (S.D. Fla. Aug. 24, 2004) (Judge Jordan) ("The plaintiffs allege that there is a policy of conducting strip and body cavity searches on all pre-first appearance, non-felony female detainees. . . . Therefore, there is a substantial likelihood that the plaintiffs and others similarly situated will be injured in the future."). Throughout this litigation, I have recognized this important distinction. *See, e.g.*, D.E. 541, Order re Partial Summ. J. at 7 ("This case is about the alleged systemic problem of delay and denial of health care."); D.E. 671, Order re Class Cert. at 3-5 (rejecting Defendants' argument that Plaintiffs lack standing).

83. A plaintiff need not wait for an injury to occur to satisfy the "injury-in-fact" requirement; an allegation of future injury satisfies this prong so long as the alleged injury is not merely "conjectural" or "hypothetical." *See Los Angeles v. Lyons*, 461 U.S. 95, 101-02 (1983). Moreover, an injury need not be physical in nature; as this Court has recognized, a violation of one's statutorily granted rights constitutes an injury for standing purposes. *See* D.E. 541, Order re Partial Summ. J. at 4. The issue is whether there is a likelihood of future denials of the rights secured by federal law. *See also Fla. State. Conf. of the NAACP v. Browning*, 522 F.3d 1153, 1163 (11th Cir. Fla. 2008) ("probabilistic harm is enough injury in fact to confer . . . standing in the undemanding Article III sense." (internal quotation marks omitted)).

84. As recognized by the Court of Appeals in *Thomas v, Bryant*, 614 F.3d 1288 (11th Cir. 2010), "the irreparable injury requirement [for injunctive relief] may be satisfied by demonstrating a history of past misconduct, which gives rise to an inference that future injury is imminent." *Id.* at 1318 (citing cases). In *Thomas*, the Court of Appeals found sufficient risk of irreparable injury even though such injury depended upon the plaintiff having future psychological disturbances, being returned to Florida State Prison ,and again subjected to spraying with chemical agents. *Id.* at 1319. The likelihood of named Plaintiffs here facing future issues with the Florida Medicaid program is at least as imminent given the evidence of systemic problems and their past history of problems in accessing care.

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85. The standing inquiry does not turn on whether an individual child received a certain service from a particular provider at some time in the past. Instead, because Plaintiffs "seek[] only injunctive relief and not individualized damages or benefits awards, the Court's focus will be on Defendant's actions (or inactions) and not individual plaintiffs. . . . [T]he Court will not be ensuring that every individual class member receives the full [public] benefits to which he or she is entitled; instead, the Court's focus will be on whether Defendant has complied with his obligations to implement" the Florida Medicaid program. *Xiufang Situ v. Leavitt*, 240 F.R.D. 551, 561 (N.D. Cal. 2007); *see also Risinger v. Concannon*, 201 F.R.D. 16, 20-21 (D. Me. 2001) ("The Court will evaluate Plaintiffs' systemic

challenge without engaging in an evaluation of the individualized needs of each class member.").

86. Throughout this litigation, Defendants have misconceived the standing inquiry. They would have this Court take an Alice-in-Wonderland approach by which the Court would have to decide the merits of the Named Plaintiffs' claims in order to determine if the Named Plaintiffs have standing to litigate those claims. Unsurprisingly, Defendants cite no authority to support such an approach. Even a plaintiff who currently was not eligible for Medicaid was found standing to seek prospective relief against the state Medicaid program "because it is highly likely that [the family] will qualify for [M]edicaid in the future." *McCree v. Odom*, No. 4:00-CV-173(H)(4), slip opinion at 19 (E.D.N.C. Nov. 26, 2002).

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87. Defendants rely upon *Lewis v. Casey*, 518 U.S. 343, 350-51 (1996), which sets forth a heightened standing requirement – but that requirement applies only to cases like *Lewis*, where the claim at issue (inadequate legal resources for prisoners) was derivative of an underlying Constitutional right (inmates' access to courts). *See Benjamin v. Fraser*, 264 F.3d 175, 185 (2d Cir. 2001). It is not applicable "where the right at issue is provided directly by . . . federal law," as in the Medicaid litigation; *see also Al-Amin v. Smith*, 511 F.3d 1317, 1334 (11th Cir. 2008).

88. Where the plaintiff is a participant in the challenged governmental program, "there is ordinarily little question that the action or inaction [of the government] has caused the plaintiff injury and that a judgment preventing or requiring the action will redress it." 25 FED. PROC., L. ED. § 59:11. To satisfy the standing inquiry's causation requirement, Plaintiffs need only show that their prospective harms are "fairly traceable" to Defendants' non-compliance with the Medicaid Act. *See Sicar v. Chertoff*, 541 F.3d 1055, 1059 (11th Cir. 2008). To satisfy the redressability requirement, Plaintiffs need only show that their prospective injuries will be remedied by a favorable outcome. *See, e.g.*, Fla. *State Conference of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1159 n.9 (11th Cir. 2008) (alleged injury would be redressed by injunction against state official in legal challenge to state voting statute).

89. Several courts have held that there is a "direct connection between Medicaid recipients' access to medical care and services and low reimbursement rates" sufficient to prove causation and redressability. *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 701 n.5 (5th Cir. 2007) (citing *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050, 1106-07 (N.D. Okla. 2005)); *see also Memisovski ex rel. Memisovski v. Maram*, No. 92C1982, 2004 WL 1878332, at *42 (N.D. Ill. 2004); *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 (E.D. Cal. 2003), *rev'd on other grounds*, 140 F. App'x 677 (9th Cir. 2005); *Clark*

*v. Kizer*, 758 F. Supp. 572, 577 (E.D. Cal. 1990), *aff'd in relevant part, Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992); *Thomas v. Johnston*, 557 F. Supp. 879, 903-04 (W.D. Tex. 1983). With respect to non-monetary aspects of Plaintiffs' claims redressability is inherent in a declaration, and if necessary, an injunction, against such future terminations of continuous eligibility or switching, or requiring the eliminations of barriers, such as in the Florida ACCESS application, to enrollment and receipt of service.

90. Defendants also confuse the standing doctrine with that of mootness. While standing is measured at the time of filing of a complaint, the related doctrine of mootness preserves the Article III requirement of a live case or controversy throughout the litigation. In a case seeking prospective relief, a plaintiff's claims are not moot so long as the challenged policy or practice is still in existence and so long as the plaintiff remains subjected to it. *See McLaughlin v. Hoffman*, 547 F.2d 918, 920-21 (11th Cir. 1977).

91. When plaintiffs are challenging systemic problems, the capable-of-repetition-but-evading-review doctrine is often applicable is the plaintiff's claim might otherwise be moot. *See, e.g., Norman v. Reed*, 502 U.S. 279, 287-88 (1992). Similarly, defendants cannot moot plaintiffs' claims by pointing to evidence showing that they have ceased certain practices that have caused harm to the plaintiffs:

> It is well settled that a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice. If it did, the courts would be compelled to leave the defendant free to return to his old ways. In accordance with this principle, the standard we have announced for determining whether a case has been mooted by the defendant's voluntary conduct is stringent: A case might become moot if subsequent events made it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.

*Sheely v. MRI Radiology Network, P.A.*, 505 F.3d 1173, 1183-84 (11th Cir. 2007) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs, Inc.*, 528 U.S. 167, 189 (2000)).

92. Moreover, in a certified class action, "termination of a class representative's claim does not moot the claims of the unnamed members of the class." *Gerstein v. Pugh*, 420 U.S. 103, 111 n.11 (1975). In *Gerstein*, the court ruled that it was unnecessary to determine whether any of the named plaintiffs had non-moot claims at the time of class certification because, *inter alia*, "the constant existence of a class of persons suffering the deprivation is certain." *Id.*

93. Applying these principles, I find the named individual plaintiffs have standing to maintain this action.

94. I have previously found that S.M. has standing to assert counts I and IV against the Secretary of AHCA, and that J.S. has standing to assert Count II against AHCA. D.E. 671 at 4-5. I adhere to those rulings. I also previously found

that S.M. had standing to assert courts I and IV against the Secretary of DCF. D.E. 541 at 4-9. I adhere to that ruling as well.

95. I previously found that Thomas Gorenflo had standing to assert counts I and II against the Secretary of DOH, also known as the Surgeon General. D.E. 541 at 13-17. Thomas Gorenflo is now deceased and accordingly does not have standing in an action seeking prospective relief only, and is hereby dismissed as a named plaintiff. I find that Nathaniel Gorenflo, who is also enrolled in the CMS program run the Florida's Department of Health, does have standing to bring counts I and II against the Secretary of DOH.

96. Because plaintiffs are seeking prospective relief, the focus under the injury element is on prospective harm. D.E. 541 at 5.

97. The evidence adduced at trial shows that S.M. faces a "realistic danger" of not receiving EPSDT care and effective outreach. *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979). For instance, the evidence, considered in section IV.B. below, amply demonstrates that children on Medicaid are regularly switched, that their care is frequently and significantly delayed by switching, and that the actions of both AHCA and DCF contribute to switching. The evidence, discussed in that same section, also shows that children on Medicaid regularly are terminated in violation of their right to continuous eligibility, their care is frequently and significantly delayed by improper terminations, and that the

actions of both AHCA and DCF contribute to improper terminations of eligibility. Similarly, the evidence, considered below in section IV.4. shows that the defendants have curtailed their outreach program, that Florida has a large population of children eligible for but not enrolled in Title XIX, and that many enrollees do not receive any preventative care. A ruling awarding prospective relief favorable to the plaintiffs would prevent or minimize such injuries in the future, and according the redressabilty prong of the standing inquiry is met as well. D.E. 541 at 9.

98. While it is in no way essential to my ruling, S.M.'s past experiences with Florida Medicaid are illustrative of his standing. He was switched at least twice, and as a result of one switch, his 18-month child health check up was delayed by two months. *Infra* at ¶¶ 121-128. His eligibility was terminated twice in violation of his right to continuous eligibility. *Id.* And his mother did not know he was entitled to free transportation to medical appointments. *Id.*

99. Thus, I find there is a "realistic danger" S.M. may be terminated in violation of his rights of continuous eligibility, switched, deprived of information he needs, and not provided services when he requests them. Accordingly, I find that S.M. may bring claims against the Secretaries of AHCA and DCF on Count I under both a(8) and (a)(10); and County IV under a(43)(A), (B), and (C).

100. In my prior ruling on J.S., I focused on whether she had standing to bring Count II against the Secretary of AHCA. I find again that she does.

101. The evidence adduced at trial shows that J.S. faces a "realistic danger" of not being able to obtain equal access to specialty care, as compared to children with private insurance. *Babbitt*, 442 U.S. at 298. The evidence, summarized below in sectionVI.D., shows that children on Medicaid throughout Florida have difficult accessing specialty care, and often must wait considerable periods or travel significant distances to obtain such care.

102. As to causation and redressabilty, I find both the many specialty providers currently do not participate in Florida Medicaid or sharply curtail their participation, because of Florida's low reimbursement rates and further find that the evidence establishes that a significant increase in Medicaid reimbursement rates would lead to a significant increase in specialists' participation in Medicaid and so, improved access to specialty care.

103. Again, J.S.'s past experiences with the Medicaid system, while not at all pivotal to my ruling, are illuminating. Three times in the last 10 years or so, J.S. has broken her ankle or wrist, gone to the emergency room, and been directed to see an orthopedist for follow-up care. *See infra* at180-188. In all three instances she had difficulty, in varying degrees, locating an orthopedist who would agree to treat her as a Medicaid patient.

104. The issue is not, as Defendants argued, *see* D.E. 934-2 at 20, whether J.S. will again have trouble accessing orthopedic care in the future. Rather, the issue is whether she will have trouble accessing any type of medical or dental care covered by the Medicaid Act. Nor is the issue whether AHCA might have been able to assist her in obtaining care in the past, had she contacted the local AHCA area office. Rather, the issue is whether she has a "realistic danger" of not having equal access in the future to covered care.

105. I find the factual record in this case show she faces a "realistic danger" of not receiving specialty care in the future, that her injury would be caused by AHCA's conduct, that a ruling in plaintiff's favor would prevent or minimize future injuries, and hence that J.S. has standing to bring count II against the Secretary of AHCA.

106. I find Nathaniel Gorenflo has standing to bring Counts I and II against the Secretary of DOH. Nathaniel is enrolled in CMS. He faces a "realistic danger" of not being able to obtain specialty care, as well as a danger of not being able to obtain primary care or dental care through CMS. For example, the evidence, considered below at VI.D., shows that children on Medicaid have trouble accessing specialty care and that those problems extend to children on CMS. The issue is not, as Defendants have claimed, whether Nathaniel Gorenflo will likely suffer a "recurring injury related to ENT care," D.E. 934-2 at 13, but rather whether is

faces a "realistic danger" of not receiving any type of care to which he is entitled under federal law. I find, based on the evidence of widespread deficiencies in the Florida Medicaid system, that he does. As I also previously found, D.E. 541 at 15-16, because CMS regional medical directors sometimes use discretionary funds to pay providers rates in excess of the Medicare rates when they cannot otherwise not obtain care for CMS children on Medicaid, the causality prong of standing as to the Secretary of DOH is also met.

107. More generally I find that all named plaintiffs have standing to bring claims under Counts I, II, and IV against AHCA. With the exception of J.W., nothing in the record suggests that any of the children will soon become ineligible for Medicaid or will age out of the program in the near future. And as to J.W., the record indicates he is likely to be eligible for Medicaid again in April. *See* D.E. 1072 and Ex. A. Because J.W. is likely to be enrolled in Medicaid again shortly, the fact that he is not currently enrolled does not deprive him of standing if he otherwise meets the requirements for standing. *See McCree v. Odom*, No. 4:00-CV-173(H)(4), at 19; (finding standing for individual not currently eligible for Medicaid because it is "highly likely" she will be eligible in the future).

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108. The factual record in this case contains substantial evidence of widespread deficiencies in Florida's Medicaid program including but not limited to widespread deficiencies concerning children's access to EPSDT care, dental care,

and specialty care. The record also establishes that improper termination of eligibility and switching occur on a regular basis and lead at a minimum to a delay in children obtaining care; that since the elimination of the statewide outreach program in 2003, Defendants have not had a coordinated and effective statewide outreach campaign regarding EPSDT services; and that the on-line application is a substantial obstacle to children obtaining care. Based on that factual record, I find that all the named plaintiffs face a "realistic danger" of not receiving the medical or dental care and information about ESPDT service which they are entitled to receive under the Medicaid Act.

109. For children in the Florida Medicaid Program, as explained above, those likely injuries would be caused by the actions of AHCA and DCF and for children in CMS, by DOH as well, and so the causality prong of standing is readily met.

2. Organizational Plaintiffs Have Derivative Standing To Assert Third Party Claims of their Members.

110. Organizations have associational standing to assert the claims of their members. If their members have standing to assert claims of third parties, then the organizations have associational standing to assert their members' claims on behalf of third parties. *Pa. Psych. Soc. v. Green Spring Health Servs.*, 280 F.3d 278, 293 (3d Cir. 2002) ("So long as the association's members have or will suffer sufficient injury to merit standing and their members possess standing to represent the

interests of third-parties, then associations can advance the third-party claims of their members[.]").[6]

111. An organization has associational standing to bring suit on behalf of its members when (1) its members would have standing to sue in their own right; (2) the interest the organization seeks to protect are germane to the organization's interests; and (3) the participation of individual members in the lawsuit is not required for either the claim asserted or the relief sought. *See Fla. State Conf. of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1160 (11th Cir. 2008); *United Food and Commercial Workers Union Local 751 v. Brown Group, Inc.*, 517 U.S. 544, 553 (1996).

112. Here, the members of FPS and FAPD have standing to sue in their own right.

113. FPS has about 2,200 dues paying members. St. Petery on 12/7/2009 Final Tr. at 84:4-6. Numerous FPS' members treat children on Medicaid and are injured by Defendants' failure to comply with the requirements of the Medicaid Act. FPS members are injured because they: (1) periodically treat children who have been switched away from their practice, even though there is no guarantee they will be paid for providing such care. Middlemas on 1/31/2012 Rough Tr. at

[6] I previously did not decide the issues of organizational standing because there was at least one named plaintiff with standing. D.E. 40 at 2-3. At this juncture, with the case being tried, considerations of judicial efficiency support making findings on organizational standing so that there is a complete record on appeal.

22-23; Silva on 5/20/2010 Final Tr. at 2798:12-15; St. Petery on 11/11/2008 Depo Desig. at 190:10-19; (2) have their staff spend time trying to help patients who have been switched navigate the Medicaid system and get returned to their practice. Cosgrove on 5/19/2010 Final Tr. at 2583:13 – 2584:3; Silva on 5/20/2010 Final Tr. at 2801:1-9; 2798:16 – 2799:3; Schechtman on 5/20/2010 Final Tr. at 2847:25 – 2848:4; Isaac on 8/11/2010 Final Tr. at 3896:25 – 3897:7; (3) treat children who have had their eligibility terminated in violation of their rights to continuous eligibility. Silva on 5/20/2010 Final Tr. at 2804:12 – 2805:9; St. Petery on 11/11/2008 Depo. Desig. at 106:12 – 107:12; Isaac on 8/10/2010 Final Tr. at 3916:9-21; Ritrosky on 11/10/2008 Depo. Desig. at 97:9 – 98:2; 98:15 – 99:25; 101:7-16; (4) spend significantly more time trying to refer children on Medicaid to specialists than they do children on commercial insurance. Cosgrove on 5/19/2010 Final Tr. at 2562:19 – 2563:8; 2572:21 – 2573:6; Schechtman on 5/20/2010 Final Tr. at 2835:22 – 2836:18; 2839:3-11; 2850:11 – 2851:15; Silva on 5/20/2010 Final Tr. at 2779:3 – 2780:8; Seay on 11/14/2008 Depo. Desig. at 15:9 – 16:24, 20:2-9, 57:7-21; 103:7-20; St. Petery Depo. Desig. on 11/11/2008 at 191:1-4, 195:7 – 196:11, 197:15-25; 198:21 – 199:10; Knappenberger on 11/20/2008 Depo. Desig. at 32:9 – 33:5; 99:12 – 100-8; Curran on 10/7/2008 Depo. Desig. at 30:4 – 31:8, 32:16 – 34:14, 37:13 – 38:11, 55:8 – 56:4; Ritrosky on 11/10/2008 Depo. Desig. at 17:17 – 18:14; 27:18-22; 39:9 – 40:3l; 45:2 – 47:7; 50:8 – 51:1;

and (5) and treat children on Medicaid at inadequate reimbursement rates that are significantly less than what they are paid by private insurance companies and that strain their economic viability. St. Petery on 12/10/2009 Final Tr. at 556:11 – 558:4; Silva on 5/20/2010 Final Tr. at 2798:16 – 2799:3; 2825:6-20; Cosgrove on 5/19/2010 Final Tr. at 2560:25 – 2561:3; 2607:6-8; 2617:4-11; 2635:2-5; Schechtman on 5/20/2010 Final Tr. at 2895:5 – 2896:5; *see also infra* at IV.A and VI.B. (discussing switching, improper terminations, and reimbursement rates).

114. FAPD has about 135 active members and 30 plus members who are faculty, students, lifetime, or retired. Primosch on 8/10/2010 Final Tr. at 3736:11-14. Similarly, FAPD has members that provide services to children enrolled in Medicaid. Deposition of Peter Claussen, FAPD 30(b)(6) designee 3/14/2008 at 40:2-5. Those members are injured by the low reimbursement rates that Florida Medicaid pays dentists for treating children on Medicaid. Claussen on 3/14/2008 Depo. Desig. at 7:9-10; 14:2-3; 39:22-25; 14:17 – 15:4, 110:10-16; 118:13-24, 119:13 – 122:18; 140:11 – 142:4; McIlwaine on 11/13/2008 Depo. Desig. at 4:13-17; 5:4-17; 10:13-15;18:1-12; 21:4-17; 22: 2-4; *see also infra* at VI.E. (discussing dental reimbursement rates).

115. These injuries to FPS and FAPD members are current and ongoing and absent relief will continue to manifest future injury and suffice to confer standing on the doctors and dentists. *See Singleton v. Wulff*, 428 U.S. 106, 112-

113 (1976); *Am. Iron & Steel Inst. v. O.S.H.A.*, 182 F.3d 1261, 1274 n.10 (11th Cir. 1999); *Planned Parenthood of the Atlanta Area, Inc. v. Miller*, 934 F.2d 1462, 1465 n.2 (11th Cir. 1991). In this action, the interests that FPS and FAPD seek to protect are germane to the organizations' interests. The FPS is an advocacy organization consisting of physicians, and its mission is to enhance the health of the children of Florida, and to support the pediatricians who care for those children. St. Petery on 12/7/2009 Final Tr. at 83:20-22. The FAPD is an advocacy organization consisting of dentists, and its mission is to practice the art and science of pediatric dentistry and to promote optimal health care for infants, children, and persons with special health care needs. Primosch on 8/10/2010 Final Tr. at 3738:23 – 3739:1; PX 307. The interests at stake in this litigation, *i.e.*, Defendants' failure to adequately fund or provide legally required healthcare services to children eligible for Medicaid, are germane to the Organizational Plaintiffs' interests and their respective missions. St. Petery on 12/10/2009 Final Tr. at 539:21 – 541:7; Primosch on 8/10/2010 Final Tr. at 3740:23 – 3741:15.

116. Where an organization seeks only prospective relief and its members have standing, participation of the members in the lawsuit is not required. *Browning*, 522 F.3d at 1160-61; *see also Brown Group*, 517 U.S. at 522, 546, 553-54. Here, the two organizations seek only prospective relief.

117. Third party standing may be asserted when (1) the litigant has also suffered an injury in fact giving them a concrete interest in the issue in dispute, (2) the litigant has a close relationship to the third party, and (3) there exist some hindrance to the third party's ability to protect their own rights and interests. *Powers v. Ohio*, 499 U.S. 400, 410-411 (1991) (holding that a defendant had standing to bring action on behalf of jurors allegedly dismissed due to their race); *see also Singleton v. Wulff*, 428 U.S. 106, 114-17 (1976) (holding physicians had third-party standing to bring action on behalf of patients against interference in patients' rights to obtain Medicaid benefits for abortion services).

118. As already noted, the members of FPS and FAPD have suffered an injury in fact. They also have a close relation to the children on whose behalf they sue. The doctor-patient relationship is sufficiently close so as to allow doctors to assert patients' rights. *See, e.g.*, *Singleton*, 428 U.S. at 117 ("the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against" a Medicaid patient); *Pa. Psychiatric Soc'y v. Green Spring Health Servs.*, 280 F.3d 278, 289 (3d Cir. 2002); *Nasir v. Morgan*, 350 F.3d 366, 376 (3d Cir. 2003) (third-party standing and doctor-patient relationship); *Aid for Women v. Foulston*, 441 F.3d 1101, 1109-14 (10th Cir. 2006) (physicians could assert rights of minor patients); *see also Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 1810 (2005) ( "[Teachers] are often in the best position to vindicate the

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rights of their [minor] students because they are better able to identify discrimination and bring it to the attention of administrators.")

119. I also find that children on Medicaid face a considerable hindrance to bringing suit on their own. Many of these children and their guardians are not even aware of their legal rights, including their right to EPSDT services and their right to seek legal recourse if they don't receive them. Many are also afraid to bring suit against state agencies because they are fearful of retaliation, including loss of benefits for their children. St. Petery on 2/9/2010 Final Tr. at 1493:18 – 1494:17. Moreover, many welfare recipients are living day to day, struggling to make ends meet, and cannot take on the added burden of serving as a plaintiff in a lawsuit, including sitting for a deposition and traveling to court to testify.

120. Accordingly, I find, consistent with numerous similar court decisions, that FPS and FAPD have associational standing to raise claims of their members, and that doctors and dentists have third-party standing to assert the claims of Florida children who are eligible for Medicaid. *See Pa. Psychiatric Soc'y v. Green Spring Health Servs.*, 280 F.3d 278, 293 (3d Cir. 2002) (reversing district court's decision that organization consisting of psychiatrists could not assert the psychiatrists' third-party claims on behalf of patients); *Ohio Ass'n of Indep. Sch. v. Goff*, 92 F.3d 419, 421-22 (6th Cir. 1996) (organization consisting of member schools could assert schools' third-party claims on behalf of parents of

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schoolchildren); *Public Citizen v. FTC*, 869 F.2d 1541, 1551 (D.C. Cir. 1989) (organization consisting of, inter alia, parents could assert parents' third-party claims on behalf of children); *Mgmt. Ass'n for Private Photogrammetric Surveyors v. United States*, 492 F. Supp. 2d 540, 548 (E.D. Va. 2007) ("[S]everal circuits have permitted such 'derivative standing,' apparently concluding…that the requirements of third party and associational standing, faithfully applied, are sufficiently rigorous to ensure the concrete adversity of interests necessary for an Article III 'case.'").

**B. Proposed Findings of Fact As To All Named Plaintiffs**

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1. S.M.

121. S.M. became eligible for Medicaid shortly after he was born in August 2006. PX 583-2 at TPF02294-98, TPF02305-07. S.B., S.M.'s mother, chose Dr. Simmons, who practices with the Tallahassee Pediatric Foundation ("TPF") and who was her pediatrician for about 16 years, to be S.M.'s doctor. S.B. on 2/11/2010 Final Tr. at 1782:9-22. S.M. was on MediPass and assigned to TPF from October 1, 2006 through June 30, 2007. PX 582 at 5. S.M. lost eligibility for Medicaid on June 30, 2007, in violation of his right to twelve months of continuous eligibility, as confirmed by a FMMIS print screen from AHCA's computer system. *Id.*; PX 583-2 at TPF002308. S.M.'s eligibility was restored

retroactively, making it appear as if he had never lost eligibility. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1491:3-7.

122. S.M. was again on Medicaid and again assigned to TPF from August 1, 2007 through September 30, 2007. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1486:21 – 1487:5, 1491:3-18. S.M.'s Medicaid eligibility was terminated again on September 30, 2007, two months after his Medicaid eligibility started on August 1, 2007, in violation of his right to 12 months of continuous eligibility. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1486:21 – 1487:5, 1491:3-18; 1494:2-17; McCormick on 8/12/2010 Final Tr. at 4132:24 – 4133:8; S.B. on 2/11/2010 Final Tr. at 1787:9 – 1788:1; PX 583-2 at TPF02295,TPF002310. Once again, his eligibility was retroactively restored. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1494:14 – 1495:11.

123. From September 30, 2007 until November 1, 2007, S.M. was not assigned to TPF. PX 582 at 5. S.B.'s Medicaid eligibility resumed on November 1, 2007, and he was again assigned to TPF. *Id.*

124. S.M. was scheduled to see Dr. Simmons in February 2008 when he was 18 months old for a well child check-up. S.B. on 2/11/2010 Final Tr. at 1788:11 – 1789:14. Dr. Simmons' office told S.B. not to bring her son in because S.M had been assigned or "switched" to a Medicaid HMO. S.B. on 2/11/2010 Final Tr. at 1788:11-1789:14; St. Petery on 12/10/2009 Final Tr. at 1389:17 –

1391: 25; *see also* PX 658 at Simmons000002. A FMMIS print screen shows S.M. was assigned to a Medicaid HMO from February 1, 2008 through March 31, 2008. McCormick on 8/12/2010 Final Tr. at 4136:25 – 4138: 21; PX 583-2 at TPF02319.

125. S.B. did not receive a letter during that time period from Florida Medicaid or any other state agency that she did not open; nor did she receive a letter that she did not respond to. S.B. on 2/11/2010 Final Tr. at 1789:15 – 1790:3. Her grandmother let her know if she received any mail at her former address. *Id.* at 1784:6-21, 1821:12-22.[7]

126. S.M. was not switched back to MediPass until March 31, 2008. S.B. on 2/11/2010 Final Tr. at 1790:23-25, 1804:24 – 1805:7, 1817:18 – 1818:7. During that interval, S.B. was not able to take her son to see Dr. Simmons and was concerned about her son's health. S.B. on 2/11/2010 Final Tr. at 1791:9 – 1792:7.

127. S.B. would travel an hour by bus to Dr. Simmons' office. *Id.* at 1784:24-1785:12. Dr. Simmons referred S.M. to a laboratory for a lead blood screening test. S.B. was not able to get her son's blood tested for exposure to lead

[7] An employee of Medicaid Options, which handled plan assignments for Medicaid in non-Reform counties, said S.B. received a letter asking her to choose a Medicaid plan and was auto-assigned to a Medicaid HMO when she allegedly failed to make a choice. PX 583-2 at TPF02312-13. There is no evidence, however, that such a letter was actually sent, let alone received, and if S.M. had not been improperly terminated short of 12 months of continuous eligibility, his mother would not have had to apply for reinstatement, S.B. on 2/11/2010 Final Tr. at 1821:23 – 1822:7, let alone choose a Medicaid plan for him again. And if she had been automatically re-assigned to her former PCP, she would not have been switched.

because of transportation problems. S.B. on 2/11/2010 Final Tr. at 1793:17 – 1794:11, 1798:19 – 1799:17; S.B. on 12/06/2011 Rough Tr. at 111, 143, 146. She also missed appointments with Dr. Simmons because of transportation problems. *Id.* at 145-46. She did not know she was entitled through Medicaid to free transportation. *Id.* at 144-46.

128. In addition, Dr. Simmons office was not able, during either of two separate visits to recommend a dentist that would treat S.M. when he was under five years of age. *Id.* at 145-49. S.B. called several dentists who purportedly accepted young children on Medicaid but was not able to find a dentist for S.M. *Id.* at 147, 149, 151-52.

129. S.B. voluntarily sent S.M. to live with his father in August of 2011 so she could devote more time and energy looking for a job and an apartment where she could live with her three minor children. S.B. on 12/06/2011 Rough Tr. at 90, 135. Later, S.M. and S.B.'s two other minor children were removed from her legal custody as the result of a court order and proceedings initiated by DCF. *Id.* at 89-90, 135.[8]

[8] While S.B. did not inform her counsel on one occasion when she moved, *id.* at 105-106, that does not undermine her adequacy as a class representative. S.B. sat for a deposition and testified twice in court, once traveling to Miami to do so, and once testifying by video hook-up from the federal courthouse in Tallahassee. Nor does the fact that she was warned about Dr. Simmons' office about missing appointments and dropped as a patient by Dr. Simmons, *id.* at 122-23, mean she is not an adequate class representative. Not only did she subsequently seek a new

130. While S.M. is living with his father about 25 minutes outside Tallahassee, S.B. has continued to see her son every week. *Id.* at 136. Those weekly visits are not supervised by DCF. *Id.* at 154.

131. Even though S.B. currently does not have legal custody of S.M., S.B. is still a proper and appropriate next friend. An individual may serve as a "next friend" of a minor as long as the "next friend's" interests are not adverse to the minor and the "next friend" is sufficiently dedicated to the minor's interest. *Gonzalez ex rel. Gonzalez v. Reno*, 86 F. Supp. 2d 1167, 1185 (S.D. Fla. 2000) *aff'd sub nom. Gonzalez v. Reno*, 212 F.3d 1338 (11th Cir. 2000). A parent may sue as a "next friend" even if he or she has lost custody to the state and his or her rights have been terminated provided the parent is advancing the child's interests, and not his own. *Miracle by Miracle v. Spooner*, 978 F. Supp. 1161, 1163-64, 1168 (N.D. Ga. 1997). The key issue is whether the next friend's interests are aligned with those of the minor child. *See Dolin on Behalf of N.D. v. W.*, 22 F. Supp. 2d 1343, 1353 (M.D. Fla. 1998), *aff'd sub nom. Dolin v. W.*, 207 F.3d 661 (11th Cir. 2000) ("parent may not sue on behalf of a child where the parent's interests are not aligned with those of the child").

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pediatrician for her children, *id.* at 126, her adequacy is judged by her ability to represent the interests of the class in this action. *See London v. Wal-Mart Stores, Inc.*, 340 F.3d 1246, 1253 (11th Cir. 2003) ("considering "the forthrightness and vigor with which the representative party can be expected to assert and defend the interests of the members of the class").

132. S.B. has no interests antagonistic to S.M.'s interests, and, in fact, no motive to serve as his next friend other than to advance his interests and the interests of other children on Medicaid. S.M.'s father, T.M., is also willing to serve as S.M's next friend. *See* PX 788 (Declaration of T.M., filed on 01/31/2012, D.E. 1121). His son has been living with him since August, and T.M. has no interest in this litigation other than to look out for the interests of his son. *Id.* at ¶¶ 1-8. If for any reason S.B. is not able to continue as next friend for S.M., I find that T.M. is an appropriate, substitute next friend for S.M.

2. L.C.

133. L.C. was hospitalized for seizures when he was about 15 months old and had seizures later as well. PX 655 at Tridas Center000008; PX 651 at Peace River000016. L.C. moved into S.C.'s home as a foster child when he was two years, eight months old, and S.C. later adopted him. S.C. on 1/11/2010 Final Tr. at 1319:21 – 1320:1; 1322:1-3. As a child adopted through foster care, L.C. is eligible for Medicaid regardless of income. *Id.* at 1322:4-9.

134. In August of 2004, when L.C. was about 7 years old, S.C. took him to be evaluated by a developmental pediatrician because of his developmental delays and his anxiety, which manifested itself in panic attacks and other extreme behavior. *Id.* at 1327:13 – 1329:15; PX 655 at Tridas Center000001, 000003,

000007. The doctor recommended intense psychological services. S.C. on 1/11/2010 Final Tr. at 1331:21 – 1332:1; PX 655 at Tridas Center000011.

135. The appropriate modality of therapy for a young child such as L.C., especially a child with delays in comprehension of oral language, is play therapy, which is what the doctor recommended. Dr. Elias Sarkis on 1/19/2012 Rough Tr. at 44-47.

136. Based on her doctor's recommendation, S.C. took L.C. to see Elizabeth Craig, who had an extensive history working with children with attachment disorder. S.C. on 1/11/2010 Final Tr. at 1332:19 – 1333:10. Ms. Craig, who does not take Medicaid, recommended weekly play therapy. PX 652 at Craig000105; S.C. on 1/11/2010 Final Tr. at 1336:20-21. In September of 2004, S.C. took her son to Peace River, the exclusive Medicaid mental health provider in her area. *Id.* at 1336:22 – 1338:12; PX 651 at Peace River000009. Peace River, however, was not able provide play therapy, let alone from a registered play therapist, and was not able to provide weekly therapy. *Id.* at 1338:13-17; 1338:20 – 1341:25; PX 740 at DEFENDANTS011707.[9] And the therapist Peace River wanted L.C. to see was leaving Peace River because she had a case load of 110.

[9] The therapist plan offered by Peace River called for therapy twice a month as needed, PX 651 at Peace River000008, meaning he would be seen at most twice a month. S.C. was told by the therapist that her son would be seen only once a month. S.C. on 1/11/2010 Final Tr. at 1374:14-21.

S.C. on 1/11/2010 Final Tr. at 1342:19 – 1343:25.[10] Because her son could not get the care he needed at Peace River, L.C. paid for her son to see Ms. Craig weekly for play therapy. *Id.* at 1345:18 – 1346:6. Although these sums were ultimately reimbursed, her son was denied the care on Medicaid to which he was entitled.

137. L.C. also suffered harm from lack of proper medications. In 2005, a developmental pediatrician recommended starting L.C. on certain medications. In 2007, Dr. Hubbard refused to continue to see L.C. *Id.* at 1355:2 – 1357:24. S.C. returned to Peace River because she needed a psychiatrist to prescribe and monitor L.C.'s medications. *Id.* at 1357:12-15; PX 651 at Peace River000053. One of the medications L.C. was on was Depakote. S.C. on 1/11/2010 Final Tr. at 1357:16-18; PX 651 at Peace River000054 ("Current Mental Health Medications" include "Depakote 500 m.g. S.C. told the people at Peace River that she needed a psychiatrist to write a refill of L.C.'s prescriptions, that she had only a week left of Depakote, and that abrupt removal of Depakote can cause seizures. S.C. on 1/11/2010 Final Tr. at 1357:19-24; PX 651 at Peace River000053. Despite explaining the urgency of the situation, S.C. was not able to obtain a prompt appointment for her son to see a psychiatrist but was rather going to have to wait two to three months. S.C. on 1/11/2010 Final Tr. at 1357:19 – 1358:16; 1385:15 – 1386:3. Desperate for someone to help her son, S.C. paid Dr. Hubbard to monitor

[10] The therapist said she was quitting because she "could not deliver adequate service to her clients because of her large caseload." PX 650 at LCOL0000001.

her son's psychotropic medications for about two years. *Id.* at 1358:17-25; 1359:7-9, and was accordingly injured by having to pay out of pocket for treatment that should have been covered by Medicaid. Dr. Hubbard had previously accepted payment though Medicaid but would not continue to see L.C. through Medicaid. *Id.* at 1359:1-3.

138. With the help of DCF, S.C. was later able to get her son in to see a psychiatrist at The Sweet Center in Winter Haven, who continued to monitor his medications. *Id.* at 1361:9 – 1362:23.

139. Dr. Elias Sarkis is board certified in both general psychiatry and also in child and adolescent psychiatry, and is a past president of the Florida Psychiatric Society, among other positions. Sarkis on 1/19/2012 Rough Tr. at 6-9, 13; PX 647 at Ex. B.

140. Dr. Sarkins opined that it was important for L.C. to be seen by a licensed therapist, because his was a complicated case and he needed a therapist with sufficient experience. Sarkis on 1/19/2012 Rough Tr. at 47-48. A caseload of 110 patients is unheard of in private practice and is so demanding that a therapist could not provide adequate care to children with such a heavy caseload. *Id.* at 48-49, 52-53, 79-80.

141. Depakote is an anti-convulsant and is also prescribed to control aggressions and mood liability (intense mood shifts or changes). Sarkis on

1/19/2012 Rough Tr. at 44-47. Terminating Depakote abruptly in children can cause significant health risks, including seizures, and is inconsistent with the standard of care. *Id.* at 34-35, 37-38, 41, 112. Because L.C. had been on Depakote for more than a year halting the medication suddenly would be especially risky for him. *Id.* at 35-36. Making S.C. wait two to three months for an appointment for L.C. to see a therapist, when L.C. was about to run out of Depakote, was not medically reasonable and was below the standard of care. *Id.* at 36-37, 43, 53.[11]

3. K.K.

142. A.D. is the mother of K.K., one of the named plaintiffs in this action. A.D. on 8/12/2010 Final Tr. at 4046:22 – 4047:13. K.K was born in December of 2003; at the time, A.D. was living in Lehigh Acres, near Ft. Myers. *Id.* at 4049:8-9. K.K. went on Medicaid at birth. *Id.* at 4050:5-6. A.D. herself has been on Medicaid on and off since then. *Id.* at 4050:1-2.

143. A.D. periodically has to renew her son's Medicaid. She can call and get a packet by mail to fill out or fill out the renewal form on line but in either case she has to figure out how to complete the form on her own. Sometimes she had to call five times per day. *Id.* at 4069:5-11; 4072:1-14. K.K. was switched from

[11] A number of the named plaintiffs were reluctant to serve as plaintiffs in this case because they were fearful of retaliation by the Defendants. K.S. on 5/17/2010 Final Tr. at 1978:18-24; S.C. on 1/11/2010 Final Tr. at 1365:1-7; 1365:14 – 1366:1; E.W. on June 16, 2010 Depo. Desig. 87:12-23.

MediPass to a Medicaid HMO called Prestige, without her knowledge or consent. *Id.* at 4055:24 – 4056:14.

144. As a young child, K.K. suffered from chronic and recurring ear infections. PX 612 at K Kel 00008. On March 9, 2005, A.D. took K.K. to the emergency room at Cape Coral hospital because he was bleeding from his ear. A.D. on 8/12/2010 at 4056:18-22; 4057:13-25; PX 604 at Cape Coral000008. K.K. was discharged shortly after midnight and directed to see an ENT specialist in the morning. *Id.* at 4058:18-25.

145. The next morning, A.D. called and made an appointment with the office of Dr. Liu, the ENT who had already seen K.K. several times and performed ear balance surgery and put tubes in both K.K.'s ears. *Id.* at 4059:1-13. She soon received a call back, informing her that because K.K. was on, Staywell, the doctor could not see him, even though he had been seen at that office before. *Id.* at 4059:14-21; 4087:8-15.

146. A Staywell representative told A.D. she had to go to Sarasota to see an ENT affiliated with Staywell. *Id.* at 4059:22 – 4060:25; 4061:1-6; 4081:3-7. A.D. did not own a car at the time and had a sick baby to take care of and was not able to go to Sarasota. *Id.* at 4061:1-10. "Sarasota is probably an hour and 45 minutes to two hours depending on where you're going in Sarasota. With no vehicle, that's pretty far." *Id.* at 4061:17-20.

147. Dr. Donaldson, Dr. Liu's partner, ended up seeing K.K. later that day. PX 612 at K KEL 00006. K.K. had puss running out of his left ear, a tube displaced in his right ear, and an effusion behind the middle ear. *Id.* at K KEL 00006.[12] Dr. Donaldson saw K.K. even though he did not accept Staywell. Donaldson Depo. Desig. at 78:18 – 80:18; 206:21-25. Because Dr. Donaldson was not a Staywell provider, he risked not getting paid for seeing K.K. Becker on 2/1/2012 Rough Tr. at 30, 59-61.

148. Dr. Marie Becker is a board certified otolaryngologist who has been in private practice since 1995, treating children and adults covered by both private insurance and Medicaid. Becker on 2/1/2012 Rough Tr. at 9-10. I find her credible and knowledgeable and certify her as an expert in otolaryngology.

149. Ear nose and throat diseases such as otitis media, sinusitis, and tonsillitis are frequently encountered illnesses with the pediatric population, and Staywell should have had an ENT on its panel in a metropolitan area such as Ft. Myers. *Id.* at 27. Children on private insurance would not be subjected to the

[12] The emergency room physician called Dr. Liu while K.K. was in the ER at Cape Coral Hospital. PX 604 at Cape Coral 000010. Dr. Liu indicated that his partner, Dr. Donaldson, would see K.K. the next day because Dr. Liu himself was going to be operating. *Id.*; A.D. on 8/12/2010 Final Tr. at 4089:14-24. That does not indicate that Drs. Liu and Donaldson accepted Staywell. K.K. was previously on MediPass, which they accept, and Dr. Liu cannot be expected to know when called after midnight that one of his patients had changed to a Medicaid HMO, which he does not accept, less than ten days ago. Testimony of A.D. on 8/12/2010 Final Tr. at 4073:19 – 4074:4.

hardship of traveling to a different metropolitan area to obtain routine ENT care.[13] *Id.* at 28. The mother of a child with private insurance would not have had to go through the steps A.D. did in order to get K.K. seen by the partner of his former doctor without any assurance the doctor would be paid. *Id.* at 30-31.

150. A.D. did not know that K.K. was entitled to dental coverage through Medicaid until after she became a plaintiff. A.D. on 8/12/2010 Final Tr. at 4063:13-21. She did not realize, even after receiving a letter dated December12, 2007 from AHCA regarding well child check-ups, that Medicaid covered dental care for A.D. *Id.* at 4064:11-25; 4106:17 – 4108:2; 4066:13 – 4067:1; PX 612 at K KEL00097.

151. K.K. was diagnosed with attention deficit hyperactivity disorder or ADHD. A.D. on 1/25/2012 Rough Tr. at 54; DX 55C at Associates in Pediatrics000366-67. In November 2009, he was prescribed Adderall. DX 55C at Associates in Pediatrics000366-67. A.D. and K.K.'s pediatrician went through a process of trial and error lasting several months to find out what medication and at what dosage was most beneficial for K.K. A.D. on 1/25/2012 at 55-56; DX 55C at Associates in Pediatrics000278, 295-96, 300, 322, 324. Eventually they settled on

[13] The fact that Staywell had ENT providers near Ft. Myers on its panel as of May of 2009, *see* DX 65A, does not mean that those providers would have accepted K.K. as a patient in May of 2009, and it certainly does not indicate that they were affiliated with Staywell and were willing or able to treat K.K. four years earlier in March of 2005.

Vyvance at about 50 m.g. a day. A.D. on 1/25/2012 Rough Tr. at 56. At that dosage, K.K., who failed kindergarten the year before, became a straight A student. *Id.* at 56-57.

152. K.K. was not on Medicaid for a few months in late 2010 through early 2011 because A.D. at that time was making more money. *Id.* at 70. Then she lost her job in January, and in February K.K. was back on Medicaid. *Id.* at 70. A.D. was asked to pick a plan for K.K. and chose MediPass. *Id.* at 71-72. K.K. however, was assigned to Staywell, though A.D. did not request Staywell. *Id.* at 58. Nor did she know her child was being assigned or "switched" to Staywell. *Id.* at 58.[14]

153. The result of the switch was harmful to K.K.. Staywell denied the prescription for Vyvance because K.K. first needed to fail on Dextroamphetamine, the key ingredient in Adderall. DX 55C at Associates in Pediatrics000076.

154. While appealing Staywell's denial, *id.*; A.D. on 1/25/2012 Rough Tr. at 57-59, the pediatrician put K.K. back on Adderall, as a "substitute," because that is what the insurance company would pay for. DX 55C at Associates in Pediatrics000076-77; A.D. on 1/25/2012 Rough Tr. at 59-60, 63. When K.K. went back on Adderall, his teacher complained about his conduct; his mother also saw a

[14] K.K. was also switched on another occasion to a Medicaid HMO K.K's pediatrician's office did not accept. A.D. on 1/25/2012 Rough Tr. at 73.

significant deterioration in his conduct. *Id.* at 64-65; DX 55C at Associates in Pediatrics000076-77.

155. A.D. was able to get K.K. back on MediPass, and on Vyvance about mid-May. A.D. on 1/25/2012 Rough Tr. at 75. The doctor had to increase the dosage of Vyvance to get it to work as it had before. *Id.* at 65.

4. Nathaniel Gorenflo

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156. Rita Gorenflo is the mother of Nathaniel Gorenflo, one of the named plaintiffs in this action. Gorenflo on 5/18/2010 Final Tr. at 2290:23 to 2291:2.[15] The Gorenflos live in Palm Beach County. *Id.* at 2298:3-4.

157. Ms. Gorenflo is a registered nurse who spent 18 years working in the emergency department at different hospitals in Ohio and Florida. *Id.* at 2289:19 – 2290:7; 2290:11-13. She has adopted seven children with special health care needs who were in foster care. *Id.* at 2291:3-6, 2291:15-16; 2292:1-8. All the children are enrolled in CMS and all are eligible for Medicaid regardless of the family's income because they were adopted through foster care. *Id.* at 2291:17-21; 2291:22-25.

158. Nathaniel's mother was on cocaine at the time of Nathaniel's birth. *Id.* at 2293:16-21. He later developed AIDS. *Id.* at 2293:20-22; 2294:11-12. He

[15] Ms. Gorenflo has agreed to allow her name and her children's name to be used in these proceedings. *Id.* at 2288:21-23.

is developmentally delayed and has multiple psychiatric issues, *id.* at 2294:6-10, sees a number of different medical providers and specialists. *Id.* at 2294:20-22.

159. In 2005, Ms. Gorenflo was unable to obtain timely ENT care for Nathaniel. The incident began on July 13, 2005, when Ms. Gorenflo called her nurse coordinator at CMS and said Nathaniel needed to see an ENT physician right away. *Id.* at 2295:23 – 2296:23; PX 617 at NG_CMS000756. Ms. Gorenflo called CMS because she did not know of any ENT in Palm Beach County that accepted Medicaid other than through C*MS.* *Id.* at 2297:24 – 2298:4.

160. When Ms. Gorenflo called CMS to request an ENT appointment for Nathaniel, her son was in pain. *Id.* at 2299:2-23. He could not tell her where the pain was but he would "scream and bang his head" and put the whole house in "total chaos." *Id.* at 2299:24 – 2300:6. Ms. Gorenflo told CMS when she called that her son was in pain because she was trying to explain why he needed to get in right away. *Id.* at 2300:7-13.

161. Ms. Gorenflo wanted her son seen quickly because he has AIDS and so has a compromised immune system. *Id.* at 2311:24 – 2312:5. She also wanted him seen quickly because she knew he had a history of ear problems and suffers from chronic sinusitis. *Id.* at 2294:17-19; 2311:14-23.

162. When Ms. Gorenflo called CMS on July 13, the next available appointment in the ENT clinic was in six months. *Id.* at 2300:14-18.[16] Ms. Gorenflo said a six-month wait was not acceptable because Nathaniel was in pain and needed an ENT evaluation to get to the bottom of his ear pain. *Id.* at 2302:10-20.[17] After numerous phone calls stretching out over several days, Nathaniel was finally seen in an ENT physician's office on July 18 – five days after his mother said he need an appointment right away. *Id.* at 2303:13 – 2304:8; 2305:11 – 2306:4; 2310:4-8; 2310:15 – 2311:13; PX 617 at NG_CMS00756.

163. Paula Dorhout is the nursing director at the Children Medical Service's office that serves Palm Beach County. Dorhout on 4/4/2011 Rough Tr. at 3. She agrees that Ms. Gorenflo is a very dutiful caregiver and that if she said her son was in pain, Ms. Dorhout would accept Ms. Gorenflo's judgment. *Id.* at

[16] The July 14, 2005 entry in the CMS nursing notes, which indicates that Ms. Gorenflo called on July 13 and asked for an ENT appointment for Nathaniel ASAP, does not say Ms. Gorenflo was offered an appointment in six months. However, the notes are incomplete and in fact there is a 16 or 17 month gap at one point between entries even though Ms. Gorenflo never went that long without taking Nathaniel to a CMS clinic. Gorenflo on 5/18/2010 Final Tr. at 2300:23–2302:7; PX 617 at NG_CMS000756.

[17] Ms. Gorenflo also called CMS in February of 2008 to see how long the wait would be for another of her children to get into a CMS ENT clinic; the wait was four months." Gorenflo ON 5/18/2010 Final Tr. at 2315:3 – 2316:5. Ms. Dorhout, the CMS nursing supervisor in Palm Beach County, testified that in April of 2011 the waiting list for the CMS ENT clinic was probably two to three months. Dorhout on 4/4/2011 Rough Tr. at 52.

144. The proper procedure for a child who is in great deal of pain from his ear is for the child to see an ENT physician immediately. *Id.* at 145.

164. I find Ms. Gorenflo to be a credible witness and credit her testimony that her son was in pain and that she said her son was in pain when she called CMS and the ENT's office in July of 2005 and asked for a prompt appointment for Nathaniel.

165. Dr. Marie Becker is a board certified otolaryngologist who has been in private practice since 1995, treating children and adults covered by both private insurance and Medicaid. Becker on 2/1/2012 Rough Tr. at 9-10; PX 597 Appendix B (Becker resume). I find her credible and knowledgeable and certify her as an expert in otolaryngology.[18]

166. Nathaniel has a history of chronic sinusitis, as evidenced by his medical records. Becker on 2/1/2012 Rough Tr. at 12; DX 43 N.G._CMS000717, 731, and 734. That history makes it more likely he will suffer from sinusitis again. Becker on 2/1/2012 Rough Tr. at 14. Because Nathaniel had AIDS, he was immune-compromised and susceptible to infection. *Id.* at 15. The fact that he had

[18] Defendants have objected to Dr. Becker and the other witnesses who have given expert testimony as to the named plaintiffs' lack of adequate and prompt care. I have considered these motions to exclude the expert witness testimony and deny them as each of these experts is competent to testify as an expert based on a review of the medical records and the trial testimony. Further, I find their testimony more credible than the conclusory opinion of Ms. Sreckovich, defendants' expert, a non-physician, regarding the care afforded each of the named plaintiffs.

AIDS made it important that he be seen and diagnosed quickly, before any infection could spread. *Id.* at 14-15, 19-21. Pain is one of the key signs an infection is progressing. *Id.* at 15. Typically, th*e* person who spends most time with the child is most knowledgeable about whether the child's behavior is normal, and because Nathaniel was developmental delayed and could not express through words whether he was in pain, what his mother said about his condition was particularly important. *Id.* at 15-16. Given his symptoms, the fact that he was in pain, and suffered from AIDS, Nathaniel should have been evaluated by an ENT physician the day his mother requested an appointment or at the latest on the next day. *Id.* at 19-21.

167. A patient with the same symptoms and private insurance would have been seen by an ENT either the same day or at the latest, the following day. *Id.* at 21-22.[19]

168. Nathaniel experienced much greater difficulty accessing care than would a similarly situated child with private insurance. *Id.* at 23. Having Nathaniel wait five days for an ENT evaluation was "unreasonable." *Id.* at 25. He

[19] In her practice, Dr. Becker makes sure to see a child in pain the same day or at the latest the next day, regardless of whether the child is HIV positive or has AIDS. *Id.* at 22. If a child is HIV positive or had AIDS that adds to the importance of seeing the child quickly. *Id.* at 22. She also makes sure, if she receive a call about a child in pain on a Friday, to see the child that day so the child does not have to wait until Monday for an appointment. *Id.* at 22-23.

should have received an ENT evaluation the same day his mother called or at the very the latest, the next day. *Id.* at 25.

5. N.A.

169. C.R., next friend of plaintiff N.A., has been N.A.'s guardian since he was less than a week old, first as a foster mother and now as his adoptive mother.[20] C.R. on 1/14/2008 Depo. Desig. at 18:2-16. C.R. and N.A. reside in Tallahassee, Florida. *Id.* at 7:6.

170. N.A.'s birth mother voluntarily gave up her parental rights to N.A. *Id.* at 18:17-22. N.A. was exposed to cocaine and marijuana in utero, *see* DX 20 at TPF02293, and is at risk for developmental delays. C.R. on 1/14/2008 Depo. Desig. at 51:25 – 52:3.

171. Within a month of N.A.'s placement in C.R.'s home, he became sick and was hospitalized. What started as cold symptoms developed into respiratory syncytial virus (RSV) and necessitated an eight-day stay in the hospital's intensive care unit. *Id.* at 24:8-16; 65:15-22.

172. On the morning of January 19, 2007, just two months after his eight-day hospital stay, N.A. awoke coughing and congested, so C.R. called his doctor to

[20] Since his adoption, the boy's initials are now N.R. *See* DX 20 at TPF02210-02211. He is referred to here as N.A. because that is the way he was referred in the record during the key times at issue. On March 1, 2007, shortly after the incident in question, C.R. enrolled N.A. in CMS. C.R. on 2/24/2008 Depo. Desig. at 31:10-22.

schedule an immediate appointment. *Id.* at 26:12-14. It was not until that time that C.R. was informed that N.A. had been randomly assigned to a different insurance plan, a Medicaid HMO called Buena Vista, and assigned to a pediatrician located in Monitcello, about thirty minutes away from her home. DX 20 at TPF02229.

173. Although N.A. never resided with his birth mother, AHCA sent a request to her, not C.R., to choose a Medicare provider for N.A.; because N.A.'s birth mother did not respond, N.A. was auto-assigned. D.E. at 19 (Pretrial Stipulation, stipulated fact No. 111); Lewis on 11/29/2011 Rough Tr. at 39; Sreckovich on 12/13/2011 Rough Tr. at 94.

174. Because of his history of RSV and hospitalization, simple cold symptoms can quickly progress to significant problems for N.A. C.R. on 1/14/2008 Depo. Desig. at 65:15 – 66:4. When C.R. contacted Buena Vista, the representative refused to discuss N.A. with her because they lacked record of her relationship to N.A. *Id.* at 27:3-5.

175. Ultimately Tallahassee Pediatrics instructed C.R. to bring N.A. for treatment with his regular pediatrician, Dr. Charles Long, and said they would try to resolve the insurance issues later. *Id.* at 27:5-12; DX 20 at TPF02229. N.A. was seen that same morning, only because the doctor's office agreed to see him without confirmation that the office would be reimbursed for the visit. Middlemas on 1/31/2012 Rough Tr. at 22-23.

176. Later that same day, C.R. went to the pharmacy to fill two prescriptions for N.A. *Id.* at 27:16-20. The pharmacy was unable to process N.A.'s Medicaid number. *Id.* at 27:25 – 28:4. C.R. had to pay approximately $70 out of pocket for N.A.'s medications. *Id.* at 28:4-5; 29:15-17; 30:13-14; DX 20 at TPF02229.

177. At C.R.'s next trip to the pharmacy on the following Monday, a different pharmacist found the Buena Vista insurance numbers needed to process claims for medication for N.A. and also reimbursed C.R. for medication she had paid for on Friday. C.R. on 1/14/2008 Depo. Desig. at 30:7-13.

178. Dr. Middlemas practiced as a pediatrician, treating children on private insurance and Medicaid for 42 years, before recently retiring. Middlemas on 1/31/2012 Rough Tr. at 5-6. In the later years of his practice, he worked as a clinical instructor in the family practice residency program at Tallahassee Memorial Hospital. *Id.* at 5-6.

179. I find Dr. Middlemas qualified as an expert in pediatric medicine and find his testimony credible. Children with commercial insurance are never switched to another primary care provider with their parents' knowledge or consent. *Id.* at 21. Children on Medicaid sometimes are. *Id.*[21] A parent whose

[21] Dr. Middelmas' testimony is equally applicable to S.B., K.K, and J.W., who were also switched.

child had private insurance would not have had these obstacles in obtaining care for her child. *Id.* at 23.

6. J.S.

180. K.S. is the mother and next friend of J.S., one of the named plaintiffs in this action and lives in Jupiter. K.S. on 5/17/2010 Final Tr. at 1953:24-25; 1955:23 – 1956:5. J.S. has been on Medicaid since birth. *Id.* at 1957:13-14.

181. J.S. has variable immune deficiency, which means she lacks an immune system and can get sick very easily. *Id.* at 1958:11-19; 1958:23 – 1959:2. J.S. sees Dr. Gary Kleiner at the University of Miami for her immune deficiency. *Id.* at 1959:16-21. She has to see him on Thursday when he has clinic appointments because she has Medicaid. *Id.* at 1959:22 – 1960:4. He also sees patients on other days, but J.S., who is on Medicaid, can only see him on Thursdays. *Id.* at 1960:13-18. She has had to wait up to a month for an appointment. *Id.* at 1960:19-21.

182. J.S. has broken her ankle on several occasions. The first time was in 2000. *Id.* at 1961:10-13. K.S. took her daughter to Jupiter Medical Center, where they splinted her ankle, and told her to see an orthopedist. *Id.* at 1961:10-19. The orthopedist that the hospital recommended did not take Medicaid, and it took K.S. several days calling orthopedists in the phone book to find one to treat J.S. *Id.* at 1961:20 – 1962:5.

183. J.S. injured her ankle a second time in 2003 on a Saturday when she was seven year old and slipped on some water in a Winn Dixie. *Id.* at 1962:6-13; PX 743 at JMC000152. She took her daughter to the Jupiter Medical Center again, and again, they put on a splint, gave her crutches, and referred her to an orthopedist for follow-up care. *Id.* at 1962:14-21; PX 743at JMC000147-157. That orthopedist agreed to see her daughter but only if she paid for the visit. K.S. on 5/17/2010 Final Tr. at 1962:19 – 1963:4. The initial visit alone was going to cost about $300. *Id.*

184. K.S. then called a 1-800 Medicaid number for suggestions for an orthopedist. *Id.* at 1965:17-22. She called all the doctors she was given but none agreed to treat her daughter because she was on Medicaid. *Id.* at 1965:23 – 1966:5; 1967:10-13. She also called orthopedists listed in the Yellow Pages for Palm Beach County but without success. *Id.* at 1966:6-18; 1967:10-13. She tried call St. Mary's Hospital for a referral but could not find an orthopedist that way either. *Id.* at 1966:19-22. None of the orthopedists she called would agree to treat her daughter as a Medicaid patient. *Id.* at 1967:17-19; 1996:22 – 1997:13; 2023:18 – 2024:1.

185. Finally, with help from a law firm, she obtained an appointment with an orthopedist. *Id.* at 1967:20 – 1968:7; 2024:2-3. In 2007, J.S. injured her wrist, K.S. on 5/17/2010 Final Tr. at 1971:1-6; 2001:4-12, was given a splint in the E.R.

and referred to an orthopedist. *Id.* at 1971:7-13. K.S. called the orthopedist that the emergency room recommended, but she was not able to get an appointment. *Id.* at 1971:14-23. Again, she was unable to locate an orthopedist who would see her daughter despite extensive efforts. *Id.* at 1971:21 – 1973:6.

186. Finally, she was referred to the University of Miami, which gave her some suggestions for an orthopedic doctor. *Id.* at 1973:7-14. Two of those doctors told her that they could not see J.S. for a couple of weeks, even though K.S. explained that her daughter had a broken wrist and needed follow-up care. *Id.* at 1973:15-16; 1973:22 – 1974:3. The third doctor, Dr. Aileen Danko, agreed to see J.S. three days after she broke her wrist. *Id.* at 1973:20-21; 1974:14 – 1975:9; 2023:1-3; PX 746 at DANKO000001 to 000020.[22] Dr. Danko's office is in Coral Springs and is about an hour and a half drive each way from K.S.'s home. *Id.* at 1975:10-15. K.S. had to take her daughter to see Dr. Danko about four to five times. *Id.* at 1975:16-18.

187. The dentist who used to see J.S. and bill Medicaid for her treatment refused to continue seeing her when J.S. turned 14. *Id.* at 1976:25 – 1977:5. K.S. called a number of dentists trying to find a dentist who would accept Medicaid and

[22] Defendants asked this court to take judicial notice of the distance and purported driving time, according to Google and MapQuest, from Jupiter to Dr. Danko's office. *See* D.E. 1127, 1136, and 1137. Both the distance and driving time are farther if one starts from K.S.'s actual home address, not simply from Jupiter.

treat her, but could not find a Medicaid dentist for her. *Id.* at 1977: 6-11. Eventually, her old dentist agreed to see her.

188. To maintain J.S.'s Medicaid, K.S. has to go through a recertification process every six months. *Id.* at 1977:14 to 1987:4. When she has tried to call the Medicaid office, she had difficulty getting through because the line was busy. *Id.* at 1978:5-17.

7. N.V.

189. N.V. was born in February of 2004, in New Jersey. K.V. on 8/13/2010 Final Tr. at 4228:16-17. N.V. suffers from hydrocephalus and was ultimately diagnosed with Shwachman Diamond Syndrome, which causes pancreatic insufficiency. *Id.* at 4229:6-20; 4243:3-9. Proper nutrition is therefore critical to N.V.'s health. *Id.* at 4242:23 – 4243:2.

190. K.V. applied for Medicaid for N.V. while the family was still residing in New Jersey. *Id.* at 4230:3-16. N.V. is disabled, by social security standards, and thus entitled to receive Medicaid. *Id.*

191. K.V. and her family moved to Florida in 2005. *Id.* at 4246:22 – 4247:1. When N.V. was about three, he developed tooth decay, which he is prone to as part of Shwachman Diamond Syndrome. *Id.* at 4243:17-25.

192. K.V. took N.V. to Dr. Robbins, who treated N.V. for his tooth decay and administered his cleanings from January to September, 2007. *Id.* at 4236:18-

20. In September 2007, however, Dr. Robbins advised K.V. he would no longer treat N.V. because N.V. needed caps, and he explained further, that if the child lost a cap, Medicaid would not pay for a replacement. *Id.* at 4238:18-22.[23] Dr. Robbins told K.V. it would be "very hard" "to find someone who will accept Medicaid to do that work." *Id.* at 4278:11-23.

193. Using the Medicaid handbook, K.V. made multiple calls to multiple offices but could not a dentist in her area willing to treat N.V. *Id.* at 4240:10-16. She said nothing about N.V.'s complex medical condition; she did, however, identify Medicaid as the form of payment. *Id.* at 4241:13-16.

194. Ultimately, she was referred to Dr. Schneider whose office is two hours from her home. *Id.* at 4231:11-16; 4242:8-19; 4243:22-25. A month later, N.V. had his first appointment with Dr. Schneider. *Id.* at 4242:13-17; PX 673. By this time, N.V.'s appetite had diminished because of the tooth decay to the point that he was only drinking milk. *Id.* at 4243:15-19. Dr. Schneider was the only dentist K.V. could find who was willing to treat N.V. *Id.* at 4279:7-10; 4279:18-25. N.V. continues to see Dr. Schneider. *Id.* at 4231:11-20. K.V. takes N.V. to

[23] Though Dr. Robbins' notes include a notation that he does not do "white" fillings, PX 672, K.V. recalled the only reason Dr. Robbins told her for refusing to treat N.V. was that Medicaid would not pay for a second cap in the event the child lost one. *Id.* at 4239:3-15. Ultimately N.V. got both stainless and white caps. *Id.*at 18-20.

see Dr. Schneider four times a year due to his proclivity to tooth decay. *Id.* at 4243:22-25.

195. In the Fall of 2011, N.V.'s treating neurosurgeon Dr. Olivera referred him to see a neuropsychologist, and K.V. encountered difficulty in obtaining an appointment with a neuropsychologist. K.V. on 2/1/2012 Rough Tr. at 75.

196. Dr. Olivera made the referral as a result of K.V. reporting to him that N.V. was experiencing difficulty in comprehension at school. *Id.* at 73. Because, Dr. Olivera explained to K.V., learning problems are a common issue for children with hydrocephalus, he referred N.V. for an evaluation with a neuropsychologist before the start of the school year. *Id.*

197. Dr. Olivera referred N.V. to a neuropsychologist group with two offices: one in Orlando, near N.V.'s home, the other in Melbourne. *Id.* at 74-75. In early September, K.V. attempted to make an appointment, saying her son was on Medicaid. *Id.* at 74-75. She was not able to make an appointment to be seen at all in the Orlando office, and was not offered a date until January 2012 for N.V. to be seen by Dr. Lyons in the Melbourne office. *Id.* at 76-77. Moreover, Dr. Lyons's office did not commit to seeing N.V. at that appointment in January, but instructed K.V. to call back for confirmation of whether N.V. could be seen. *Id.* at 76. K.V. called back to the office every week for the next six weeks to find out whether or not Dr. Lyons would agree to treat N.V. *Id.* at 77-78. During this

period, K.V. asked both Dr. Lyons's and Dr. Olivera's treating neurosurgeon for a referral for a neuropsychologist who would accept Medicaid, but neither could provide one. *Id.* at 77. Finally, with assistance from Dr. Olivera, K.V. was seen by Dr. Lyons about two months after N.V. first sought an appointment. *Id.* at 77-79.

8. J.W.

198. In 2004 and until otherwise specified, J.W. resided in Pensacola, Florida with his grandmother, E.W., who serves as his next friend in this action. On December 21, 2004, E.W. took J.W. to see his pediatrician because he was complaining of a pain in his thigh. PX 629 at Whibbs000008. The pediatrician ordered x-rays of his knee and femur, and found a tumor on J.W.'s thigh. E.W. 6/16/2010 Depo. Desig. at 11:24 – 12:10.

199. The physician referred J.W. to an oncologist at the Nemours Hospital in Pensacola for an urgent consult. The oncologist examined J.W. a few days later, and because it was almost Christmas, agreed to let J.W. go home for the holiday, and began treatment immediately thereafter. PX 630 at JW_CMS000027.[24] On December 27, 2004, less than a week from the time when J.W. went to his

[24] The admission history states the x-ray was made on 10/22/04, PX 630 at JW_CMS000027, but that is clearly a typographical error because the x-ray was done on 12/22/04.

pediatrician, he was operated on and a tumor was removed from his left thigh. PX 630 at JW_CMS000031; E.W. 6/16/2010 Depo. Desig. at 12:11 – 14:14.

200. On July 20, 2005, J.W. complained of pain in his neck that was like the pain in his thigh six months before, and his grandmother took him to Nemours to see Dr. Assanasen, the oncologist who treated him previously. E.W. 6/16/2010 Depo. Desig. at 19:22 – 20:17. Dr. Assanasen suspected a recurrence of his tumor, saying the complaints of "neck pain" "were highly concerning of new disease," PX 634 at Nemours000145, and wanted to perform an imaging study, either a CT scan or an MRI, to see if the tumor had returned. PX 634 at Nemours000157.

201. At that time, J.W. was on Medicaid, and assigned to Health Ease, a Medicaid HMO. Dr. Assanasen's office sought authorization from Health Ease on July 20, 2005 to perform an imaging study, the same day Dr. Assanasen saw J.W. and the same day he ordered a neck CT. PX 634 at Nemours000145; 000157. On August 2, the request was still pending and Dr. Assanasen personally called the HMO to try to expedite authorization for the CT scan. PX 634 at Nemours000157 (8/2/2005 note at 11:45 a.m.). Authorization was still further delayed. Nemours000145 ("difficulty obtaining authorization for imaging studies"); Nemours000065 ("difficulty abtaining [sic] imaging studies"); E.W. on 6/16/2010 Depo. Desig. at 26:22-25; 31:6-19; 36:17-24; 137:2-24; 195:5-22.

202. E.W. and the rest of the family were deeply concerned. PX 634 at Nemours000157, as J.W.'s pain was getting worse. E.W. on 6/16/2010 Depo. Desig. at 27:6 – 28:15. E.W. called Dr. Assanasen's office every day to see if he had been able to obtain authorization for an imaging study. *Id.* at 27:25 – 28:15; 29:9-20. The study was finally done on August 24, about five weeks from when J.W.'s oncologist ordered an imaging study and had his staff seek authorization from the insurance company. PX 634 at Nemours000219-22. While Defendants note this was same date that his follow-up appointment had been scheduled, it appears reasonable to infer a more timely imaging study would likely have resulted in an earlier appointment and commencement of treatment.

203. The study revealed that the tumor had spread to E.W.'s neck and caused "significant bony disruption and tumor infiltration to the spinal canal." PX 634 at Nemours000143. "The site of this new lesion was highly concerning for cervical instability as well as risk of spinal cord depression if the mass was allowed to spread." PX 634 at Nemours000145. J.W. was "emergently admitted" for evaluation by both oncology and pediatrics. *Id.* The doctors began treating J.W. with chemotherapy and placed him in a Philadelphia collar to stabilize his neck. PX 634 at Nemours000149.

204. His oncologist wanted to administer the chemotherapeutic agents through an infusaport because the agents are caustic and could burn his skin, but

due to delay in receiving approval, this was not done. PX 634 at Nemours000146 ("therapeutic agents which can if extravasated into peripheral skin cause significant burns"); *id.* at Nemours000150 ("The chemotherapy was given through a peripheral vein, as we have not yet received approval from Health Ease to have a surgical consultation for Port-A-Cath placement.") The doctors began administering the chemotherapy intravenously, through a syringe in late August, so there would not be a delay. PX 634 at Nemours000149; E.W. 6/16/2010 Depo. Desig. at 57:5-15; 58:2 – 59:15; 149:8-19. The infusaport was subsequently approved by the Medicaid HMO, and installed on September 15, 2005, more than two weeks after the chemotherapy began. PX 631 at Sacred Heart000117.

205. Part of the delay in approving the imagining study apparently resulted from the fact that the Medicaid HMO had switched J.W.'s primary care provider without the knowledge or consent of E.W., who was her grandson's medical care taker. J.W.'s primary care provider was Dr. Whibbs. PX 629 at Whibbs000008; PX 630 at JW_CMS000003; E.W. 6/16/2010 Depo. Desig. at 46:16 – 47: 8. J.W. was subsequently switched to Dr. Murray, without E.W.'s knowledge or consent. E.W. 6/16/2010 Depo. Desig. at 49:23 – 50:23. E.W. had to take J.W. to see Dr. Murray, as part of the process of getting Health Ease to approve the imagining study to see if the tumor had spread to J.W.'s neck. PX 632 at Murray00001-3; E.W. 6/16/2010 Depo. Desig. at 51:21 – 52:16.

206. Dr. Middlemas practiced as a pediatrician, treating children on private insurance and Medicaid for 42 years, before recently retiring. Middlemas on 1/31/2012 Rough Tr. at 5-6. As part of his 42 years of practice, he ordered imaging studies on children at least 40 to 50 times, and also treated children with cancers and tumors. *Id.* at 65. In the later years of his practice, he worked as a clinical instructor in the family practice residency program at Tallahassee Memorial Hospital. *Id.* at 5-6.

207. I find Dr. Middlemas qualified as an expert in pediatric medicine and find his testimony credible. A child with private insurance whose physician ordered an imaging test because he suspected the child had a tumor would likely be able to obtain an imaging study within a day or two, and in no event, would have to wait more than a week. The treatment that J.W. received, waiting five weeks for a study, was below the standard of care.

208. J.W. was later switched for a second time, this time from Health Ease to straight Medicaid in about March of 2007. E.W. 6/16/2010 Depo. Desig. at 64:23 – 66:2; 67:22 – 69:3. E.W. did not request the switch and had to pay for J.W.'s psychologist herself because the psychologist would not accept straight Medicaid. *Id.*

209. E.W. later had trouble obtaining dental care for J.W. and there was a period of several months when he did not have dental care until E.W. heard about a new dental clinic at Sacred Heart Hospital. *Id.* at 74:2-24.

210. Still later, E.W. had trouble renewing J.W.'s Medicaid and had to call the 800 number to try to fix the problem. Every time she called the 800 number she had to spend two hours on hold. *Id.* at 76:16 – 77:15. J.W. was off Medicaid for about six weeks before E.W. was able to negotiate the bureaucracy and get his Medicaid renewed. *Id.* at 79:2-9. She had to pay out of pocket for J.W.'s ADHD medicine because he could not go without the mediation. Since she did not have the money her daughter paid for the medication for her. *Id.* at 80:24 – 81:25. E.W. has had repeated problems with the Medicaid application and thinks it is far more complicated than it should be. *Id.* at 199:11-19.

211. As of November 2011, J.W. was incarcerated and as a result lost eligibility for Medicaid during the period of his incarceration. Mr. Lewis on 11/29/2011 Rough Tr. at 6-7. The only reason he lost eligibility was because of his incarceration. *Id.* He is expected to be released in April 2012, when he will still be 18 years old, and should be eligible for Medicaid again. D.E. 1072 and Ex. A; Fla. R. 65 FL ADC 65A-1.703(3).

## VI. PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW AS TO PLAINTIFFS' CLAIMS

### A. Florida Medicaid Reimbursement Rates (Fee for Service)

212. AHCA is responsible for setting the reimbursement rates paid to physicians who provide Medicaid services. *See* FLA. STAT. § 409.902.

213. AHCA sets Medicaid rates for physicians' services as a fraction of Medicare rates, which are determined by the federal government. *See* PX 128A, 1/3/08 Memorandum from B. Kidder to D. Snipes; PX 685, HB 329 AHCA Bill Analysis at AHCA00755762; PX 495, Dr. Samuel Flint Report at 13-14. The "Medicare fee schedule is derived and updated through a complex process done in collaboration with . . . medical provider groups as well as health policy researchers." PX 495, Flint Report at 13. That process results in the Resource Based Relative Value System ("RBRVS"), by which all health care services are assigned a code and a total relative value based on physician work, practice expense, and malpractice expense. *See* PX 128A; PX 685 at AHCA00755762. The federal government adjusts the Medicare rates for each procedure code to account for geographical practice cost variations. *See* PX 495, Flint Report at 13. Even though the resulting Medicare rates "historically have been below private market rates[,]" they are intended to "provide current, fair relative reimbursement rates through [a] quasi-public utility model driven by production cost theory and tempered by real world data and clinician review." *Id.* at 13-14.

214. AHCA determines Florida Medicaid rates for physician services, except for certain codes that are held apart from the normal budgetary process, by

applying a conversion factor to the Medicare rates so that total expected outlays for Medicaid services fit within the program's appropriations from the Florida Legislature. *See* PX 128A; PX 685. In other words, to achieve budget-neutrality, AHCA uses a conversion factor to convert Medicare's reimbursement rates into lower rates for use in the Florida Medicaid program. As an internal State memorandum explains:

> The Agency determines physician fees using the Medicare Resource Based Relative Value System. . . . The relative value is multiplied by a conversion factor to determine the fee. The Agency for Health Care Administration calculates a conversion factor to maintain budget neutrality, unless the legislature provides additional funding for the physician services budget.

PX 128A; *see also* PX 685; Snipes on 12/9/2009 Final Tr. at 354:19 (Florida "places relative value and relative weights on certain practitioner procedures [and] utilizes those relative values and weights each year in calculating the practitioner fees."); Kidder on 5/19/2010 Final Tr. at 2490:3-23.

215. In 2008, the conversion factor was 34.0682 for Medicare, compared with just 19.6332 for Medicaid. *See* PX 128A at AHCA00981413; Snipes on 12/9/2009 Final Tr. at 357:7-23. Generally speaking, this means that Medicaid rates for children's primary care services are about 40% less than Medicare rates for comparable services, both in the fee-for-service and the managed care contexts.

*See* PX 128A; PX 495, Flint Report at 13–14 (comparing Florida Medicaid rates for primary care and specialty care services to Medicare rates).[25]

216. Dyke Snipes, a former AHCA Medicaid director testified:

> "Really, what contributes to the level that Medicaid is of Medicare is the amount of funding that's put in the program by the Florida legislature." Snipes on 12/9/2009 Final Tr. at 360:6-8.
> • "[T]he agency is limited to establishing the fees in accordance with the funding that we get from the Florida legislature when they pass the budget." *Id.* at 361:24 – 362:4.
> • "Q:[T]he reason that Medicaid fees are 40 percent [less than] Medicare fees is not based on a judgment that that's appropriate in terms of operating the program, it's a function of how much money the Florida legislature has put into that program, right? A: That is correct." *Id.* at 360:12-17.
> • "[T]he fees are . . . based on what's built into the budget[.]" *Id.* at 362:4.
> • "The Court: [D]o you take any other factors [other than the budget] into account in setting rates for a given year, in the aggregate? A: I believe the answer to that is probably no. If we were to do anything other than that, that would increase or decrease spending in the aggregate, then we would be out of compliance with what drives the budget." *Id.* at 364:21 – 365:2.

217. In discharging its responsibility to set physician reimbursement rates, AHCA does not consider whether the reimbursement rates are sufficient to ensure that children on Medicaid have access to health care services equal to that of other children in the general population. *See* Snipes on 12/9/2009 Final Tr. at 360:9-20; Kidder on 5/19/2010 Final Tr. at 2492:14 – 2494:19. Nor does AHCA consider

[25] Medicaid reimbursement in the context of managed care is discussed below. Most HMOs that contract with the states pay physicians at the state's Medicaid fee-for-service level at most. Flint on 8/3/2010 Final Trial Tr. at 2976:13 –2977:8.

whether the rates are sufficient to ensure that EPSDT services are made available with reasonable promptness. *Id.* In fact, in this litigation, the State repeatedly has disavowed any legal responsibility for ensuring that health care services are made available to children on Medicaid, arguing that its only duty is to cut checks with reasonable promptness when such services are rendered. *See, e.g.*, D.E. 548-3 (Def. Mot. for Summ. J. at 5).

218. Because AHCA does not consider the Medicaid Act's mandates when it sets physicians' fees, it has not bothered to study whether those fees are sufficient to comply with the law. *See, e.g.*, Snipes on 12/9/2009 Final Tr. at 360:21 – 362:23; *see also* Kidder on 5/19/10 Final Tr. at 2649:2-18 (AHCA has not conducted any studies since that referenced in a 2003 LBR stating that AHCA had "found critical shortages of Medicaid participating physicians in the state.").

219. Although certain codes for office-based and preventative health care visits are held outside the "budget neutrality" and conversion factor analysis, the overwhelming number of codes are not. *See* Williams on 10/17/2011 Rough Tr. at 133-134; Kidder on 5/19/2010 Final Tr. at 2502:5-14; DX 470. Even for those codes, trial testimony shows that current Florida reimbursement for Medicaid is substantially below the level provided for Medicare reimbursement for the same office-based services that are the most commonly billed codes. *See* Kidder on 5/19/2010 Final Tr. at 2497:16 – 2499:1.

220. The following table, reflecting undisputed testimony at trial and rates the Court has taken judicial notice of from official websites, reflects the difference for commonly based office services between current Medicaid and Medicare rates for Florida outside of the Miami and Ft. Lauderdale areas. *See* PX 781, Louis St. Petery Demonstrative Exhibit A.

| Code | Description | 2012 Medicaid Rates | 2012 Medicare Rates | Medicaid / Medicare Percentage |
|---|---|---|---|---|
| 99201 | Office/outpatient visit, new | $32.45 | $42.50 | 76% |
| 99202 | Office/outpatient visit, new | $34.01 | $72.59 | 47% |
| 99203 | Office/outpatient visit, new | $50.63 | $106.14 | 48% |
| 99204 | Office/outpatient visit, new | $71.59 | $162.74 | 44% |
| 99205 | Office/outpatient visit, new | $90.98 | $201.91 | 45% |
| 99211 | Office/outpatient visit, est | $12.48 | $19.51 | 64% |
| 99212 | Office/outpatient visit, est | $26.45 | $42.50 | 62% |
| 99213 | Office/outpatient visit, est | $32.56 | $70.65 | 46% |
| 99214 | Office/outpatient visit, est | $48.27 | $104.45 | 46% |
| 99215 | Office/outpatient visit, est | $62.68 | $140.50 | 45% |

221. Thus, for areas in Florida outside of Miami and Ft. Lauderdale, office-based services under Medicaid for primary care physicians serving children are

compensated at rates that for most codes are less than half of the Medicaid rate. *See* PX 781, Louis St. Petery Demonstrative Exhibit A.

222. The following table, reflecting undisputed testimony at trial and rates the Court has taken judicial notice of from official websites, reflects the difference for commonly based preventative services between current Medicaid and Medicare rates for Florida outside of the Miami and Ft. Lauderdale areas. *See* PX 781, Louis St. Petery Demonstrative Exhibit A.

| Code | Description | 2012 Medicaid Rates | 2012 Medicare Rates | Medicaid / Medicare Percentage |
|---|---|---|---|---|
| 99381 | Prev visit, new, infant | $71.59 | $108.07 | 66% |
| 99382 | Prev visit, new, age 1-4 | $71.59 | $112.59 | 64% |
| 99383 | Prev visit, new, age 5-11 | $71.59 | $116.85 | 61% |
| 99384 | Prev visit, new, age 12-17 | $71.59 | $132.28 | 54% |
| 99385 | Prev visit, new, age 18-39 | $71.59 | $128.90 | 56% |
| 99391 | Prev visit, est, infant | $71.59 | $96.20 | 74% |
| 99392 | Prev visit, est, age 1-4 | $71.59 | $103.13 | 69% |
| 99393 | Prev visit, est, age 5-11 | $71.59 | $102.80 | 70% |
| 99394 | Prev visit, est, age 12-17 | $71.59 | $112.24 | 64% |

| Code | Description | 2012 Medicaid Rates | 2012 Medicare Rates | Medicaid / Medicare Percentage |
|---|---|---|---|---|
| 99395 | Prev visit, est, age 18-39 | $71.59 | $114.60 | 62% |

223. The cost of living adjustments to Miami and Ft. Lauderdale Medicare rates are higher in those areas, whereas Medicaid reimbursement is the same statewide. Thus, the differential between Medicaid and Medicare reimbursement is greater in the Miami and Ft. Lauderdale areas, with Medicaid paying an even lower percentage of Medicare reimbursement. *See* PX 780 (Medicare Rates); PX 781 (Medicaid Rates).

224. Medicaid reimbursement in Florida is even further below levels of private reimbursement programs. Andrew Agwunobi, former secretary of AHCA acknowledged that "one thing is very clear: [p]roviders are in general underpaid in contrast to commercial insurance and Medicaid." PX 126a at 6. A number of primary care providers testified that Medicaid reimbursement is substantially below private insurer reimbursement for the same procedures in the same geographical areas. *See* Schechtman on 5/20/2010 Final Tr. at 2867:19 – 2868:3 (one of the largest pediatric practices in Palm Beach County); Schechtman on 10/19/2010 Final Tr. at 4439:14 – 4440:22 (CPT codes 99213 and 99214 account for approximately 25% of his practice and are compensated at 55-60% of commercial insurance rates); *id.* at 4444:24 – 4446:15 (numerous ancillary services

billable under commercial insurance are not reimbursed or billable under Medicaid, up to $115 vs. $20 for Medicaid); Cosgrove on 1/31/2012 Rough Trial Tr. at 138. (For CPT code 99213 "Medicaid pays 32.56. The Medicaid HMO, Well Care, pays 35.82; Health First, which is a local HMO pays $80.13; CIGNA pays 58.60; Blue Cross/Blue Shield PPO pays 82.87; and Aetna pays 51.63.") *Id.* at 140 (for CPT code 99383 "Medicaid pays $71.59; the Medicaid HMO Well Care pace 78.75; Health First pace 122.67; CIGNA pays $93.15; Blue Cross/Blue Shield PPO pays 121.14; Aetna pays 105.42."); Nancy Silva on 5/20/2010 Final Tr. at 2826:7-10 (makes less than commercial insurance every time she sees a Medicaid patient); Jerome Isaacs on 8/11/2010 Final Tr. at 3856:16 – 3858:11 (two largest commercial insurance carriers in his practice pay from 50% more to double what Medicaid pays for four most common non CHCUP CPT codes); *Id.* at 3858:12 – 3861:4 (commercial insurance pays 20% more for CHCUP codes plus $40 to $50 for additional components that Medicaid does not pay for); Louis St. Petery on 2/2/2012 Rough Tr. at 48-52 (detailing rate differential for primary care physicians between commercial insurance and Medicaid for common CPT codes, commercial rates ranged from 160 to 289% of Medicaid rates.)

225. The difference between Medicaid reimbursement and private reimbursement is also true for specialists. *See* Postma on 8/4/2010 Final Tr. at 3193:9 – 3195:5; PX 144 (Medicaid reimbursement less than half of private

reimbursement for top 25 ENT procedures that generate 90-99% of revenue); Adam Fenichel on 10/18/2010 Final Tr. at 4340:7-13 (commercial insurance pays about 30% of standard charge rate where Medicaid pays less than 10%); Ricardo Ayala on 8/9/201 Final Tr. at 3587:2-24 (for the six CPT codes that make up bulk of his practice commercial insurance pays more than Medicare, which pays more than Medicaid); Brett Baynham on 1/24/2012 Rough Tr. at 11 (Medicaid reimburses at 55 to 65% of Medicare rates, while commercial insurers generally range from 110 to 150% of Medicare rates); Louis St. Petery on 2/2/2012 Rough Tr. at 48-52 (detailing rate differential for specialists between commercial insurance and Medicaid for common CPT codes, commercial rates ranged from 129 to 233% of Medicaid rates, most exceeded 200%).

226. Primary care fees were increased in 2000 by a total of $1.8 million for 3 office visit codes; in 2002, the Florida legislature authorized a 4% increase for all providers treating children. No other increases for primary care providers for children have occurred since 2000.[26] PX 128A. Rather, in October of 2008, the legislature cut by one-third from $3 to $2, the monthly per child fee paid primary care providers participating in the MediPass system for managing the care

[26] Minor budget neutral changes have been made, both increases and decreases, in reimbursement rates for individual codes based on the annual Resources Based Relative Value System adjustments.

provided to children on Medicaid. St. Petery on 12/10/2009 Final Tr. at 625:11-15; Williams on 10/17/2011 Rough Tr. at 141.

227. Certain specialists received an increase in 2004 of 24% for treating children on Medicaid. *See* PX 128A – this is the only adjustment in nearly 10 years –and leaves specialist reimbursement substantially below the current Medicare levels for office-based services, as reflected on the following table:

| Code | Description | 2012 Medicaid Specialist Rates | 2012 Medicare Rates | Medicaid/ Medicare Percentage for Specialists |
|---|---|---|---|---|
| 99201 | Office/outpatient visit, new | $40.24 | $42.50 | 95% |
| 99202 | Office/outpatient visit, new | $42.17 | $72.59 | 58% |
| 99203 | Office/outpatient visit, new | $62.78 | $106.14 | 59% |
| 99204 | Office/outpatient visit, new | $88.77 | $162.74 | 55% |
| 99205 | Office/outpatient visit, new | $112.82 | $201.91 | 56% |
| 99211 | Office/outpatient visit, est | $15.48 | $19.51 | 79% |
| 99212 | Office/outpatient visit, est | $32.80 | $42.50 | 77% |
| 99213 | Office/outpatient visit, est | $40.37 | $70.65 | 57% |
| 99214 | Office/outpatient visit, est | $59.85 | $104.45 | 57% |
| 99215 | Office/outpatient visit, est | $77.72 | $140.50 | 55% |

PX 780; PX 781; *see also* St. Petery Demonstrative Exhibit B.

228. The difference between Medicaid reimbursement levels and those for Medicare will likely increase in coming years as Medicare reimbursement accounts for cost-of-living changes whereas Florida's Medicaid program does not. *See* Williams on 10/17/2011 Rough Tr. at 131.

229. Florida's Medicaid reimbursement level was in the lowest quintile of states in the United States as of 2003, and given the lack of increases since that time, they have declined further relative to other states. Flint on 8/5/2010 Final Tr. at 3521:2-20.

230. The inadequacy of Florida's reimbursement for Medicaid providers has been acknowledged by AHCA in a series of legislative budget requests proposed over a number of years to the Florida legislature. These legislative budget requests included both the need for an increase in the compensation paid for healthy kid check-ups as well as for specialist care. As explained by Dyke Snipes, the agency singled out 4 specialty areas (dermatologists, neurologists, neurosurgeons, and orthopedists) for modest fee increases, not because these were the only areas in which an increase was needed, but in hopes that a modest request would be more politically acceptable. Notwithstanding this approach, and the fact that requests were renewed annually for a number of years, and were at the top of the legislative priority list for AHCA proposals, none of these proposed increases was enacted. The legislative budget proposals from AHCA made in each

legislative year from the 2005-2006 legislative session through the 2009-2010 legislative session called for an increase in child-health check-up fees. PX 92-96; PX 702-703; PX 734. In addition, AHCA proposed increases in 2008-2009 and 2009-2010 budgets for a 40% increase for four specialty areas. Those, too, were rejected each year. PX 89-90; PX 727; Snipes on 12/9/2009 Final Tr. at 405:21 – 406:14. Finally, a $2 fee proposal made to incent physicians to collect lead blood specimens also was made but failed to pass each year for each legislative year from 2005-2006 through 2009-2010. PX 97-98; PX 704-705.

231. The Defendants, and certain of their witnesses, claim that these legislative budget requests were predicated on exaggerated and inaccurate information. *See* Williams on 10/17/2011 Rough Tr. at 163-164; Kidder on 10/3/2011 Rough Tr. at 77. The Court finds these explanations advanced at trial unpersuasive. The legislative budget requests were prepared by officials who recognized their obligation to be accurate and honest in presenting the views of their agency to the governor and the legislature. Moreover, these very witnesses had admitted under oath as agency representative witnesses during deposition that the legislative budget requests were truthful and correct. Finally, the asserted inaccuracies in the requests are in the nature of certain relationships between fee levels and usage being overly simplistic or that certain data was not updated. Neither of these alleged inaccuracies challenges the conclusion that the agency

itself – out of court – acknowledged regarding the importance of reimbursement increases, repeatedly in submissions to the legislature. As former Medicaid Director Snipes acknowledged, these requests were indicative not of simply wanting to pay doctors more but of a substantial problem in current reimbursement levels. Snipes on 12/9/2009 Final Tr. at 380:4 – 381:10; Snipes on 1/8/2010 Final Tr. at 1243:6-23; *see also* PX 701; PX 727. I agree and find these submissions to the legislature to be tantamount to admissions by defendants that the current level of primary and specialist reimbursement for Florida Medicaid is inadequate. Inadequate. *See also Cockrum v. Califano*, 475 F. Supp. 1222, 1227 n. 1 (D.D.C. 1979) (Secretary of Health, Education and Welfare estopped from asserting claimants responsibility for delays in administrative hearings by his admissions elsewhere that the delay problem was nationwide in scope.)

232. Based on this data, expert testimony at trial competently supported the proposition that the Florida Medicaid reimbursements levels are not sufficient for Florida Medicaid to be a competitive purchaser for medical services. Dr. Samuel Flint – an Assistant Professor of Public Affairs at Indiana University Northwest who has published extensively on health economics – studied the health care market in Florida and concluded that "the Florida Medicaid program is not a competitive purchaser for pediatric care at this time." PX 495, Flint Report at 20; *see also id.* at 2.

233. Prof. Flint measured the difference in 2008 rates between Medicaid and Medicare for common office based procedure codes and concluded: "Florida Medicaid reimburses primary care physicians at slightly more than one-half of what Medicare pays, and specialists receive about two-thirds of Medicare rates." *Id.* at 2; *see* also PX 782. This is a straight-forward comparison that the Court finds essentially undisputed.

234. Defendants noted correctly that Prof Flint could have compared the rates for Medicare for EPSDT codes, even though Medicare does not actually compensate for such services. While the constructed Medicare reimbursement for such EPSDT services is less than the differential for office-based non preventative care visits, the difference for current rates is still substantial. For 2012, Medicaid reimbursement for such procedures measured against Medicare – constructed reimbursement levels ranges from 51 to 74% of the Medicare reimbursement levels. PX 783; *see also* PX 782 (2008 comparison); St. Petery on 2/2/2012 Rough Trial Tr. at 38-42.

235. Dr. Flint also compared Florida Medicaid rates against cost measures, finding that "a primary care practice comprised of 75% Medicaid patients could not remain solvent, even if the physician worked for free." PX 495, Flint Report at 19.

236. Defendants' expert witness Catherine Sreckovich admittedly did not conduct any analysis of the adequacy of Florida reimbursement rates. Sreckovich on 1/10/2012 Rough Tr. at 140-141.

237. Based on the evidence at trial, I find that Florida's Medicaid program has not compensated primary physicians or specialists at a competitive rate as compared with either that of Medicare or private insurance payors.

238. I further find that Florida's structure for setting physician reimbursement does not seek to account for any of the statutorily mandated factors in the Medicaid Act, such as the level of compensation needed to assure an adequate supply of physicians so as to discharge the mandate to provide EPSDT services or set rates at a level that will promote quality of care, let alone equal access to care as required under 42 U.S.C. § 1396a(a)(30)(A). Indeed, on the contrary, except for certain codes held outside the normal budgetary process, Florida's conversion ratio and budget-neutrality mandates results in artificially setting rates for many services without any consideration of the costs incurred by physicians or what is needed for even a minimally competitive rate or a rate sufficient to attract medical providers.

239. Defendants argue that it is not necessary for states to conduct studies in order to set rates in accordance with Section 30(A)'s Equal Access requirements. Whether or not studies are required, it is clear that a system which

mandates budget neutrality as the determining factor in rate-setting, and takes no consideration of the factors required by federal law, cannot be squared with federal law. The Eleventh Circuit's statement in *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, supra 109 F. 3d at 704 is applicable here:

> "Defendant AHCA seems to concede that budgetary constraints and the failure of the Legislature to adopt a provision for inappropriate level of care services, have left it incapable of compensating Plaintiffs for medically necessary outpatient psychiatric services provided in an in-patient setting. However, as the Tenth Circuit has held:
>
> > While budgetary constraints may be a factor to be considered by a state when amending a current plan, implementing a new plan, or making the annually mandated findings, budgetary constraints alone can never be sufficient. *Illinois Hosp. Ass'n [v. Illinois Dept of Public Aid*, 576 F. Supp. 360, 368 (N.D. Ill. 1983).] If a state could evade the requirements of the [Medicaid] [**36] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the Congressionally imposed standards at will. *Alabama Nursing Home Ass'n v. Califano*, 433 F. Supp. 1325, 1330 (M.D. Ala. 1977), *rev'd and vacated in part on other grounds, sub nom.*, 617 F.2d 388 (5th Cir. 1980).
>
> *AMISUB (PSL), Inc. v. Colo. Dept. of Social Serv.*, 879 F.2d 789, 800-01 (10th Cir. 1989), cert. denied, 496 U.S. 935, 110 S. Ct. 3212, 110 L. Ed. 2d 660 (1990). Yet this is precisely what the State of Florida has attempted to do in the case at bar."

240. Even for those codes set by statute outside the normal budgetary process, there is no process for evaluating the sufficiency of those rates to attract a sufficient supply of primary and specialist physicians to treat Medicaid children. There also is no process to adjust those rates for increases in the cost of living.

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Factually, while the Medical cost of living index has increased over the past decade, there has not been any commensurate increase in Medicaid reimbursement, and accordingly the gap between Medicaid reimbursement and that of Medicare has widened for most codes, and will continue to do so.

**B. Newborns, Continuous Eligibility and Switching**

1. Continuous Eligibility

241. Florida must provide children under the age of five with 12 months of continuous eligibility and children between the ages of 5 and 18 with six months of continuous eligibility. PX 712 at FL-MED 08336. Children should not lose eligibility within that period unless they move out of the state or die. Lewis on 10/20/2010 Final Tr. at 4654:10 – 4655:4. Every time a child is determined or re-determined to be eligible for Medicaid, a new period of continuous eligibility starts. *Id.* at 4661:11 – 4662:1.

242. The undisputed evidence shows that thousands of children lose their eligibility in their first year of life in violation of their right to continuous eligibility.

243. Defendants' expert, Ms. Sreckovich, indicates in her initial report that between 2004 and 2008 the Medicaid eligibility of children under one year of age for Medicaid was terminated 2.1% to 2.9% of the time and for children one to five years of age, their eligibility was terminated 6.8 % to 7.0 % of the time. DX 607 at

¶ 22. These numbers reflected only children whose eligibility was terminated and subsequently reinstated during a single fiscal year. Sreckovich on 1/12/2012 Rough Tr. at 96-97. In the case of the children aged one to five this would be approximately a total of 65,000 children in the course of a year. *Id.* at 93-96. Those figures are an underestimate since, among other reasons, they exclude children who never regained eligibility. St. Petery on 2/2/2012 Rough Tr. at 75-76.

244. Because those children had their eligibility reinstated, they could not have died or moved out of the state. Sreckovich on 1/12/2012 Rough Tr. at 97. Ms. Sreckovich acknowledged that for children under one all those terminations were improper. *Id.* at 98. (She also acknowledged that for older children some of those terminations were improper. *Id.* at 97-98.) That means, based on the range of improper terminations (2.1 to 2.9%) and the number of children enrolled in Medicaid, from 3,234 to 4,466 children were improperly terminated in one fiscal year in violation of their right to continuous eligibility. *Id.* at 98-99. Ms. Sreckovich acknowledged those children were wrongfully terminated. *Id.* Dr. St. Petery pointed out that Ms. Sreckovich's own report demonstrates that many thousands of Florida children under five years of age had their eligibility terminated and then restored when they should have had continuous eligibility. St. Petery on 2/02/2012 Rough Tr. at 73-76.

245. DCF acknowledged that for each federal fiscal year from 2003 to 2007, at least 25,000 (and sometimes more than 31,000) children under five years of age had their eligibility terminated before they had received 12 months of continuous eligibility. PX 737 at answer to Interrogatory No. 1. By DCF's own admission, the percentage of children under five enrolled in Medicaid whose Medicaid eligibility was terminated ranged each year from less than 3.5% to less than 5%. *Id.* Those figures are an underestimate. They do not include children whose eligibility was retroactively restored making it seem as if they had not lost eligibility, and so understates the number of improper terminations. St. Petery on 12/10/2009 Final Tr. at 593:19 – 594:19; PX 688. Those figures, even if an underestimate, quantify the minimum number of children wrongfully terminated. St. Petery on 2/2/2012 Rough Tr. at 74-75.

246. DCF officials have acknowledged a "tremendous problem with the issue of maintaining continuous eligibility" and "that the problem was that [DCF's] eligibility system does not automatically know what period of continuous eligibility a child" is entitled to so that "it is dependent on staff, when they're ready to close a Medicaid case that involves children, that there's a child inside who may be entitled to continuous period of eligibility and should not be terminated." Lewis on 10/20/2010 Final Tr. at 4656: 2-4; 4657:18 – 4658:22. Mr. Lewis acknowledged at trial: "That problem continues to this day." *Id.* at 4658:23-24.

247. DCF conducted a Medicaid eligibility quality control analysis study in 2010 for federal CMS, and reported, in a Sept. 20, 2010 letter to the acting regional administrator of CMS, that based on a review of 1200 cases, that there were 7% of the cases "in which the Medicaid coverage was not provided through the entitlement period." DX 169a at 2; Lewis on 10/20/2010 Final Tr. at 4660:24 – 4664:8. Mr. Lewis conceded that is not an "acceptable" error rate. Lewis on 11/29/2011 Rough Tr. at 16-17. Among the reasons for these "incorrect actions" were closing a Medicaid category without simultaneously opening the new Medicaid category. Lewis on 10/20/2010 Final Tr. at 4666:14-25.

248. As part of the same analysis sent to federal CMS, DCF also looked more generally at whether or not there had been wrongful denials of coverage or terminations and found that twenty percent of the terminations of both children and adults were in error. DX 169a at 3-4; Lewis on 10/20/2010 Final Tr. at 4667:16-25, 4671:1-12. Mr. Lewis knew of no reason why the percentage of termination for adults or children would differ. *Id.* at 4671:13-18.

249. DCF states it has been trying since 2002 to fix the problems that cause some children to be terminated in violation of their rights to continuous eligibility. Poirier on 10/5/2011 Rough Tr. at 71-72. For years, DCF has been considering implementing a computerized system for monitoring continuous eligibility of Medicaid Children, but has not done so–even though there's no technical problem

that would prevent DCF from instituting an automatic system for ensuring continuous eligibility. Lewis on 10/21/2010 Final Tr. at 4800:10 – 4801:15.

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250. DCF officials have repeatedly acknowledged the young infants are sometimes improperly terminated. A DCF employee acknowledged receiving "a string of inquiries" from Carol McCormick of the Tallahassee Pediatric Foundation concerning "newborns being cut from their Medicaid coverage too soon." PX 345 at L-STP-R 000496. The DCF worker told her colleagues, "Each one that I have looked into was just that." *Id.* She said she had received about 32 such inquiries in the last two months. *Id.*; *see also* McCormick on 8/12/2010 Final Tr. at 4123:13 – 4125:19. Another DCF official admitted to Dr. St. Petery that it was not uncommon that DCF case workers would inadvertently terminate a child's eligibility when the mother's pregnancy Medicaid terminated. St. Petery on 12/10/2009 Final Tr. at 572:18 –573:10.

251. Dr. St. Petery is the executive director of Tallahassee Pediatric Foundation (TPF), which has access to FMMIS print screens which provide certain information regarding a child's eligibility and assignment to a primary care provider. St. Petery on 12/10/2009 Final Tr. at 554:19 – 555:10. Dr. St. Petery has personally seen cases of improper termination of continuous eligibility with patients of TPF by studying those patients' FMMIS print screens from which he

could tell their eligibility had been incorrectly terminated and then restored retroactively. *Id.* at 555:1-21, 575:18 – 576:11.

252. Primary care providers regularly see children who lose their Medicaid eligibility in their first year of life. Cosgrove on 5/19/2010 Final Tr. at 2586:16 – 2587:10; Silva on 5/20/2010 Final Tr. at 2804:10 – 2805:9; J. St. Petery Depo. Desig. on 11/11/2008 at 194:6-13; J. Ritrosky, Depo. Desig. on 11/10/2008 at 97:4 – 98:2, 98:15 – 99:25.

253. When a child's Medicaid eligibility is incorrectly terminated, the physician to whom the child presents has the choice of treating the patient and likely not get paid (unless eligibility is retroactively restored, the physician's office finds out about it, and incurs the expense of resubmitting its prior bill) or not treating the child. St. Petery on 12/10/2010 Final Tr. at 594:20 – 596:6.

2. Switching

254. "Switching' is the situation when a child appears at a pediatrician's office for care, the pediatrician queries the Medicaid system and determines that the child, without the parent's knowledge or consent, and without the physician's office previous knowledge, has been switched to a different Medicaid plan from the one the child was on previously, frequently a plan for which that physician is not a provider." St. Petery on 12/10/2009 Final Tr. at 548:13-19. As explained below, improper termination is a common cause of switching.

255. When patients are switched they are most frequently switched from Medipass to a Medicaid HMO, but they can also be switched from one provider to another within the same program. *Id.* at 549:25 – 550:5. "Switching most commonly comes to light when the parent brings her child to a physician and is told, 'Sorry, you can't come here today; it looks like Medicaid has changed you to another provider, another plan, and you have to go there.'" *Id.* at 550:7-10. The physician finds out that a child has been switched to another provider by checking the Florida Medicaid Management Information System (FMMIS) to make sure the child is eligible for Medicaid and that the physician will be reimbursed by Medicaid for treating that child. *Id.* at 550:11-24. Typically, the parent of the child does not realize the child has been switched until the doctor's office informs them. *Id.* at 554:5-18.

256. When a child is switched, the physician's office has the choice of seeing the child and risk not getting paid or declining to see the child until or unless the child is switched back. *Id.* at 556:11 – 557:15. "Many times the provider's staff spends a lot of time trying to fix the problem so that the child can come back to their practice." *Id.* at 558:1-4. A primary care doctor from whom a child has been switched no longer can authorize a referral for further care, even for an x-ray. *Id.* at 559:6 – 560:9. Generally, if a child has been switched to an HMO,

the HMO will not pay the physician to whom the child was previously assigned. *Id.* at 558:5-19.

257. Switching is an obstacle to Medicaid children's accessing care. *Id.* at 560:18-20. Because switching moves children from one medical home to another, it interferes with continuity of care, and may delay care and can lead to children not receiving care at all. *Id.* at 560:23 – 561:10. Switching does not occur with privately-insured patients. *Id.* at 561:1-6.

258. Switching is not a new problem. Dr. St. Petery has been complaining to ACHA and DCF about switching for 20-25 years, but the problem still continues. *Id.* at 572:7-19.

259. Robert Sharpe was ACHA Medicaid Director from 2000 to 2004 and assistant Medicaid Director 1998-2000. Sharpe on 11/16/10 Final Tr. at 4926:19 – 4927:2; 4929:24 – 4930:8. Dr. St. Petery met with him on multiple occasions to discuss switching. *Id.* at 4932:22 – 4933:2. Mr. Sharpe had his staff investigate cases brought to him by Dr. St. Petery and they determined that the children were indeed switched without the parent requesting a change of provider. *Id.* at 4933:2:2 – 4933:12.

260. Phyllis Sloyer, then assistant director of CMS, also complained to Mr. Sharpe about switching and how it affected continuity of care for children in the CMS program. *Id.* at 4933:13 – 4935: 9. Mr. Sharpe was not able to eliminate

switching, which remained a problem during his entire tenure as deputy secretary of Medicaid. *Id.* at 4935:10-15; 4936:13-15.

3. Evidence of switching

261. Several of the named plaintiffs in this case were switched – S.B, K.K. J.W. – some multiple times, and their switching lead to delayed or interrupted care. For S.B. his 18-month check-up was delayed. Because K.K. was switched, he had to change from Vyvance, an ADHD drug that was working for him, to Adderall, one that was not. In J.W.'s case, on one occasion switching contributed to a five-week delay in performing an imaging study to see if a tumor had reappeared on his neck, and in another, it caused his family to have to pay out of pocket for his ADHD medication. *See supra* at 208.

262. Testimony at trial showed that switching is a regular occurrence for primary care providers. Dr. Lisa Cosgrove is a primary care physician who practices in Merritt Island, Florida which is in Brevard County. Cosgrove on 05/19/2010 Final Tr. at 2550:8-9, 2552:15-25. Dr. Cosgrove's Medicaid patients are switched to other plans on a "regular basis"; it occurs on a daily basis. *Id.* at 2575:16 – 2577:19. Some of Cosgrove's patients who get switched end up in the emergency room. *Id.* at 2579:1-4, 2580:14-20. Switching interferes with continuity of care. *Id.* at 2581:15 – 2582:13. Switching also consumes time of

office staff who try to assist patients in getting switched back to her practice, for which there is no compensation. *Id.* at 2583:13 – 2584:5.

263. Nancy Silva is a pediatrician who practices in Brandon, Florida. Silva on 5/20/2010 Final Tr. at 2767:19-21; 2768:1-2. Dr. Silva's Medicaid patients are switched "all the time" from one primary care provider to another and one insurer to another. *Id.* at 2796:11-21. Seldom does the primary care doctor to whom the patient has been switched give authorization to Dr. Silva's office to see the child unless there is an acute significant illness. Without authorization for a child no longer assigned to Dr. Silva, she cannot get paid for any care provided. *Id.* at 2798:16 – 2799: 3. Switching interferes with continuity of care. *Id.* at 2799:4-20. Switching results in lost staff time for pediatricians and is a deterrent to participating in Medicaid. *Id.* at 2799:21 – 2800:11. It takes approximately six weeks to get a Medicaid child who has been switched to another provider reassigned to her practice. Silva on 1/19/2012 Rough Tr. at 147-48.

264. Jerome Isaac is a pediatrician who practices in Sarasota and Bradenton. Isaac on 8/11/2010 Final Tr. at 3852:13-14; 3853:20-21. Dr. Isaac's Medicaid patients are sometimes switched away from his practice. *Id.* at 3894:12-20. Generally, after a couple of months they return to his practice after getting switched back. *Id.* at 3895:8-25. Switching generally leads to delayed care. *Id.* at 3896:15-24.

265. Dr. Delores Falcone Tamer is a pediatric cardiologist at the University of Miami Medical School. Tamer on 10/19/2010 Final Tr. at 4494:13-23. Dr. Tamer currently has a CMS clinic, a private clinic and a clinic for the Jackson Memorial Hospital. *Id.* at 4496:8 – 4497:5. Dr. Tamer becomes aware of switching when, in checking the authorization of the primary care doctor to refer a patient to her, it turns out that primary care doctor no longer has authority to refer because the child has been switched to a different primary care doctor. *Id.* at 4531:9-18; 4532:21 – 4533:13. When such switching occurs, it usually means the procedures are postponed a month. *Id.* at 4533:14-17. Common diagnostic tests that are delayed for a month by switching are: echocardiograms and electrocardiograms which test the competency, anatomy and function of the heart. *Id.* at 4533:25 – 4434:12.

266. Dr. Thomas Schechtman is a pediatrician who practices at three offices in Palm Beach County: Palm Beach Gardens, Jupiter and Boca. Schechtman on 5/20/2010 Final Tr. at 2832:8-13; 2833:7-14; 2833:18-22. Quite frequently in Dr. Schechtman's practice Medicaid patients are, without their knowledge, switched from one primary care provider to another or from one Medicaid product to another. *Id.* at 2847:6-20. The frequency of switching in Dr. Schechtman's practice is several times a day and he has a "person in his business office who spends 50% of her time dealing with Medicaid eligibility, Medicaid

switching and issues along those lines." *Id.* at 2847:21 – 2848:4. Switching causes a number of adverse consequences on the health and well-being of the child being switched including: interrupting continuity of care and delaying check-ups and vaccinations. *Id.* at 2848:5 – 2849:8.

267. Other doctors regularly encounter switching as well. Donaldson Depo. Desig. on 10/15/2008 at 140:9 – 141:4; Knappenberger Depo. Designation on 11/20/2008 at 93:8 –94:12, 95:4-6; Ritrosky, Depo. Designation on 11/10/2008 at 97:4 – 98:2, 98:15 – 99:25; Weber Depo. Desig. on 11/6/2008 at 24:22 – 25:2; J. St. Petery Depo. Desig. on 11/11/2008 at 81:19 – 82:1; 84:22 – 85:7; W. Knappenberger Depo. Desig. on 11/20/2008 at 95:23 – 96:7, 116:15 – 117:1; Ritrosky, Depo. Desig. on 11/10/2008 at 105:5 – 106:22, 107:7-11; Knappenberger Depo. Desig. on 11/20/2008 at 115:20 – 16:9; J. St. Petery Depo. Desig. on 11/11/2008 at 104:9 – 105:21; Knappenberger Depo. Desig. on 11/20/2008 at 117:5-21; Ritrosky, Depo. Desig. on 11/10/2008 at 103:12-14, 107:16-18.

268. In the practice Dr. Louis St. Petery shares with his wife, switching is "almost an everyday occurrence." St. Petery on 12/10/2009 Final Tr. at 561:11 – 562:5; Dr. Julia St. Petery Depo. Desig. on 11/11/2008 at 108:2-12. Dr. Louis St. Petery has since 1984 served as executive director of the Tallahassee Pediatric Foundation ("TPF"). St. Petery on 12/07/2009 Final Tr. at 88:9-14. TPF provides

case management services to 7,200 children in the Tallahassee area, the vast majority of whom are enrolled in Medicaid. *Id.* at 89:15 – 89:20. Dr. St. Petery sees switching occurring with the 7,000 plus patients of TPF in even larger numbers than in his personal practice. St. Petery on 12/10/2009 Final Tr. at 561:24 – 562:5.

269. Getting a child switched back to the original primary care provider can be a time-consuming process because the system only allows a change once a month. *Id.* at 562:14 – 563:15.

4. Reasons for Switching

270. Switching is caused by a termination of eligibility and a subsequent reinstatement.

271. One way switching occurs is when DCF (the Department of Children and Families), which determines eligibility, incorrectly terminates a child's eligibility and then, realizing the error, re-establishes the child's eligibility. Since eligibility information is transported nightly from DCF's computer to ACHA's FMMIS computer system, these actions cause ACHA's FMMIS system to send a letter to the child's parent, as it does to any new Medicaid beneficiary, telling the parent that he or she must chose a plan for the child. Sometimes the parents do not receive the letters because as many as 40% of the letters directing Medicaid beneficiaries to choose a managed care plan come back as undeliverable. Brown-

Woofter on 11/8/2011 Rough Tr. at 149-151. At least in some instances when ACHA investigated examples of switching, it was not able to confirm that a choice letter was indeed sent the beneficiary. Depo. Desig. of Hamilton on 11/6/2008 at 184:9 – 186:12. Sometimes the parents do not understand the letter, perhaps because the parent does not even know the child was terminated and reinstated. St. Petery on 12/10/2009 Final Tr. at 565:10 – 566:6. In either event, the parent does not respond. So when AHCA does not hear back from the child's parent with a plan choice within the allotted time, ACHA then auto-assigns the child to a plan. Brown-Woofter on 11/8/2011 Rough Tr. at 148. By statute, 65% of auto-assignments are to Medicaid HMOs so the child is auto-assigned to an HMO which may not be a plan in which the child's pediatrician is enrolled. St. Petery on 12/10/2009 Final Tr. at 570:1-25; Plaintiffs' Demonstrative Exhibit C on Switching used with Dr. St. Petery.

272. There are multiple eligibility categories for children on Medicaid. Lewis on 10/20/2010 Final Tr. at 4649: 8-10. When a parent makes a change in the family's case "such as applying for food stamps or cash assistance, this can also cause switching". St. Petery on Final Tr. at 571:3-18. This occurs because when DCF makes such a change, even though the child does not lose Medicaid eligibility in DCF's computer system, it sometimes loses eligibility in AHCA's FEMMIS system.

273. During the course of this litigation, DCF discovered that when it deletes the Medicaid eligibility category code for a child and places the child in a new eligibility category, ACHA sometimes interpreted that change as a termination of the child's Medicaid eligibility, even though the second Medicaid category picked up immediately after the first category was terminated. Lewis on 10/20/2010 Final Tr. at 4645:15 – 4646:22. To avoid that situation, instructions were given to DCF case workers to close an old category and open a new category the same time so that ACHA wouldn't confuse a category change with an eligibility termination. Lewis on 10/20/2010 Final Tr. at 4646:23 – 4647:6. That advice was memorialized in a 2009 Memorandum called Minimizing Medicaid File Errors, sent by Mr. Lewis to DCF staff. DX 178 at DEFENDANTS015019 (re Changing Assistance Groups"); DX 175 at 3 (second to last bullet); Lewis on 10/20/2010 Final Tr. at 4653:24 – 4654:6. In fact, DCF not only learned how changes in eligibility categories in its FLORIDA computer system could affect a child's Medicaid eligibility in ACHA's FMMIS system during this litigation, it learned that ***because of*** this litigation. Lewis on 11/29/2011 Rough Tr. at 12-13.

274. DCF has not taken any steps to measure what impact the April 29, 2009 directive in PX 178 has had on "switching." Lewis on 10/20/2010 Final Tr. at 4654:7-9.

275. Switching is related to interruption of eligibility because every time eligibility is interrupted and restored, the patient is required to request a plan and if the patient doesn't, a switch may occur. McCormick on 8/12/2010 Final Tr. at 4148:3 – 4149:14. Switching can occur even following a proper termination and subsequent reinstatement if parents or guardians do not receive or respond to the letter directing them to choose a plan for their child.

276. The requirement that children whose eligibility has been terminated and then within 60 days reinstated are to be assigned back to the plan they originally chose is not always followed, leading to more "switching." McCormick on 8/12/2010 Final Tr. at 4148:3 – 4149:14.

5. Baby Of Process

277. A "presumptively eligible" newborn or PEN baby is a child whose Medicaid eligibility is presumed by DCF based on the pregnant mother's Medicaid eligibility. Lewis on 10/20/2010 Final Tr. at 4650:12-21. The purpose of "presumptive eligibility," also known as the "baby of" process, is to make a child eligible for Medicaid as soon as possible. St. Petery on 12/10/2009 Final Tr. at 602:3-15. It is called the "baby of" process because it describes the practice of a pregnant mother applying to DCF for a Medicaid number for her unborn child. *Id.* at 601:1-11. And when the child is born, the Medicaid number is supposed to be activated. *Id.* at 602:16 – 603:1.

278. Dr. St. Petery has observed three problems with the "baby of" process; (1) the mother is not provided with the opportunity to register in the first place; (2) even if the mother pre-registers, there are delays in activating the child's Medicaid number; and (3) children are sometimes issued two Medicaid numbers which later becomes problematic because, when DCF realizes there are two numbers, it cancels one number and if that is the one the physician has been using, all the services billed are denied even though the child is actually eligible. *Id.* at 603:2-25.

279. Since, under the applicable periodicity schedule, children are supposed to have a visit when they are five days old, the failure of the DCF promptly to activate the child's Medicaid eligibility can cause a delay in the child obtaining care or in the provider getting paid. *Id.* at 604:1-14; 605:19-22. Primary care providers find that the activation process for PEN babies is often delayed. Isaac on 8/11/2010 Final Tr. at 3892:16 – 3893:24; Schechtman on 5/20/2010 Final Tr. at 2849:9 – 2850: 7. Cosgrove on Final Tr. on 5/19/2010 at 2584:6 – 2586:15.

280. Carol McCormick is the administrator and nursing director of TPF. McCormick on 8/12/2010 Final Tr. at 4110:9-19. TPF had about 7,400 children enrolled at the time of her testimony of which 7,300 were enrolled in Medicaid. *Id*. at 4114:22-25. Nurse case managers at TPF frequently encounter newborns presumptively eligible for Medicaid whose Medicaid is not activated and where

children's eligibility has been terminated in less than a year's time. *Id.* at 4118:8-24. In the fall of 2008, when a subpoena for documents was served on TPF, Ms. McCormick instructed her staff to provide her with all the charts of children that the nurses were then currently experiencing eligibility problems with. In response to this request, 90 charts were provided to her. *Id.* at 4120:8 – 4121:20. Twenty-four of those charts involved an issue of continuous eligibility, 15 concerned presumptive eligibility, and 47 were cases in which the parent's choice of health care plan had not been implemented or had been switched; 20 files with other problems. *Id.* at 4121:21 – 4122: 25. Some files reflected more than one problem. *Id*. at 4123:1-5.

281. Until 2008, under the Baby Of process, a mother and her baby each had a separate personal identification number and also a separate case number. In 2008, DCF reprogrammed its computers so that when a pregnant woman applied for Medicaid for herself and her unborn child, both the mother and the child were assigned to the same "case" number, even though the mother and eventually the child would each be assigned a separate Medicaid personal identification number. DCF made this change because under the old system babies were sometimes given two personal identification numbers because of the difficulty of matching the Baby Of application with the actual new born child. Poirier on 10/5/2011 Rough Tr. at 39; 43; *see also* PX 738. And as soon as DCF found out there were two numbers

for a child, it would cancel one. St. Petery on 12/10/2009 Final Tr. at 603:18-25. However, if a number that a provider was billing under was the number that was cancelled, AHCA would deny payment for the services billed under that number. *Id.*

282. The new policy was set forth in a July 2008 memorandum to DCF workers. PX 738. Under that policy, workers must manually input data at 12 different steps. Poirier on 10/5/2011 Rough Tr. at 43-45. If a worker makes a mistake in that manual process, made necessary because DCF has an old computer system that requires complicated work-arounds, a child may be improperly terminated. *Id.* at 45-47, 68-69. Less than a year after that memorandum was issued, DCF changed part of the policy again. *Id.* at 48-51; DX 178.

283. DCF's new procedure has not resolved the problems with the Baby Of process. St. Petery on 12/10/2009 Final Tr. at 607:2 – 607:9. Moreover, the change of placing newborns into the mother's "case" has the potential to increase the amount of switching because it increases the chances that a change in the mother's eligibility category at DCF will trigger ACHA's FMMIS system to deem the child's eligibility cancelled. St. Petery on 2/2/2012 Rough Tr. at 82-83.

284. Despite the issuance in 2009 by DCF of a memo directing that babies be kept in their original Medicaid category for 13 months regardless of household

circumstances, interruptions of eligibility for such children continue to occur all the time. *Id.* at 136.

285. Primary care providers continue to see problems with switching, and terminations in violations of the right to continuous eligibility. Cosgrove on 1/31/2012 Rough Tr. at 154-155; Silva on 1/19/2012 Rough Tr. at 149-150.

6. Legal Conclusions

286. Violations of continuous eligibility deprive the children who are improperly terminated from Medicaid of their rights to EPSDT care and any needed follow-up care under § 1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and also their rights to medical care under the Reasonable Promptness and Equal Access provisions of Title XIX.

287. The improper switching of children from one provider to another without their parents' knowledge or consent deprives the children who are improperly switched of their rights to EPSDT care and any needed follow-up care under §1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and also their rights to medical care under the Reasonable Promptness and Equal Access provisions of Title XIX.

288. The failure of ACHA or DCF promptly to respond to notification that presumptively eligible children (*i.e.* "babies of") have been born by promptly making those babies' Medicaid eligibility operative, deprives those babies of their

rights to EPSDT care and any needed follow-up care under §1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and their rights to medical care under the Reasonable Promptness and Equal access provisions of Title XIX.

**C. Provision/Utilization Of Primary Care (*e.g.*, EPSDT)**

289. The purpose of the Early Periodic Screening, Diagnosis, and Treatment Program ("EPSDT") is to identify and correct medical conditions in children and young people before the conditions become serious and disabling; to provide entry into the health care system and access to a medical home for each child; and to provide preventative/well child care on a regularly scheduled basis. PX 31 at AHCA00963753; St. Petery on 12/10/2009 Final Tr. at 518:11 – 519:8.

290. Medicaid eligible children are entitled to check-ups from birth through age 20 in accordance with Florida's periodicity schedule. They should receive check-ups at 2 to 4 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and then once per year from 2 to 6, one at 8, one at 10, and one per year from 11 to 20. A check-up includes a comprehensive medical history, a dental screening, vision screening, hearing screening, appropriate immunizations, and other services. PX 31 at AHCA00963754 – AHCA00963757; St. Petery on 12/10/2009 Final Tr. at 519:9 – 522:6.

291. Children who do not receive check-ups are more than twice as likely to require emergency room care. PX 31 at AHCA00963773; St. Petery on

12/10/2009 Final Tr. at 522:11-23. As Defendants have stated in one of their Legislative Budget Requests ("LBR"), more child checkups "may increase the early identification of medical conditions before they become serious and disabling." PX 95.

1. The CMS 416 Reports

292. More than 380,000 children on Medicaid in Florida who should have received at least one screening examination according to Florida's periodicity schedule did not receive any preventative care in the federal fiscal year ending on Sept. 30, 2007. *See* PX 8 at AHCA0000087 (compare line Line 9, the total eligibles who should have received at least one initial or periodic, with Line 10, the total eligibles receiving at least one initial or periodic screen); Snipes on 12/9/2009 Final Tr. at 369:4 – 370:8. The 380,000 figure represents, not simply the number of children enrolled in Medicaid who did not receive a well child check-up during the year, but rather the number of children who were expected to receive a check-up – given the length of their enrollment in Medicaid and the periodicity schedule for children their age – but did not receive a screen. Snipes on 1/8/2010 Final Tr. at 1261:7 – 1264:19; PX 8 at AHCA0000087; PX 25 (see instructions for line 4 and line 8).

293. Those figures come from a formal report, the CMS 416 report, which Florida and all other states must submit annually to the federal Centers for

Medicare and Medicaid Services. *See* 42 U.S.C. 1396a(a)(43)(D) and Snipes on 1/7/2010 Final Tr. at 1146:25 – 1147:7. The report for the federal fiscal year ending Sept. 30, 2007 is the most recent CMS 416 report in the record.

294. This figure is expressed in The CMS 416 report as a "participation ratio" – the total eligibles receiving at least one initial or periodic screen divided by the total eligibles who should receive at least one initial or periodic screen. PX 25 (see instructions for line 10). For the federal fiscal year ending on September 30, 2007, Florida had a participation ratio of 68%. PX 8 at AHCA0000087; Snipes on 12/09/2009 Final Tr. at 370:10-14. That means that 32% of the children enrolled in Medicaid who were expected to receive at least one preventative screen did not receive any. The federal government has a goal of an 80% participation ratio. Snipes on 12/09/2009 Final Tr. at 370:15-17.

295. Those percentage of children in Medicaid HMOs who received a well child check-up was even lower. For the fiscal year ending Sept. 30, 2007, the combined participation ratio for all Florida Medicaid HMOs was 55.10%. PX 16.

296. While there is some criticism of the methodology underlying the CMS 416 report, and some evidence that the data underlying the reports are not complete, the CMS 416 report is widely considered the best data source available regarding the number of children on Medicaid who receive preventative care as well as the number of children eligible for preventative care through Medicaid but

who do not receive such care. The CMS 416 reports are considered reliable by the federal government and by the health services research community. Flint on 1/24/2012 Rough Tr. at 154.

297. Defendants' expert, Catherine Sreckovich, and other defense witnesses contend that the CMS 416 reports under report the care delivered to children in Florida. They claim the 416 reports do not include some well child check-ups because: (1) There is a time lag in reporting some claims data; (2) Some doctors provide child health check-up services but then bill for those services under another CPT code; and (3) Encounter data from HMOs is not complete. These contentions are speculative and not supported by the record. *See id.* at 154-155.

298. As to potential delay with reporting claims, the federal fiscal year ends on September 30, and the CMS 416 report is not due until April of the following year, providing at least five months for submission of claims or encounter data for services provided on September 30, and proportionally more, for services provided earlier in the year. Flint on 1/24/2012 Rough Tr. at 162. While physicians compensated on a fee for service basis have up to one year from the date of service to submit a claim for reimbursement to AHCA, there is no evidence that physicians wait to submit their claims, and it would be economically irrational for them to do so. *Id.* at 161. Tellingly, while AHCA could submit an amended CMS 416 report to account for any claims omitted during the initial submission because of a so-

called "claims lag," AHCA has never done so, though it is in its clear interest, especially during this litigation, to do so if that would improve its performance on the CMS 416 report. Snipes on 12/9/2009 Final Tr. at 368:15-21; Snipes on 1/8/2010 Final Tr. at 1275:23-25, 1276:7-15; Flint on 1/24/2012 Rough Tr. at 161.

299. For physicians to provide well child screens and then bill under an alternative CPT code would be economically irrational because almost all the alternative codes pay less than the CHCUP codes. Flint on 1/24/2012 Rough Tr. at 155-58.[27] Often the compensation for the physician is twice as high under the EPSDT code as under the alternative codes Ms. Sreckovich claims the doctors actually billed. *Id.* at 158. In any event, Defendants have provided no evidence that such miscoding is systemic or widespread. Ms. Sreckovich admitted she could not quantify any such alleged coding errors. Sreckovich on 1/10/2012 Rough Tr. at 43-44.

300. Defendants also claim that the CMS 416 reports under-report the well child check-up services provided because the encounter data that Florida HMOs provide to AHCA is incomplete and does not capture all the well child check-ups performed by the HMOs. There is no quantification, however, of any significant problems with the reporting of encounter data in Florida or that any such alleged

[27] While one new child codes, 99205, pays more than well child codes, a new child code can only be used once per provider per child.

problems led to under reporting on the CMS 416 report for the federal fiscal year ending on September 30, 2007.

301. Tellingly, Defendants do not rely upon any Florida specific studies or analyses to support the assertions that Florida HMOs encounter data suffers from under reporting or that such under reporting has lead to failure to report well child checkups on the CMS 416 report. The 2007 GAO report, Concerns Remain Regarding Sufficiency of Data for Oversight of Children's Dental Services, noted that the quality and completeness of encounter data had improved since 2001. Flint on 1/30/2012 Rough Tr. at 103-104.

302. Florida HMOs, as part of their contractual requirements with AHCA, are required to provide a mini CMS 416 report. Brown-Woofter 10/26/11 Rough Tr. at 43. They are also required to have that report audited, and to provide a certification that the information on that report is true and correct. Brown-Woofter on 10/18/2011 Rough Tr. at 121-122; Boone on 10/22/2008 Depo. Desig. at 153:10-18. Defendants have not provided any basis for calling into question the accuracy of the audited results, which are incorporated into the final 416 reports. In fact they tout the accuracy of other reporting performed by the Medicaid HMOs and do not provide any basis for singling out the HMOs 416 reports as inaccurate or unreliable. Flint on 1/24/2012 Rough Tr. at 154-155.

303. If anything, as explained by Dr. Tom Darling, the results in the 416 reports overstate the number of children who get care, especially with respect to the screening ratios that compare the total number of healthy kid checkups to the number of expected examinations. Dr. Darling is an associate professor at the University of Baltimore's School of Public Administration and a director of government technology for the Schaefer Center for Public Policy. Darling on 1/6/2010 Final Tr. at 813:24 – 814:9. He has a Ph.D. in public administration and policy from the University of Albany. *Id.* at 815:21 to 816:6. He had served as an expert witness in other cases involving children's Medicaid and he has consulted the State of Maryland's state agencies. *Id.* at 817:3 to 819:24. He is qualified and was accepted as an expert, *id.* at 819:25 – 821:10, and I again accept him as an expert and find his testimony to be credible.

304. First, Florida does not have separate encounter data that would allow it to ensure that children are not double-counted if they move between two HMOs in a year or between fee-for-service and an HMO. That means Florida's reported participation rate is likely inflated as a result of double counting some children. *Id.* at 852:13 – 854:5; 873:14 – 876:16.

305. Second, the federal instructions for compiling the CMS-416s result in an over-reporting of screening ratios for the "less than one" and "one to two year" age groups because the periodicity schedule the periodicity schedule does not

require screens at set intervals, but the CMS reporting requirements assume that it does. Darling on 1/6/2010 Final Tr. at 850:5-17, 857:25 – 859:10. The screening ratio that is reported by Florida is 28.92% higher than what it should be because the error in reporting results in the expected number of screens being too low. *Id.* at 859:11 – 865:21; PX 461 at 32-33.

306. Third, because screenings "flow with the child," that is, are reported in the age category that corresponds to the child's age at the end of the federal fiscal year, there is a 45% over reporting for the 1-2 year category. Darling on 1/6/2010 Final Tr. at 866:12 – 868:15.

307. Once the data are adjusted to account for Dr. Darling's recommended corrections, the screening ratios go down to .62, .61, .62, .66, and .68 for 2003 to 2007 instead of .67, .66, .73., .78, and .81. *Id.* at 869:5-20; PX 461 (Table 2-8). These results reflect that Florida children on Medicaid consistently receive substantially fewer screens than called for under the state periodicity schedule.

308. Defendants contested these statistics. In her analysis, Defendants' expert, Ms. Sreckovich purported to analyze the well child care that Medicaid beneficiaries in Florida received by combining the total number of well child examinations provided to children on Medicaid with certain sick child or "problem-oriented" examinations. Sreckovich on 1/10/012 Rough Tr. at 35.

309. There are serious problems with this analysis. First, the credibility of Ms. Sreckovich and her report were undermined by the fact that her initial report wrongly confused "visits" with "services." Sreckovich 1/10/2012 Rough Tr. at 23-24. She made this mistake even though her own work sheets labeled this same column as "services", not "visits." *Id.* 26-27. She made the identical error in her analysis of dental care provided to children on Medicaid. *Id.* Because, as Sreckovich admitted, it is customary for multiple services to be performed during a child's visit to a doctor or dentists, *id.* at 23, the result was significantly to overstate how much care children in Medicaid were receiving. *Id.* 30-35. She did not learn of this error until she read Dr. Darling's rebuttal report. *Id.* at 23-24. She does not know how she made such a significant error that occurred at several points in her report. *Id.* at 26-27. She also admitted that she did not realize that her analysis, which purported to include only claims data, also improperly included some encounter data, until she read Dr. Darling's rebuttal report. *Id.* at 22-23. If these errors were not detected by Dr. Darling in his responsive report, highly misleading information would have been presented during trial. I find Ms. Sreckovich's error in repeatedly mis-categorizing services, as visits, an error that made it seem as if children on Medicaid were receiving much more care than was the case, undermines her credibility.

310. Second, even in her revised tables purporting to correct two of the errors noted by Dr. Darling, Ms. Sreckovich continued to combine the total number of well child examinations with certain sick child examinations. She calls the combined services "preventative assessment and evaluation services," a made up category without any basis in the CPT codes, which includes 7,000 codes and 5,000 adjustors and modifiers. Flint on 1/24/2012 Rough Tr. at 163. She justified that unprecedented approach by saying that for those sick child visits, the children received at least some components of a well child exam, even though they did not receive all components of a well child exam. Sreckovich on 1/17/2012 Rough Tr. at 109. She acknowledged that she is not aware of any peer review study that has endorsed such an approach. Sreckovich on 1/10/2012 Rough Tr. at 38-40. Dr. Darling, who works extensively with CMS 416 reports, has never seen anyone else combine well and sick child visits, as Ms. Sreckovich did. Darling on 01/23/2012 Rough Tr. at 40-42.

311. Plaintiffs' experts, Drs. Flint and Darling, criticized that approach. They said a sick visit was usually focused around a particular presenting condition, and that there was no evidence that during such visits, children receive preventative care and that such visits were not a substitute or proxy for well child visits. Darling on 1/23/2012 Rough Tr. at 35-38; Flint on 1/24/2012 Rough Tr. at

163-67. Dr. Flint sharply criticized Ms. Sreckovich's analysis. Flint on 1/24/2012 Rough Tr. at 163-64.

312. I agree that sick child visits are not a proxy or substitute for well child visits and do not place any weight on this part of Ms. Sreckovich's analysis.

313. Ms. Sreckovich, in her analysis, also looked at the average number of visits per Medicaid child. Not only did she include both well child visits and certain sick child visits, she did not cap the maximum of visits per child at the number set by Florida's periodicity schedule, as recommended by Dr. Darling; rather she included all visits, no matter how many there were. Darling on 1/23/2012 Rough Tr. at 37; Sreckovich on 1/10/2012 Rough Tr. at 46-47.

314. Because of Ms. Sreckovich's methodology, sick or ill child care provided to certain children can make it seem as if other children obtained care, when in actuality that did not. Sreckovich on 1/12/212 Rough Tr. at 46-47. Both Dr. Darling and Dr. Flint are strongly critical of Ms. Sreckovich's averaging approach, which they clam presents a misleading picture of how much care children on Medicaid are receiving. Darling on 1/23/2012 Rough Tr. at 36-38; Flint on 1/24/2012 Rough Tr. at 163-65. I agree that when it comes to determining

the scope of preventative care provided to children in Florida, an average approach is misleading, and do not place weight on it.[28]

315. The consensus view among health care researchers and others in the field is that the CMS 416 reports are reliable. Flint on 1/30/2012 Rough Tr. at 105-06. The CMS 416 report is the "best yardstick we have now" and is "what CMS relies on." Crall on 1/26/2012 Rough Tr. at 155. I agree that CMS 416 reports are reliable and an important indicator of access to care. In addition, I find Dr. Darling's testimony persuasive and conclude that, directionally, the 416 Reports more likely than not overstate rather than understate the amount of EPSDT screening services actually received.

2. HEDIS Reports

[28] As part of her analysis, Ms. Sreckovich focused on the care provided to the named plaintiffs. While some of the named plaintiffs with chronic medical conditions received a significant amount of specialty care, they did not always receive all their well child check-ups. For instance, J.W. did not receive numerous well child check-ups, according to Ms. Sreckovich's own analysis. Her analysis shows he should have received 5 well child visits during certain years when he was enrolled in Medicaid, but only received one such visit. DX 410 at Table 2B. Similarly, J.S. should have received 6 well child visits but only received three. DX 418 at Table 2B. And S.M. did not receive his 18-month well child check-up on time because he had been switched. *See supra* ¶¶ 121-128. N.A. was switched from his pediatrician in Tallahassee to a pediatrician in another county, and was able to receive a timely sick child visit, only because his pediatrician was willing to treat him, even though N.A. was no longer assigned at that point to the pediatrician and even though the pediatrician risked not being paid for the visit. *See supra* ¶¶ 169-179.

316. The CMS 416 report is not the only report that shows children enrolled in Florida Medicaid do not receive the primary care to which they are entitled under federal law and sometimes do not receive any primary care. AHCA requires its Medicaid HMOS, in accordance with 42 C.F.R. Section 438.358, to collect and report on certain performance measures to the state on an annual basis. PX 733 at 1-1. AHCA chose to use Healthcare Effectiveness Data and Information Set ("HEDIS") measures, a set of performance data that is broadly accepted in the managed care environment as the industry standard to compare and measure health plan performances. *Id.* "AHCA expects its contracted HMOs to support health care claims systems, membership data, provider files, and hardware/software management tools, which facilitate accurate and reliable reporting of HEDIS measures." *Id.* The agency contracts with Health Services Advisory Group, its external quality review organization, to evaluate how Florida Medicaid's HMOS perform against certain HEDIS measures. Brown-Woofter on 11/8/2011 Rough Tr. at 12; PX 733 at 1-1.

317. All Florida HMOs were required to have their results confirmed by a HEDIS compliance audit. PX 733 at 2-4. The results are within a plus or minus 5 points sampling error at the 95 percent confidence level. *Id.* HEDIS measures track the care provided to beneficiaries who are continuously enrolled in Medicaid

for a certain period of time – typically eleven months in a year. Crall on 2/7/2011 Final Tr. at 5213:2-6.

318. For all the HEDIS measures at issue in this action, AHCA allowed HMOs to determine their results using the hybrid method where claims records and administrative data is supplemented by a chart review for beneficiaries for whom encounter data is missing. Brown-Woofter on 11/8/2001 Rough Tr. at 24-26. Thus, the hybrid method does not depend on the completeness of the encounter data. *Id.*

319. All the HEDIS measures involve an apples-to-apples comparison because Florida Medicaid HMOs are compared to Medicaid HMOs nationally. Brown-Woofter on 11/8/2001 Rough Tr. at 20-21. One HEDIS measure tracks the number of children who do not receive any well child screens in the first fifteen months of their lives.

320. Of the 12 Florida HMOs operating in non-Reform counties, 11 HMOs scored below the national median, and six scored below the low performing level. Brown-Woofter on 11/8/2011 Rough Tr. at 19. For Healthy Palm Beaches, 5.9 percent of the infants received no well child screens in the first 15 months of their lives; for Preferred Medical Plan, Inc. percent; for Humana Family c/o Human Medical Plan, Inc. 6.7 percent; for Vista Health Plan Inc. – Vista South Florida 7.6 percent; for Vista Health Plan, Inc. – Buena Vista Medicaid 7.7 percent; and for

Jackson Memorial Health Plan 9.2 percent. PX 733 at 3-4. For the following year, 2007, for six of the HMOs, 5 percent or more of the infants received no well child checkups in the first fifteen months of life. DX 361 at DEFENDANTS022774. These figures are extremely troubling as they indicate that many infants received no preventative care at all.

321. While well child check-ups are important for children of all ages, "[t]he need for appropriate immunizations and health checkups has ever greater importance and significance at younger ages. If undetected in toddlers, abnormalities in growth, hearing, and vision impact future learning opportunities and experiences. Early detection of developmental difficulties provides the greatest opportunity for intervention and resolution so that children continue to grow and learn free from any health-related limitations." PX 733 at 3-1.

322. Other HEDIS measures also show that in both reform and non-reform counties children on Medicaid HMOs receive less primary care than children enrolled in the average HMO nationally. All 13 Medicaid HMOs operating in non-reform counties fell below that national mean in 2007. DX 361 at DEFENDANTS022775. Five of them had results that clustered around the 25th percentile, and eight of them had results around the 10th percentile. *Id.* In Reform counties, for the same year, seven of nine Florida Medicaid HMOs fell below the national mean. DX 334 at DEFENDANTS021293.

323. As for adolescent preventative care, the percentage of enrolled members 12 to 21 years of age who had at least one well child visit with a primary care provider or an OB/GYN practitioner during the measurement year, Florida Medicaid HMOs again generally ranked below the national mean of 43.6 percent. DX 361 at Defendants 022757. Five of the 13 HMOs in Florida operating in non-Reform counties were at or above the mean, eight were below it, with six clustered near the 25th percentile and two near the tenth percentile. *Id.* In Reform counties, the results were similar. Six Medicaid HMOs scored above the national mean; nine were below it. DX334 at DEFENDANTS021277.

324. Another HEDIS study looked at the well care provided to children between 11 to 20 years of age and found that only 19.6 percent of the children overall received even one well child visit during the study period; PX 689 at Summary of Findings; Brown-Woofter on 11/9/2011 Rough Tr. at 14.

325. Florida Medicaid HMOs also scored extremely low in terms of the percentage of pregnant women who received prenatal care. Some percentage of those women are teenage mothers on Medicaid, and for them prenatal care is a type of primary care. For seven Medicaid HMOs, more than one-third of the women did not receive even a single prenatal visit during the study period. DX 361at DEFENDANTS022772.

326. The HEDIS data show that on a number of measures of preventative child care, Florida's HMOs, both in reform and non-reform counties, rank below and often far below the national mean for Medicaid HMOs.

3. Primary Care Providers Participation in Medicaid.

327. There is a shortage of pediatricians in Florida. *See* DX 290c at 1. As a matter of supply and demand, that shortage means pediatricians have a greater ability, if they chose to do so, to treat higher paying patients and either not treat Medicaid patients at all or limit the number of Medicaid patients they treat. The shortage of pediatricians in rural areas is especially acute. There are 10 Florida counties with no pediatricians, and seven more counties with only one pediatrician. DX 290c at 2-7; Swanon Rivenbark on 11/15/2011 Rough Tr. at 50. Again, as a matter of economics, that shortage, disadvantages children on Medicaid who must compete with higher paying patients for the services of pediatricians in other counties.

328. The number of children on the Medicaid rolls has grown sharply, but the number of pediatricians willing to treat them has not. The number of Florida children enrolled in Medicaid increased from 713,540 as of October 1998 to about 1.2 million as of October 2005, then dipped slightly as of October 2007 only to rise again to 1,272,342 as of December 2008, and then jumped to 1,517,606 as of October 2009, as more children came on the Medicaid rolls as a result of the

economic downturn. PX 682 at FL-MED 07816; DX 262; Snipes on 1/8/2010 Final Tr. at 1274:15 – 1275:5. As of 2011, the enrollment had soared again, this time rising to 1.7 million children. Lewis on 11/29/2011 Rough Tr. at 48-49. Thus, the percentage of children on Medicaid has increased by more than 33% in just under three years, from December 2008 to November 2011. There is no indication that the number of primary care providers has increased at all, let alone proportionately, thus placing an increased demand on existing providers. *See* PX 682 at FL-MED 07816; DX 262. In fact, Florida has an overall shortage of physicians per 100,000 residents, compared to the United States as a whole, PX 742 at DEFENDANTS026980, and a shortage of pediatricians, DX 290c; PX 742 at DEFENDANTS026979 thereby placing more demand on Florida physicians to treat children on Medicaid, even though Medicaid pays far less than other payors.

329. More than twenty percent of pediatricians in Florida were accepting no new Medicaid patients, according to a 2009 physician workforce survey. PX 742 at DEFENDANTS027039; Swanson Rivenbark on 11/15/2011 Rough Tr. at 40-41. For family practitioners, more than 60 percent were not accepting a single new Medicaid patient. *Id.* That is significant because family medicine

practitioners provide well care for older children. St. Petery on 2/9/2010 at 1514:9-13.[29]

330. In addition, numerous pediatricians limit the number of children on Medicaid they will accept. *See* Cosgrove on 5/19/2010 Final Tr. at 2553:15 – 2557:12 (limiting practice for financial reasons to about 20 percent children on Medicaid)[30]; Silva on 5/20/2010 Final Tr. at 2768:23 – 2775:23 (only two of the non-for-profit company's seven pediatric sites accept new children on Medicaid, and for Dr. Silva's site, the company has limited the number of new Medicaid patients by (1) not accepting Medicaid HMOs; (2) only accepting new patients under 5; and (3) further limiting new patients to newborns, siblings of existing patients, or existing patients who go on Medicaid; about 20% of her patients are on Medicaid compared to 50% in 2001); Isaac on 8/11/2010 Final Tr. at 3855:13-17; 3856:4-12; 3861:5-25 (limits number of Medicaid patients he accepts; doesn't take any Medicaid HMOs; approves new MediPass patients on a case by case basis;

[29] The contrast between the percentage of physicians who accept no new Medicaid patients (46%) and the percentage who accept no new Medicare patients (only 22%) is stark and illustrates the inadequacy of the Medicaid reimbursement rates. PX 742 at DEFENDANTS027033, DEFENDANTS027037.

[30] In 2012, Dr. Cosgrove's practice had about 29 to 32% Medicaid patients, and she had loosened some of the restrictions on taking new Medicaid patients because the practice had hired a new nurse practitioner and because, as a result of the end of the space shuttle program at the Kennedy Space station and the ensuing loss of jobs, a number of existing patients went from having private insurance to being on Medicaid, and Dr. Cosgrove and her partner tried to accommodate them. Cosgrove on 1/31/2012 Final Tr. at 158-160, 171.

about one-third of his patients are on Medicaid); Ritrowski on 11/10/2008 Depo. Desig. at 8:13 – 9:12; 11:1-11 (to remain economically "viable" practice limited number of Medicaid patients by only accepting as new Medicaid patients (1) siblings of existing patients; (2) existing patients who lose private insurances; and (3) limited number of newborns); Orellana on 11/23/2008 Depo. Desig. at 99:24 – 100:11 (had to stop accepting Medicaid patients in his Gainesville but not his Lake City location).

331. The principal reason pediatricians do not participate in or limit their participation is Medicaid's low reimbursement rates. Flint on 8/3/2010 Final Tr. at 2949:21 – 2950:5("The fundamental issue that drives participation, that determines physician, physicians' decisions to participate in the program at all, or to limit their participation, is the rate of reimbursement."); Cosgrove on 5/19/2010 Final Tr. at 2554:19 – 2555:2; Ritrowski on 11/10/2008 Depo. Desig. at 11:1-11 (limited number of Medicaid patients to remain economically "viable"). I make further findings on this issue in Section VI. F, *infra*.

332. Defendants have pointed to the availability of care at county health departments and federal qualified health centers. County health departments, while they provide some primary care, are not an alternative to private pediatricians. The county health departments (CHDs) collectively only employed 27 pediatricians and no pediatric subspecialist as of 2009. Swanson Rivenbark on

11/15/2011 Rough Tr. at 57-58. Federal qualified health centers (FQHCs) had just 32 pediatricians collectively and one pediatric subspecialist. *Id.* Moreover, all well child visits provided by CHDs and FQHCs are included on the CMS 416 report. Crall on 2/8/2011 Rough Tr. at 83-84. There is no reason to believe CHDs will provide increasing care in the future. Indeed, the Florida Legislature sliced $30 million from the budget for the CHDs as of July 2011, leading to 300-400 positions being cut at the CHDs. Sentman on 10/6/2011 Rough Tr. at 11-13.

4. Child Health Check-Up Rate Increases

333. An increase in the reimbursement rate for well child check-up examinations translated directly into an increase in the number of children receiving well child check-ups. In 1995, AHCA increased the reimbursement rate for well child check-ups "from $30 to $64.82, and the participation rates increased from 32 percent to 64 percent." PX 734. AHCA has made that same assertion repeatedly in formal budget submissions to the governor and Legislature, *see* PX 734, PX 92, PX 93, PX 95, and in internal legislative budget requests, PX 94, PX 96, PX 702, PX 703. *See also* DX 600.

334. AHCA highlighted the effect of the 1995 well child check-up rate increase on the participation rate in proposing a child health check-up rate increase from $71.59 to $90.97 for the 2007-2008 budget year. Williams on 10/13/2011 Rough Tr. at 88-89; PX 734. AHCA predicted that same pattern would hold in the

future. "Increasing the Child Health Check-up reimbursement rate will increase access to service, which will increase the early identification of medication conditions before they become serious and disabling, thereby decreasing future costly treatment services." PX 734. AHCA noted that since 1995 provider fees for well child check-ups "have increased only a few dollars due to the Resource Based Relative Value System" and said, "An increase will also more accurately reflect the cost of providing and documenting this comprehensive, preventive service and will encourage provider participation and retention in the Child Heath Check-Up Program." *Id.*

335. In 2007, that same proposal was one of AHCA's top three priorities. PX 720; *see* also PX 92; Snipes on 12/9/2009 Final Tr. at 387:10 – 388:12; Snipes on 1/7/2010 Final Tr. at 1094:24 – 1095:10. Again, the agency told the Governor and Legislature that increasing the Child Health Check-Up "**will increase access to service**, which will increase the early identification of medical conditions before they become serious and disabling, thereby decreasing future costly treatment." PX 92 (emphasis added); Kidder on 5/19/2010 Final Tr. at 2512:4 – 2514:13; Kidder on 10/3/2011 Rough Tr. at 28.

336. While continuing to support legislative budget requests to increase the child heath check-up fee, AHCA subsequently changed the language to indicate that a fee increase "may," not will "increase access to services, which may increase

the early identification of medical conditions." PX 96; *see also* DX 600. That change was made during the course of this litigation and was not based on any study or formal analysis. Kidder on 5/19/2010 Final Tr. at 2519:21 to 2520:5. Dyke Snipes, who was head of the Medicaid program for AHCA from February 2008 through September of 2009, never reached a different conclusion as Medicaid director than that set forth in the "will increase" language. Snipes on 12/9/2009 Final Tr. at 351:3-9; 382:11-24.

337. Even with the modified language, however, the LBRs continued to say: "In 1995, there was a fee increase from $30 to $64.82 and the CHCUP participation rate increased from 32 percent to 64 percent." PX 96; *see also* DX 600. The Agency used that same language in LBRs for five consecutive years. Kidder on 10/3/2011 Rough Tr. at 33-35. Two senior level agency administrators testified in deposition that the statements in the 2007 final agency legislative budget request regarding a proposed increase in reimbursement for child health check-ups were true and correct. One was Beth Kidder, who testified in 2008, three years after this action began. Kidder on 10/3/2011 Rough Tr. at 28-30. Kidder acknowledged her prior testimony at trial, including her testimony that the language in the LBR was meant to indicate "causation, a causative effect here, that if you increase the rates, you will increase physician participation and in turn that will result in more kids receiving checkups." *Id.* at 29.

338. The second witness was Melanie Brown Woofter who testified in November of 2008, again as an agency designee under FED. R. CIV. P. 30(b)(6), at the very close of discovery, that the following statement was true and correct: "In 1995, there was a fee increase from $32 to $64.82 and the CHCUP participation rate increased from 32 percent to 64 percent." Brown-Woofter on 11/9/2011 Rough Tr. at 2-3; PX 96.

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339. At trial, Ms. Kidder changed her testimony when she was called in defense's case in chief, but not when she was called as an adverse witness in plaintiffs' case, and suggested that the 1995 fee increase from $32 to $64.82 did not cause the increase in the participation rate from 32 percent to 64 percent because the fee increase did not lead to an immediate increase in the participation rate and because she asserted that the increased participation rate might have resulted from other factors, such as better reporting by Medicaid HMOs. Kidder on 6/1/2011 Rough Tr. at 118-19. She amended her views based on information she was provided by defense counsel after testifying in May of 2010 as an adverse witness in plaintiff's case. Kidder on 10/3/2011 Rough Tr. at 39-43. Ms. Brown-Woofter similarly changed her views and on redirect examination provided an

amended answer similar to Ms. Kidder's; Brown-Woofter on 11/9/2011 Rough Tr. at 122-26.[31]

340. While a 30(b)(6) witness may modify his or her testimony because it does not constitute a judicial admission, a court may consider any such change in assessing the credibility of the testimony. *See, e.g., R & B Appliance Parts, Inc. v. Amana Co., L.P.*, 258 F.3d 783, 786-87 (8th Cir. 2001); *Cont'l Cas. Co. v. First Fin. Emp. Leasing, Inc.*, 716 F. Supp. 2d 1176, 1190 (M.D. Fla. 2010); Considerable authority holds that "[u]nless it can prove that the information was not known or was inaccessible, a corporation cannot later proffer new or different allegations that could have been made at the time of the 30(b)(6) deposition." *Rainey v. Am. Forest and Paper Ass'n, Inc.*, 26 F. Supp. 2d 82, 94 (D.D.C. 1998); *see also Imperial Trading Co., Inc. v. Travelers Prop. Cas. Co. of Am.*, No. 06-4262, 2009 WL 2242380, at *9 (E.D. La. July 24, 2009) ("Numerous district courts have held that a party cannot adduce additional evidence to rebut the testimony of its Rule 30(b)(6) witness when, as here, the opposing party has relied on the Rule 30(b)(6) testimony, and there is no explanation for the difference.").

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341. Defendants' only explanation to support admission of Ms. Kidder and Ms. Brown-Woofter's undisclosed and untimely decision to contradict their prior

[31] On cross examination, she said the increase in the participation rate may have been due to increased outreach, Brown-Woofter on 11/9/2011 Rough Tr. at 4, a wholly different answer than that elicited by her counsel on redirect.

testimony is that they had further time to scrutinize certain legislative budget requests. However, Ms. Kidder was deposed on August 27, 2008, more than two and one half years after this action commenced, and Ms. Brown-Woofter was not deposed until November 24, 2008. Defendants had adequate time and a duty to prepare these witnesses on the designated topics prior to their 30(b)(6) deposition.

342. I find the statements in AHCA's LBRs, repeated over five years with different secretaries and staff in place and repeatedly reported to the Governor and Florida Legislature, to be credible and demonstrate that AHCA believed there was a cause and effect relationship between a significant increase in the reimbursement rates for well child check-ups and the percentage of children eligible for Medicaid who received a well child checkup. I find Ms. Kidder and Ms. Brown-Woofter's trial testimony, while it may call into question whether ACHA believed there was a direct linear relationship, does not credibly call into question whether AHCA believes there is a cause and effect relationship.

5. AHCA's Reports and Defendants' Lay Opinion Testimony

343. Several defenses witnesses – especially Ms. Sreckovich, Ms. Kidder, and Ms. Brown-Woofter – testified regarding the various processes AHCA has in place to monitor and evaluate primary care providers enrolled in Medipass and managed care organizations.

344. While AHCA devotes considerable resources to monitoring, that monitoring does not demonstrate that children are receiving the care to which they are entitled under federal law for three fundamental reasons. First, though there is extensive testimony regarding the monitoring process in the record, there is very little in the record about the substantive results of that monitoring process. The mere fact that AHCA does monitoring is hardly probative as to whether children are receiving care. Indeed, much of this monitoring took place during the very time that AHCA's own documents demonstrate that children were not receiving care. Second, there is virtually no evidence and certainly no systematic evidence in the record that any PCPs or MCOs were fined, sanctioned, or expelled from the Medicaid program for failure to provide care to children on Medicaid or meet any contractual requirements relating to the provision of care. Thus, the contractual authority to levy sanctions is largely irrelevant. Third, and more fundamentally, the process oriented monitoring cannot show children receive care. For instance, the fact that a PCP does not have more than 1,500 children on Medicaid as patients and does not work more than 30 miles from where his or her patients live does not demonstrate that those children are able to see that PCP on a timely basis. AHCA's monitoring shows the system could work on paper, not that it works in practice.

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345. There is no evidence in Ms. Sreckovich's testimony to establish that timely care and access to an appropriate array of pediatric doctors was actually provided rather than theoretically being available, if PCPs affiliated with MediPass or an HMO chose to treat a large number of children on Medicaid, despite the low Medicaid reimbursement rates. Flint on 1/24/2012 Rough Tr. at 153. Further, Ms. Sreckovich's general opinion that she has not seen evidence of a systematic problem, Screckovich on 1/12/2012 Rough Tr. at 54-55, appears to be based on discounting of every source of evidence—agency admissions in legislative budget requests, 416 reports, Plaintiff's expert testimony—as being subject to some question or not having been "verified." *Id.* at 54-56. While this may be consistent with Ms. Sreckovich in twenty years of testifying as an expert in never having found an element of a State Medicaid program to be noncompliant with federal law, Screckovich on 1/10/2012 Rough Tr. at 14, it also suggests she may be viewing these issues through the lens of the state agencies, including AHCA, with whom she does regular work. *Id.* at 5-9. In any event, I do not find her opinions persuasive.

346. A number of AHCA witnesses, especially Ms. Brown-Woofter and Ms. Kidder offered lay opinions regarding access.

347. Ms. Brown-Woofter offered a lay opinion that there are enough primary care providers enrolled in MediPass to comply with the contractual

requirement that no provider have more than 1,500 children on MediPass. Brown-Woofter on 10/24/2011 Rough Tr. at 67-69. That testimony does not even purport to indicate whether children are actually receiving care from PCPs, who are not obligated to accept any children on Medicaid, let alone all children on Medicaid who seek their services, merely because they enrolled as a MediPass provider, let alone whether that care is timely and comparable to care provided to children on private insurance. Moreover, Defendants failed to show that 1,500 to one ratio has any bearing in reality. Ms. Brown-Woofter did not know the average number of Medicaid patients that a typical PCP enrolled in MediPass accepts, Brown-Woofter on 11/8/2011 Rough Tr. at 81, but if that number is substantially smaller than 1,500, then the 1,500 to one ratio is meaningless.

348. Ms. Kidder offered a lay opinion to the effect that AHCA is able to deliver for children on Medicaid the care they need, when they need, close to where they need it (with limited exceptions), for both primary care and specialty care and that the increase in the number of children enrolled in Medicaid has not impacted AHCA's ability provide such care. Kidder on 10/3/2011 Rough Tr. at 122-123, 150. That sweeping opinion is based largely on hearsay – what Ms. Kidder is told by others, and is contradicted by AHCA's own statements in numerous legislative budget requests; Ms. Kidder's own testimony in her deposition; the testimony of various other AHCA witnesses, including then-

Secretary Andrew Agwunobi, former Medicaid Directors Mr. Snipes and Mr. Sharpe; the testimony of pediatricians; and numerous ACHA documents. Accordingly, I find her lay opinion is entitled to little if any weight.

6. Childrens' Medical Services ("CMS")

349. The problems experienced by CMS, a branch of the Department of Health, dedicated to helping children with special health care needs – and not to be confused with federal CMS – has had in finding primary care providers to treat CMS children on Medicaid is consistent with the problems experienced by other children on Medicaid in accessing primary care which they have legal rights to receive under the Medicaid Act.

350. In 2004, CMS conducted a Provider Access Survey. PX 319. That survey conducted by DOH showed that "[e]very CMS area office or regional office reported that some CMS-enrolled private primary care practices were closed to new CMS patients during calendar year 2003." PX 319 at DOH00077968; St. Petery on 12/8/2009 Final Tr. at 228:5 – 229:12.

351. The 2004 Provider Access Survey showed that "[l]ow reimbursement rates and lack of capacity were the top two reasons cited for the closure of primary care practices to new CMS patients, followed by CMS patients' health conditions being considered too complex for primary care practice and administrative burden/paperwork." *Id.*

352. The 2004 Provider Access Survey conducted by DOH in 2004 showed: "Every CMS provider recruitment office attempted to recruit primary care practitioners to become CMS-enrolled providers during calendar year 2003. Almost three-fourths (72%) of the contacted private primary care providers declined to enroll as CMS providers. Low reimbursement rates and lack of capacity were the main reasons cited for declining to participate." *Id.* There is no indication in the record that these problems have disappeared or even substantially ameliorated.

7. Blood Lead Screening

353. Under federal law, as part of an EPSDT exam, children on Medicaid must be screened for blood lead poisoning at 12 and 24 months, and if they did not have a test earlier, they must be screened for lead blood poisoning between 36 and 72 months. PX 71 at AHCA00148486. Doctors can comply with the lead blood screening requirements by either doing the testing themselves or referring their patients to a laboratory for testing. Snipes on 12/9/2009 Final Tr. at 391:12 – 393:2.

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354. There is no safe level of lead in the blood. PX 77 at FL-MED 07068. The higher the blood level, the more severe the consequences. *Id.* Higher levels have even greater impact on the health and cognitive development of a child,

including lowered IQ, behavioral problems, hearing loss, neurological impairments, and death. *Id.*

355. Screening children for blood-lead poisoning at an early age is important. As Defendants have stated, "Screening for blood lead can lead to effective early interventions, decreasing overall treatment costs later." PX 98.

356. According to CDC, Florida ranks 8th in the nation for the number of estimated children with elevated blood lead levels. PX 71 at AHCA00148485; Snipes on 12/9/2009 Final Tr. at 399:12-16. The cities of Jacksonville and Miami rank 21st and 32nd respectively among large cities in the United States with an estimated 1,900 lead poisoned children. PX 71 at AHCA00148485.

357. A primary source of lead exposure in children is lead-based paint. Many home built prior to 1978 contain lead. PX 77 at FL-MED 07070. Homes built prior to 1950 pose the greatest risk for children since the amount of lead in paints from that time is generally greater and the structural condition of the homes often facilities greater risk of lead exposure. *Id.* The portion of pre-1950 housing by county in Florida varies from 3 percent to just over 15 percent. *Id.*

358. Florida's diverse population of immigrants, refugees and foreign born children are further at-risk groups for lead poisoning because of specific high risk behaviors and customary use of foreign products containing unsafe levels of lead. PX 71 at AHCA00148485; Snipes on 12/9/2009 Final Tr. at 399:8-11.

359. The CMS-416 Report submitted in April 2008 showed that only 60,000 blood-lead screens had been conducted for 250,000 eligible children between the ages of 1 and 2. PX 8 at AHCA0000087-88. Mr. Snipes testified, "I would say personally to me that's not acceptable." Snipes on 12/9/2009 Final Tr. at 372:5-11.[32]

360. In 2006, the most recent year for which there are figures in the record, there were 389 new reported cases of blood lead poisoning in Florida, with twenty or more new cases reported in Broward, Duval, Hillsborough, Miami-Dade, Orange, Pinellas, and Polk counties. PX 77 at FL-MED07073.

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361. For FY 2005-06, 2006-07, 2007-08, and 2009-10, AHCA requested an increase in reimbursement rates for blood-lead screenings for children, stating: "Because physicians are not reimbursed for the collection and handling of lab specimens during an office visit, Medicaid children are being referred to a laboratory for the required blood lead test rather than the physician collecting the specimen and forwarding it to the laboratory for analysis. Lack of reimbursement has fragmented care, due to the fact that many recipients do not follow through with the lab trip." PX 704; PX 705; PX 97; PX 98; Snipes on 12/9/2009 Final Tr. at 391:12 – 397:8.

[32] One of the named plaintiffs, S.M., has not been testified for blood lead exposure because the first time his mother took him to the laboratory the lab was closed and she subsequently was not able to take her son to the lab because of difficulties securing transportation. *See supra* at ¶¶ 121-28.

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362. Mr. Snipes supported the agency's request for an increase in fees for handling blood and believed that it would improve beneficiaries' ability to get blood-lead tests done. Snipes on 2/9/2009 Final Tr. at 397:2-8. In fact, he consistently proposed increases in reimbursement rates for blood-lead testing because he believed that there was a problem that had to be addressed. *Id.* at 399:22 – 400:2.

8. Legal Conclusions re Access to Primary Care

363. Defendants responsible for Florida's Medicaid program have failed to assure that the plaintiff class receive the preventative health care required under the EPSDT Requirements. I find, similar to other courts facing such evidence *see* *Health Care for All, Inc. v. Romney*, No. Civ.A. 00-10833RWZ, 2005 WL 1660677, *10-11 (D. Mass. July 14, 2005) (finding violation of EPSDT requirements as to dental care); *Memisovski ex. rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *50-*56 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions) that the EPSDT Requirements that children receive such care have not been met when, as shown above, approximately one-third of Florida children on Medicaid are not receiving any of the preventative medical care they are supposed to receive. This is true both for children on fee-for-service as well as in managed care, where screening rates are, if anything, lower. In addition, an

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unacceptable percentage of infants do not receive even a single well child visit in the first 18 months of their lives.

364. Because one-third of the enrolled children are not receiving any of their expected preventative care each year, I also find that they have not received care in accordance with the Reasonable Promptness requirements of the Medicaid Act. *See OKAAP v. Fogarty*, 366 F. Supp.2d 1050, 1109 (N.D. Okla. 2005) (finding violation of reasonable promptness provision as to medical care); *Health Care For All, Inc.*, 2005 WL 1660677, at *10-11 (D. Mass. July 14, 2005) (finding violation of reasonable promptness provision as to dental care); *Clark v. Kizer*, 758 F. Supp. 572, 575-579 (E.D. Cal. 1990) (finding violation of reasonable promptness provision as to dental care), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 585 (9th Cir. 1992). I also find a violation of Section 30(a) because Medicaid children lack equal access to primary care.

365. I also find that many pediatricians (and more family practitioners) refuse to take any new Medicaid patients, and other pediatricians sharply limit the number of new Medicaid patients they will accept. I also find that the percentage of children in Florida who receive blood lead screens is extremely low, notwithstanding the fact that part of Florida have an aging housing stock, which means children are likely exposed to lead-based paint.

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366. I agree with AHCA's statement in repeated legislative budget submissions that if the AHCA increased the Medicaid reimbursement rates for well child check-ups, more children will receive well child check-ups.

**D. Provision/Utilization/Timeliness Of Specialist Care**

367. The EPSDT Requirements grant children on Medicaid the right not just to preventative care screens but to treatment for the conditions identified. 42 U.S.C. § 1396a(a)(43)(C). Often the care of a specialist is required. Brown Woofter on 10/18/2011 Rough Tr. at 135.

368. The problem of access to specialists for the Florida Medicaid population, including children, was acknowledged at the highest level by the official responsible for the Florida Medicaid program. Dr. Andrew Agwunobi, in 2007, speaking as Secretary of AHCA stated as follows:

> "I personally have traveled to all of our different areas – our 11 area offices, and I found that by far, the single biggest problem facing AHCA today is access to specialty care for Medicaid recipients. The single biggest problem. We have many problems, but that's the biggest" PX. 126A at 5.

Dr. Agwunobi later in the same speech referred to the problem as "a crisis in access to specialty coverage for this population." *Id* at 6.

369. Defendants objected to these statements on the grounds that they are not applicable to children. This is wrong. Dr. Agwunobi expressly stated in his speech that he was speaking about access for specialty care for children as well as

adults: "We have children and people right now that need access to specialty care." PX 126A. He illustrated the point thusly,

> So what this means is that when a child goes to the emergency room with a broken arm, they can't find an orthopedic surgeon to follow up with. Abscess teeth, can't get care. Usually through many hours of work and basically pleading on bended knee, we have actually found care for that patient. However, there are unacceptable delays which translate into poor quality and sometimes patients have to travel for miles. So all of that is to say yes, the service indicates and our experience confirms that we have a serious access to healthcare problem in the state of Florida and, we have to address it.

PX 126A at 5.

370. As to the cause of the problem, Dr. Agwunobi said that while there are many reasons for the problem of access to specialists, "one thing is very clear. Providers are in general underpaid in contrast to commercial insurance and Medicare." P X 126a at 6; *see also* PX 305 at L-STP 012841.

371. I find Dr. Agwunobi's admissions regarding the problem of access to specialty care to be highly probative. Secretary Agwunobi was a cabinet level officer, the highest individual in the agency primarily responsible for Medicaid, – and the only agency Secretary to testify in his case.[33] He was speaking as

[33] While they did not testify as witnesses, other AHCA secretaries presented similar views in documents. Secretary Arnold observed that "we have a system that is growing by double digits, where providers are paid less and less each year, access is limited, outcomes are not measured, racial disparities in health access continue, and participants are stigmatized. I'd say that's a bad system." PX 277A. *See also* PX 195 (email of Tom Arnold, then deputy secretary for Medicaid and

Secretary and could not be clearer as to the seriousness of the issue, characterizing it as a "crisis." An admission such as this could, standing alone, be taken as sufficient evidence of an access problem with respect to specialists. *See also Cockrum v. Califano*, 475 F. Supp. 1222, 1227 n. 1 (D.D.C. 1979) (Secretary of Health, Education and Welfare estopped from asserting claimants' responsibility for delays in administrative hearings by his admissions elsewhere that the delay problem was nationwide in scope.)

372. Sec. Agwunobi's views are reinforced by a 2007 survey of the AHCA regional offices. The results of this survey were that a majority of regional area offices reported an "acute shortage" of specialists for most specialty types. The following is the chart prepared by AHCA summarizing the results:

later Secretary of AHCA, asking "can we do anything that may reduce the reluctance of specialists in participating in Medicaid?")

**AREA OFFICES – List of Most Common Specialty Shortages ***

● = *Acute Shortage of Medicaid Providers Accepting Medicaid Patients*

| Specialty | AREAS One | Two | Three | Four | Five | Six | Seven | Eight | Nine | Ten | Eleven | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Otolaryngology | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | 11 |
| Neurology/Neurosurgery (Adults & Pediatric) | ● | ● | ● | ● | ● | ● | ● | ● | ● | | ● | 10 |
| Orthopedists/Orthopedic Surgery | ● | ● | ● | ● | ● | ● | ● | ● | ● | | ● | 10 |
| Dermatology | ● | ● | ● | ● | ● | ● | | ● | ● | | ● | 9 |
| Rheumatology | ● | ● | ● | ● | ● | ● | ● | ● | | ● | | 9 |
| Pain Management | ● | | ● | | ● | ● | ● | ● | ● | | ● | 8 |
| Endocrinology | | ● | ● | ● | | | ● | ● | ● | | ● | 7 |
| Urology | ● | | ● | ● | ● | | ● | | ● | | | 6 |
| Surgery, General (Including Bariatric) | ● | ● | ● | ● | | | | ● | | | ● | 6 |
| Orthodontists | | | | | ● | | ● | ● | ● | ● | ● | 6 |
| Dentistry, General | ● | | | | ● | ● | | | ● | | ● | 5 |
| Gynecology | | | ● | ● | ● | ● | | ● | | | | 5 |
| Oral Surgery (Dentist) | ● | | | | ● | ● | ● | ● | | | | 5 |
| Allergy | | ● | | ● | ● | | | ● | | | | 4 |
| Surgery, Plastic | ● | | | ● | | | | ● | | | ● | 4 |
| Pedodontist | | | | | | | ● | ● | ● | | ● | 4 |
| Gastroenterology | | | | | | | | | ● | ● | ● | 3 |
| Cardiovascular Medicine | | ● | | ● | | ● | | | | | | 3 |

PX 205.

373. AHCA sought to make the survey as accurate as possible, Nieves on 5/17/2010 Final Tr. at 2032:14-17, and did not subsequently update the survey. *Id.* at 2030:17-24; Snipes on 12/9/2009 Final Tr. at 431:8-16 (quoting deposition testimony that he has no reason to disagree with PX 205). While certain AHCA witnesses sought to diminish the term "acute shortage of Medicaid providers accepting Medicaid patients," that term was used by AHCA, never changed or challenged until trial, and is consistent with Secretary Agwunobi's public statements.

374. The survey responses from a number of the AHCA area offices confirm, and in certain instances, go beyond the statewide summary. *See* PX 200

(Area 10; Broward County); PX 201 (Area 1 shortages – Pensacola); PX 202 (Area 9 specialist shortages – Palm Beach county); PX 203 (Area 6 specialist shortages – Tampa); PX 204 (Area 7; Central Florida); PX 722 (Area 2; Florida panhandle counties); PX 708 (Area 8; Southwest Florida). For example, the response for Area 11, including Miami-Dade and Monroe counties, states that there is a shortage of "pediatric specialists of every kind" and that "there are no specialists of any kind willing to treat Medicaid recipients" in Monroe county. PX 199. AHCA through two agency representative's deposition testimony admitted that there was no reason to believe that the problems identified in the survey were problems for adults, but not for children. Kidder on 5/19/2010 Final Tr. at 2529:20 – 2530:10 (quoting deposition testimony); Brown-Woofter on 10/25/2010 Final Tr. at 83-96 (quoting deposition testimony).

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375. AHCA proceeded to create a ranking of the different specialty practices by different geographical areas that were experiencing shortages. PX 710. These top five "priority rankings" of shortages, were applicable to children as well as adults. Nieves on 5/17/2010 Final Tr. at 2068:9-11.

376. Other internal AHCA documents and communications are consistent with the existence of difficulty in accessing specialists for the Medicaid population throughout the state. *See e.g.*, PX 210 (October 2007 letter from Secretary Agwunobi inviting providers to a Medicaid Access to Specialty Care Summit,

noting he had traveled the state, speaking about Florida Medicaid with providers, community-based organizations, and AHCA staff, and stating: "With rare exception, when asked what the most critical issue facing the program was, they identified the increasing lack of access to specialty medical care for Medicaid beneficiaries."); PX 181 (shortage of dermatologists, neurologists and neurosurgeons for kids and adults in Jacksonville); PX 182A (documenting access problems for children seeking orthopedics gastroenterologists, neurologists, and cardiology in Area 2); PX 188 (2006 survey of AHCA offices showing lack of readily available specialist care); PX 211 at 7-11 (relative number of specialists providing Medicaid services to total specialists); PX 221 (2000 survey of access to care shows relative lack of access for Medicaid population and also geographic differences in access); PX 187 (Area 3B Ocala area services not readily available in number of specialty types); PX 319 (no or very limited access to certain specialty care for Medicaid children in CMS); PX 338 ("significant crisis in Panama City area with orthopedic coverage").

377. The difficulty in access to specialist care found in the 2007 survey corroborated an earlier AHCA study entitled "Access to Medicaid physician Specialists." PX 563. This study measured access by dividing the total number of Medicaid annual visits in 2003-2004 by the national average of visits per specialist physician and then compared this "estimated Medicaid access" figure to lowest and

highest estimate of needs based on the literature. Each physician specialty was then given an access score from 1 to 5, with the following services receiving ranks of either "1 (indicating access is less than 50% of the lowest estimate of need); or "2" (access less than the low estimate of need"): Allergy, Dentists, dermatology, endocrinology, hematology, infectious disease, nephrology, neurology, oncology, orthopedic surgery, pulmonary disease, rheumatology, and urological surgery. PX 563 at Flint 01131, 01135. This study also shows the comparative lack of access per county.

378. Several AHCA witnesses who serve as area administrators nonetheless testified that they either never had or no longer were facing difficulties with respect to access to specialty care for Medicaid recipients in their areas. *See e.g.*, Nieves on 5/18/2010 Final Tr. at 2260:5-18; Albury on 11/15/2011 Rough Tr. at 107; Kimbley-Campanaro on 10/6/2011 Rough Tr. at 98-103. I find this testimony unpersuasive for a number of reasons.

379. First, certain of this testimony directly contradicted sworn deposition testimony from the same witness or prior written statements from the witness. Thus, Ms. Kidder testified in trial that she did not believe the shortages noted in the AHCA survey "were as systematic as they appear on that chart [PX 205]." Kidder on 5/20/2010 Final Tr. at 2751:1-6. At deposition, however, Ms Kidder testifying as the AHCA-designated agency representative on these issues, acknowledged that

the agency believed "there was a critical access to care problem in these specialty types" as to which a legislative budget proposal was made, and that remained true at the time of her deposition. *Id.* at 2751:7 – 2752:5. As discussed above, there are serious credibility issues raised when a witness changes her testimony from that given as a sworn 30(b)(6) witness. Similarly, Ms. Kimbley-Campanaro's testimony was directly in the face of her email, PX 203, which found "challenges" in her area for ten different areas of specialists. It is not credible that the use of the term "challenge" did not connote an understanding of difficulty in finding sufficient specialist providers.

380. Second, certain of this testimony was based on patently unreasonable assumptions as to what constituted reasonable access to care. Thus, Ms. Nieves based her opinion that there was no difficulty in securing access to any specialists in area 8, despite the fact that 14 areas of shortage were identified in 2007 for her area, *see* PX 205, on the assumption that if a single specialist was available for Medicaid recipients in that area or an adjoining area, then there was sufficient access. Nieves on 5/18/2010 Final Tr. at 2264:7-15; *id.* at 2265:1-5 (stating that "if dermatologist in downtown Miami was accepting some children on Medicaid, that would mean for purposes of Area 8 over in Sarasota you would have an available dermatologist").

381. Third, the testimony of AHCA area administrators is based on complaints they receive about difficulties in accessing care. If they do not receive such complaints, because beneficiaries or providers have not contacted the area office, the area administrator would not know that. Gray on 11/28/2011 at Rough Tr. 29; Nieves on 5/18/2010 Final Tr. at 2268:6-22; Kidder on 5/20/2010 Final Tr. at 2753:2-19. The area office also doesn't follow up and know whether care was received, or if received, whether it was unduly delayed or involved extensive travel. *See, e.g.*, Gray on 11/28/2011 Rough Tr. at 30-32; Albury on 11/16/2011 Rough Tr. at 48; Fuller on 11/29/2011 Rough Tr. at 87, 119-120. [Moreover, the volume of calls to area offices concerning specialty care is itself indicative of a problem in beneficiaries' access to such care. *See, e.g.*, Fuller on 11/29/2011 Rough Tr. at 130 (9100 calls for specialists in Area 5 in one year period).] Similarly, the inability of an AHCA employee to "recall a child going without specialty care being discussed," Albury on 11/15/2011 Rough Tr. at 121, in the office is weak evidence at best of the lack of a specialty access problem, especially in the face of documentary evidence from the same area office attesting to a shortage of specialists. *See, e.g.*, PX 202 (specialist needs in Area 9 where Mr. Albury works); PX 198 (shortage of pediatric specialists of every kind in area 11 where Ms. Gray works). As one such AHCA witness acknowledged, he could not

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say whether or not children were actually denied care – just that he was not made aware of such problems or issues. Albury on 11/16/2011 Rough Tr. at 46.

382. Fourth, when pressed, these same witnesses often conceded the existence of a specialist care problem. For example, Rhea Gray, the Area 11 administrator, had testified she personally was not aware of complaints about access problems and that an adequate number of specialists were enrolled in the Medicaid program. But Ms. Gray admitted on cross-examination that she had correctly written that the real issues were the willingness of those specialists to see Medicaid patients, and that low pay and billing difficulties were the reported reasons they were not. Gray on 11/28/2011 Rough Tr. at 43-44. Further, while in her personal experience she had not faced more than a two-week delay in having patients seen at Miami Children's Hospital or Jackson Memorial Hospital in Miami, she acknowledged that frequently the wait time for Medicaid children to be seen by a specialist at one of those hospitals was from six to nine months. *Id.* at 45. Finally, Ms. Gray asked others in the office to comment on her draft report, PX 198, before she submitted the final report. PX 199. Gray on 11/28/2011 Rough Tr. at 50. That report indicated there were no specialists "of any kind" willing to see Medicaid recipients in Monroe County, that the Area 11 office has had difficulty in finding specialty care in eleven different fields, including "pediatric specialists of every kind." PX 199.

383. Fifth, none of the testimony provides a persuasive explanation for why a situation of "acute shortages" through most specialty areas throughout most of the state has suddenly disappeared. There have been no changes in reimbursement rates for specialists during this time period, Nieves on 5/18/2010 Final Tr. at 2262:7-16, while demand has continued to increase for services.

384. For all of these same reasons, I place little weight on the conclusory "lay opinion" offered by Beth Kidder and other AHCA witnesses that there were no problems in providing care to children through the state Medicaid program.

385. The existence of a severe problem in access to specialists is also reflected in the legislative budget requests prepared by AHCA and submitted by the governor to the legislature to increase the reimbursement rates for dermatology, neurology, neurosurgery and orthopedic surgery – each of which are specialists that children utilize. Kidder on 5/19/2010 Final Tr. at 2528:12-17. The given reason for the request was a critical access to care problem in those areas. PX 89; PX 90, PX 10; Kidder on 5/19/2010 Final Tr. at 2527:8 – 2528:7. One AHCA legislative budget request stated: "The Medicaid area offices have identified a physician specialty provider shortage and *critical access to care* problem" in these specialty areas. Ex. 727 (emphasis added). These areas were selected not because they were the only ones in which there was a need but rather because a modest proposal was believed to have the best chance politically for passage, Snipes on

12/9/2009 Final Tr. at 405:6-13; Isaac on 8/11/2010 Final Tr. at 3883:4-24 (testifying to statement of Sec. Agwunobi).

386. Carlton Snipes, the former Deputy Secretary of Medicaid and Medicaid director, who was the second highest ranking AHCA official to testify at trial, confirmed that these legislative budget requests reflected the views of the agency. Carlton Snipes on 12/9/2009 Final Tr. at 403:11-22. He testified that "we supported the issues, we felt the issues were important, even critical." *Id.* at 459:1-10.

387. These legislative budget requests for an increase in specialist reimbursement were presented again and again for a number of years. AHCA says that they take the statements in those requests "extremely seriously" and "do their best to give [the Legislature] accurate information." Kidder on 5/20/2010 Final Tr. at 2741:4-6. The requests went through a review process by a number of individuals and bureaus inside AHCA, including the secretary. They were then reviewed by the Governor's office and, indeed, were listed as one of the priorities for legislative action. PX 719 (For 2009-2010 fiscal year, physician specialty fee increase was number one AHCA priority in Governor Crist's recommendations). I find the agency's consistent position expressed in these legislative budget proposals persuasive evidence as to the conditions in Medicaid relating to access to specialty care.

388. Evidence from the DOH demonstrates that CMS children on Medicaid also lack access to specialty care. CMS reported widespread problems accessing specialty care, and said the pediatric specialties for which no access was most frequently encountered were dermatology, neurological surgery, orthopedics, psychiatry and urology, according to a 2004 CMS survey of the 17 CMS area and regional offices. PX 319. In October of 208, Vickie Posner, testifying as a designee of DOH was asked whether DOH was aware of any difference in the ability of children on Medicaid to access specialty care as compared to children with other types of insurance. She replied: "Anecdotally we know that some – if you are going to include all of insurances in that question, private paying, private insurance children have access to services that Medicaid children do not have. I think that's fairly widely recognized in the State of Florida." Posner on 10/28/2008 Depo. Design. at 83:20 – 84:12 (limited by Court ruling to CMS children only).

389. A number of pediatricians throughout the state also gave consistent and persuasive testimony as to the difficulties they faced in referral of children on Medicaid to specialty care. Dr. Lisa Cosgrove, a Brevard county pediatrician whose practice consists of approximately 20 percent Medicaid patients, has difficulty referring Medicaid children to dermatologists, allergists, orthopedic surgeons, neurologists and endocrinologists. Cosgrove on 5/19/2010 Final Tr. at 2563:12-17, difficulties not faced with commercial patients, *id.* at 2566:11-15,

2569:11 – 2571:14, 2573:1-6. These difficulties have continued, as testified by Dr. Cosgrove in her rebuttal testimony on January 31, 2012, with recent and continuing problems in referring Medicaid children to rheumatologists, orthopedics, dermatologists; Cosgrove on 1/31/2012 Rough Tr. at 149-152.[34]

390. Dr. Nancy Silva, a pediatrician in Hillsborough and Pasco counties, who had approximately 20 percent of her practice with Medicaid patients, also testified that she has trouble referring Medicaid patients to dermatologists, ENTs, ophthalmologists, orthopedists, endocrinologists, general surgeons, rheumatologists, and infectious disease specialists, among others. Silva on 5/20/2010 Final Tr. at 2779:6-15. Medicaid children have to wait three to five months in Brandon and one to three months in Tampa whereas commercial-insurance patients can be seen within one to two weeks. *Id.* at 2779:17 – 2780:8. In rebuttal testimony, Dr. Silva confirmed recent difficulties and travel times

[34] Defendants' hearsay objections to this rebuttal testimony by Dr. Cosgrove concerning referrals were overruled at trial, and I adhere to that ruling. Dr. Cosgrove's knowledge of these referral issues is obtained as part of her discussions with patients' parents or guardians in the course of treating their children and is then noted in the medical records as relevant to their treatment. Cosgrove on 1/31/2012 Rough Tr. at 145-146. *See* FED. R. EVID. 803(4); *see also U.S. v. Belfast*, 611 F.3d 783, 818-19 (11th Cir. 2010) (finding no error in admission of doctor's statement that patient reported he had been tortured over hearsay objection); *In re Moore*, 165 B.R. 495, 498-99 (M.D. Ala. 1993) (overruling objection to admission of counselor's statement relaying victim's identification of sexual assailant); *Portis v. Wal-Mart Stores East, L.P.*, Case No. No. 07-0557-WS-C, 2008 WL 3929672, at *3 (S.D. Ala. Aug. 22, 2008) (overruling hearsay objection to physician's statement including medical history relayed by patient).

experienced by Medicaid patients she refers to specialists, such as allergists, dermatologists, and endocrinologists, not experienced by her private patients. Silva on 1/19/2010 Rough Tr. at 140.[35]

391. Dr. Tommy Schechtman, a pediatrician in Palm Beach County, whose practice consists of 23 percent Medicaid children, similarly testified that it is "much more difficult to find a specialist who is willing or has an open panel to see Medicaid patients." Schechtman on 5/20/2010 Final Tr. at 2836:1-5. Examples included a child with a potentially precancerous mole who could not see a dermatologist for at least a six month period. *Id.* at 2838:2-13. Orthopedic surgeons would only see Medicaid patients with limited diagnoses, *id.* at 2839:3-11. By contrast, there are "no barriers" with respect to commercially insured patients. *Id.* There were no pediatric neurologists in Palm Beach County willing to accept Medicaid patients, leaving the only option for those patients to be travel to Miami. *Id.* at 2840:16 – 2841:12. On one occasion. Dr. Schechtman had to admit a Medicaid child into the hospital to receive a cardiac care that could have been managed in a low-cost out-patient setting if the child's Medicaid HMO plan had been accepted by pediatric cardiologists. *Id.* at 2842:25 – 2844:14. Access for Medicaid patients to ENT specialists is also "extremely limited," although

[35] As with Dr. Cosgrove, the rebuttal testimony on these points – although not the similar testimony given during plaintiff's case in chief – was objected to as based on hearsay. As with Dr. Cosgrove, I find the testimony admissible on the basis of 803(4).

commercial patients have "no problem" being seen. *Id.* at 2844:15 – 2845:17. Dr. Schechtman's rebuttal testimony showed that the obstacles in providing access to specialty care for Medicaid children are continuing. Schechtman on 1/26/2012 Rough Tr. at 14-21, 30-33.

392. Dr. Jerome Isaac, a pediatrician in Sarasota and Bradenton, testified that orthopedic care is not available to children on Medicaid in the "reasonable area' around his practice and that consequently he has seen children whose broken limb was only put in a splint and not a cast, which Dr. Isaac characterized as "medical neglect." Isaac on 8/11/2010 Final Tr. at 3869:10-20. Over the past few years, Dr. Isaac has been unable to refer Medicaid patients to specialists in orthopedics, neurosurgery, dermatology or psychiatry. *Id.* at 3873:3-23.

393. Other PCPs have also experienced trouble referring children on Medicaid, but not children with private insurance, to specialists. Seay Depo. Desig. on 11/14/2008 at 15:9 – 16:24, 20:2-9, 57:7-21; J. St. Petery Depo. Desig. on 11/11/2008 at 191:1-4, 195:7 – 196:11, 197:15-25; J. Ritrosky, J. Depo. Desig. on11/10/2008 at 27:18-22, 50:8-23; Seay Depo. Desig. on 11/14/2008 at 103:7-10; J. St. Petery Depo. Desig. on 11/11/2008 at 198:21 – 199:10; J. Ritrosky, J. Depo. Desig. on 11/10/2008 at 39:9 – 40:3, 45:2 – 47:7, 50:8 – 51:1; Curran Depo. Desig. on 10/7/2008 at 30:4 – 31:8, 32:16 – 34:14, 37:13 – 38:11, 55:8 – 56:4; T. Chiu Depo. Desig. on 11/25/2008 at 103:19 – 106:1; Knappenberger Depo. Desig. on

11/20/2008 at 32:9 – 33:5, 99:12 – 100-8; J. Ritrosky, J. Depo. Desig. on 11/10/2008 at 17:17 – 18:14.

394. The barriers to access to specialist care were confirmed by testimony from the specialists. Dr. Duncan Postma, who is the supervising partner of an ENT specialty practice in Tallahassee, Tallahassee ENT, testified that their practice limits the geographical area from which they accept Medicaid patients, declining to accept patients from outside the 7 county area, and also limits the number of new Medicaid patients to two new Medicaid patients per week per doctor. Postma on 8/4/2010 Final Tr. at 3152:2-19. As a result, Medicaid patients requiring ENT care face a two-month delay as opposed to a delay of two weeks. *Id.* at 3153:7-23, 3155:7-16. These limitations are imposed because Tallahassee ENT "lose[s] money on Medicaid patients and can only afford to lose so much." *Id.* In 2006, the average cost of an ENT patient encounter was $138, but Medicaid paid approximately $88 per encounter; in 2007, the average encounter cost was $135, and Medicaid paid approximately $85 per encounter. *Id.* at 3187-89. For a Medicaid child patient, Tallahassee ENT lost an average of $45-$50 per patient in 2006 and 2007. *Id.* at 3190:5-17.

395. Dr. Brett Baynham, an orthopedic surgeon in Palm Beach County, whose practice is 95 percent children, 25 to 30 percent of which used to be children on Medicaid. In 2004 he limited the number of Medicaid patients he

would see with the low reimbursement rates being the primary driving force for the change. Baynham on 1/24/2012 Rough Tr. at 8-9, 12; *see also* PX 770 (March 2010 email from pediatric otolaryngologist, stating he is the only pediatric ENT in the West Palm Beach area seeing Medicaid patients in an office setting and that he is presently scheduling Medicaid patients more than 2-3 months out.)

396. Dr. Adam Fenichel, an orthopedic surgeon in the Orlando area, testified similarly. While 80 percent of his patients are children, only five percent are on Medicaid. While Dr. Fenichel sees 2,000 new patients a year, he limits his practice to at most only a couple of hundred Medicaid patients, because "the reimbursement for Medicaid is lower than our cost to care for patients." Fenichel on 10/18/2010 Final Tr. at 4301:20 – 4302:4, 4306:2-24; *see also* Phillips Depo. Desig. on 11/24/2008 at 14:9-17, 83:8-18; J. Phillips Depo. Desig. on 11/24/2008 at 33:2-10, 34:2-16.

397. Dr. Ricardo Ayala, a specialist in pediatric neurology, limits the number of new Medicaid patients from straight Medicaid and Medipass he sees in his Tallahassee practice, he loses money on treating these children, and such children face a four to five month wait as opposed to a two week wait for commercial patients. Ayala on 8/9/2010 Final Tr. at 3569:21 – 3570:1, 3580:4-16, 3589:2-11. Furthermore, when he needs to refer children on Medicaid to other specialists, such as orthopedists, psychiatrists, sleep disorder specialists, and

rheumatologists, the referrals are not accepted. *Id.* at 3594:1-14; 3615:6 – 3620:24.

398. Plaintiffs also presented the testimony of Dr. Rex Northup, who in addition to being a critical care pediatrician, served as the regional medical director for Northwest Florida in the CMS program that treats Medicaid children with special medical needs. There are a number of areas within that region where there is "an inability to obtain access to care without augmenting or supplementing the Medicaid rate." Northup on 2/10/2010 Final Tr. at 1598:13-21. CMS has supplemented the Medicaid rate so as to obtain dermatology care, because there are no providers that will routinely see children for the Medicaid rate. Northup on 2/10/2010 Final Tr. at 1617:8-25; *see also* J. Curran Depo. Desig. on 10/7/2008 at 45:1 – 46:9; Knappenberger Depo. Designation on 11/20/2008 at 22:17-25; Seay on 11/12/2008 Depo. Desig. at 106:14 – 108:6. There is no orthopedist to treat children, except in the emergency department of the hospital, on Medicaid in the Panama City area. *Id.* at 1620:17-20, 1622:6-22. Children requiring orthopedic specialty care must travel to other areas, such as Jacksonville or Gainesville while there are orthopedists who will see private pay patients in the area. *Id.* at 1630:19 – 1631:23.[36] ENTs in the area limit the number of Medicaid children they will see,

[36] Dr. Northup's testimony on these points is not dependent on the residual exception to the hearsay rule, as to which another aspects of Dr. Northup's testimony concerning rates was admitted, Tr. at 1636:22 – 1637:9.

and have to drive three hours or more for care. *Id.* at 1638:2-12. For pediatric neurology care, the wait for Medicaid patients is two to three months as opposed to a couple of weeks for other patients. *Id.* at 1643:23 – 1645:18.

399. I find the testimony of these pediatricians and specialists to be credible. They are testifying based on their own personal experience and actions. I note that the Defendants did not call a single primary physician or specialist that offered contrary testimony. The testimony of Plaintiffs' medical witnesses is consistent with the survey evidence and AHCA admissions that there is a serious problem faced by Medicaid children in receiving prompt, let alone equal access, to medical specialists.

400. Based on the combination of AHCA surveys showing serious shortages of specialist care for Medicaid, admissions of AHCA officials, including the Secretary of AHCA, the legislative budget requests submitted repeatedly by AHCA acknowledging a serious access to specialty care problem, and the testimony of a number of medical doctors practicing throughout the state, I find that the EPSDT guarantee of access to care for treatment of conditions identified in children on Medicaid has not been afforded. Children on Medicaid have to travel to other areas of the state and/or wait for several months to obtain care. While there are certain specialists and certain locations, where issues of access – and reasonably prompt access – may not be a problem, the evidence presented

leads me to find that the issue extends throughout the state and across many specialty types. Moreover, the evidence reflects that while a particular specialty problem in a given area may improve with the arrival of a new doctor, that situation may change or another problem may occur because of the dependency of the Medicaid population on a relatively small number of providers, and among that number, many limit the number of patients they are willing to see. Accordingly, I find with respect to specialty care that during the time covered by this case, Florida has not met the obligations of the EPSDT Requirements in Section a(10) or the reasonable promptness requirements in Section (a)(8). *See OKAAP v. Fogarty*, 366 F.Supp.2d 1050, 1109 (N.D. Okla. 2005) (finding violation of reasonable promptness provision as to medical care); *Memisovski ex. rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *50-*56 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions); *Clark v. Kizer*, 758 F. Supp. 572, 575-579 (E.D. Cal. 1990) (finding violation of reasonable promptness provision as to dental care), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 585 (9th Cir. 1992). I similarly find that children seeking specialist care have not received that care as required under Sections 43(B) and 43(C) of the Medicaid Act. *Memisovski*, 2004 WL 1878332, at *50-*56 (finding violation of 42 U.S.C. 1396a(a)(43)(C) relating to the provision of EPSDT corrective services).

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401. There is also extensive record evidence that leads me to find that children on Medicaid do not receive equal access to specialist care, compared to insured children in their geographical areas. *See, e.g.*, PX 583; *see Memisovski v. Maram*, 2004 WL 1878332, *42 -*47 (finding violation of equal access provision as to medical care); *OKAAP v. Fogarty*, 366 F.Supp.2d 1050, 1107 (finding violation of equal access provision as to medical services); *Ark. Med. Soc'y, Inc. v. Reynolds*, 819 F. Supp. 816, 825-826 (E.D. Ark. 1993) (finding violation of equal access provision as to medical care); *Health Care for All, Inc. v. Romney*, No. Civ.A.00-10833RWZ, 2005 WL 1660677 at *10-*11 (D. Mass. July 14, 2005) (finding violation of equal access provision as to dental care); *Clark v. Kizer*, 758 F. Supp. at 575-579 (finding violation of equal access provision as to dental care). As discussed elsewhere in these findings, rates are not set with any consideration of the level needed so as to provide such equal access, consistent with the other requirements of Section (30)(A) as required under the Medicaid Act.

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**E. Provision/Utilization/Timeliness Of Dental Care**

402. Dental care is especially important for children on Medicaid because poor children are at substantially higher risk for dental disease, primary tooth decay, and its sequellae, and have higher levels of untreated dental disease. PX 85, PX 707.

403. As noted above, 42 U.S.C. § 1396d(r) requires states to provide eligible children with "Dental services including relief of pain and infections, restoration of teeth and maintenance of dental health." Moreover, 42 U.S.C. § 1396a(a)(43)(D)(iii) requires reporting on the number of children receiving dental services. The CMS form 416 is required by CMS to fulfill that reporting requirement.

404. For FFY 2007, of the approximately 1.6 million children enrolled in Florida Medicaid for at least part of the year and so eligible for dental services, only 343,000 received any dental care, according to the CMS-416 Report that AHCA submitted in April of 2008. *See* PX 8 (compare lines 1 and 12a). Dyke Snipes, former Medicaid Director acknowledged, "[T]hat's not acceptable." Snipes on 12/9/2009 Final Tr. at 373:1-8; *see id.* at 442:17-23. That equates to a dental utilization of 21% based on Florida's CMS 416 report (343,529/1,611,397). PX 440 at 52-53. That tied Florida for the lowest Medicaid dental utilization rate in the nation. PX 440 at 52-53. That means 79% of the children on Medicaid in Florida were not receiving any dental care. PX 440 at 52-53. FFY 2008 was not an aberration. For FFY 2006, Florida's Medicaid dental utilization rate was also 21%, which tied it for second lowest in the nation. PX 440 at 52-53; *see also* PX 418 at p. 9.

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405. The percentage of children on private insurance who receive dental care is far higher than the percentage of children in Florida on Medicaid who receive dental care. Nationally, 55% of children with private insurance had visited a dentist within a given year, and 37% of the children on Medicaid had dental visit over the same time period, according to a 2008 GAO report. PX 452 at Crall01734; Crall on 11/17/2010 at Tr. 5093:20 – 5094:9; 5161:9 – 5162:25. Of children under 18 from families with incomes above 100% of the poverty line, 49% had a dental visit at least once during a 12-month period, and for children from families with incomes above 200% of the poverty line, the figure rose to at least 56% and perhaps as high as 73%, according to a 2001 report by the federal DHHS. PX 447 at Crall000750.

406. ACHA, through a series of legislative budget requests ("LBRs") and other documents has acknowledged for nearly a decade that Medicaid children's access to dental care is inadequate and that rates must be raised. LBRs go through multiple layers of review; the agency seeks to make them as accurate as possible. Kidder on 5/19/2010 Final Tr. at 2506:24 – 2508:13, 2741:4-6; Cerasoli on 8/11/2010 Final Tr. at 3931:4 – 3932:6. AHCA, through its LBRs, acknowledged that:

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- Dental participation in the Florida Medicaid program is declining, *e.g.*, PX 82, PX 83, PX 84, PX 85, PX 88, PX 109, PX 726; *see also* Sharpe on 11/16/2010 Final Tr. at 4947:1-8; Cerasoli on 8/11/2010 Final Tr. at 3934:18-25;

- Florida's Medicaid reimburses dentists at less than 40% of their usual and customary costs, *e.g.*, PX 80, PX 81, PX 82, PX 83, PX 109, PX 715, PX 718, PX 726; *see also* Cerasoli on 8/11/2010 Final Tr. at 3935:12 – 3939:14;

- Florida's Medicaid reimbursement rates are very low compared to other states, *e.g.*, PX 80, PX 85; PX 88, PX 155; PX 718; *see also* Cerasoli on 8/11/2010 Final Tr. at 3957:16 – 3961:18; Sharpe on 11/16/2010 Final Tr. at 4954:8-21; and

- Florida dentists say the state's Medicaid rates do not cover their costs. PX 80, PX 81, PX 82, PX 83, PX 84, PX 88, PX 109.

407. The LBRs repeatedly called for a rate increase. Most striking, the LBRs repeatedly say in almost the exact same language, year after year: "A fee increase for children's dental services is needed if service is to be available." PX 78; *see also* PX 80 (same), PX 82 (same), PX 83, PX 109 (same). The LBRs also state, "An increase of fees is expected to increase provider participation, and subsequently, increase access to dental care." PX 80. The testimony about these LBRs is equally forceful. *See, e.g.*, Sharpe on 11/16/2010 Final Tr. at 4945:18 – 4949:8; 4952:16 – 4953:19; 4956:16 – 4963:19; at 4964:19 – 4966:19; 4968:5 – 4970:25; Snipes on 12/9/2009 at 411:15 – 414:10; at 415:10 – 416:8; Kidder on 5/19/2010 Final Tr. at 2534:12-24.

408. None of the above recommendations to increase dental fees was adopted by the legislature. Snipes on 12/9/2009 Final Tr. 423: 20-22. For every year since 2005-2006, the KidCare Coordinating Council has recognized the inadequacy of Florida's dental rates and recommended, in vain, increases in dental

reimbursement rates. PX 697, 698, 699, 349, 350, 682. From 1987 through 2010, Florida Medicaid dental rates were increased once, by 13 percent in 1998. Cerasoli on 8/11/10 Final Tr. at 3951:10-25. Meanwhile, children's enrollment in the Florida Medicaid program rose by about 78% from 1998 to 2008, thus widening the gap between the services needed and those available. PX 682 at 12; Kidder on 5/19/2010 Final Tr. at 2485:4 – 2486:4.

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409. Defendants claim that some of those numbers in the LBRs showing a decline in the number of dentists participating in Medicaid were simply copied without verification from one year to the next. While that might be true, in part, it is clear that the percentage of licensed dentists enrolled in and participating in Florida Medicaid has declined. AHCA's own interrogatory response demonstrates that the number of general dentists with 100 or more paid claims for treating children declined from 616 to 377, a drop of more than 38%, from FFY 2003 to FFY 2007. PX 739 at Table 2. During the same time period, the number of oral surgeons with 100 or more paid claims for children fell more than 30% and the catchall category of other dentists plummeted from 130 to 42, a decline of 67%. *Id.*

410. It is clear that the reason for the declining participation is Florida's woefully inadequate dental reimbursement rates. A 2004 study by the American Dental Association, which AHCA relied upon in putting together its LBRs, showed

that Florida ranked 48th in the nation among state Medicaid program in its rates for preventative services and 49th in the nation in its rates for treatment services rates. PX 155 at 13-14; Cerasoli on 8/10/10 Final Tr. at 3960:22 – 3961:18. The same study showed that 15 dental procedures Florida's Medicaid reimbursement rates ranked no higher than the 5th percentile nationally, and for ten procedures, Florida's reimbursement rates were below the first percentile nationally. PX 155 at 6; PX 109 at AHCA00719087 to 88 (showing reimbursement rates were below dentists' costs for 6 of 7 procedures analyzed); Cerasoli on 8/10/11 Final Tr. at 3957:3 – 3959:24.

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411. In 2001, the Health Care Financing Agency, the predecessor to federal CMS, stated: "In general, HCFA believes that significant shortfalls in beneficiary receipt of dental services, together with evidence that Medicaid reimbursement falls below the 50th percentile of providers' fees in the marketplace, create a presumption of noncompliance with both these statutory requirements. Lack of access due to low rates is not consistent with making services available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at CRALL 00751. Ms. Kidder admitted that if Medicaid reimbursements for dentists are below the 50th percentile (which they are), then

Florida is presumptively out of compliance with the Medicaid Act. Kidder Testimony on 5/20/2010 Final Tr. at 2733:5-11.

412. Numerous other agency officials from the Secretary on down have acknowledged substantial problems with Florida's Medicaid dental program. Alan Levine, a former AHCA Secretary, sent an email lamenting that "only 16 percent of our children in Medicaid fee-for-service got any preventative dental care last year." PX 277A. Then-Deputy Secretary and later Secretary of AHCA, Tom Arnold, gave a speech at the 2007 Medicaid Access to Specialty Care Summit, in which he presented charts showing that a small fraction of dentists participated in Medicaid and even fewer actually billed for Medicaid services. St. Petery on 12/8/2009 Final Tr. at 240:3 – 245:15. Summit related documents show that only 7.8 % of the 9,021 licensed dentists in Florida were enrolled in Medicaid, and only 502 or 5.6%, actually billed Medicaid. PX 218 at 4; *see also* PX 211 at p. 9.

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413. Robert Sharpe, ACHA's Medicaid Director from 2000 to 2004, testified personally he did not believe that AHCA was in compliance with the reasonable promptness standard as to dental care. *Id.* at 4976:15 – 4977:9. He testified "Well, we're acknowledging that for a federally required service, at least for the children's portion of dental care, that the state is not even meeting federal requirements for the provision of that care." *Id.* at 4970: 20-25; PX 108. He said

he could not have made a stronger statement without being fired. *Id.* at 4962:11 – 4963:19; 4941: 8-25.

414. As recently as last year, AHCA recognized that even excluding the children enrolled in prepaid dental plans and Medicaid HMOs and PSNs that provided dental care, an astonishing figure of 834,651 children enrolled in Florida Medicaid had not received any dental care in at least six months, even though the periodicity schedule calls for them to have a dental check-up every six months. PX 150, PX 790.

415. Ms. Kidder acknowledged "a significant shortfall in beneficiary receipt of dental services." Kidder on 5/20/2010 Final Tr. at 2756:21 – 2757:5; 2728:20-22; 2730:6-9. In a November 2006 email, she wrote Medicaid reimbursement rates were "extremely low" and stated: "This is a serious barrier to dental care and is causing problems with access to dental care across much of the state…" PX 167; *see also* Cerasoli on 8/11/2010 Final Tr. at 3966:13-24. Ms. Cerasoli, AHCA's agency witness on deposition dental issues, acknowledged that Florida's Medicaid reimbursement rates "are among the lowest in the United States." Cerasoli on 8/11/2011 Final Tr. at 3932:13-15. The main reason many Florida dentists won't provide services to Medicaid recipients is because of its low reimbursement rates. *Id.* at 3933:7-11. Fewer and fewer dentists are enrolling in Florida Medicaid and treating Medicaid beneficiaries. *Id.* at 3934:18-25.

416. The Department of Health also acknowledged "a common barrier to access to services is a lack of specialty and dental providers, primarily attributable to the low Medicaid reimbursement rates." PX 315 at DOH00079770.

417. Florida Medicaid HMOs in Reform and non-Reform counties must report their HEDIS results for annual dental visits for members 2-21. Florida Medicaid HMOs in both programs score poorly compared to Medicaid HMOs nationally. The weighed measure of the Florida Reform MCOs is 15.1955% and the national measure for HMOs is 42.5%, according to a 2007 report, the most recent in the record. DX 334 at 2; Brown-Woofter on 11/8/2011 Rough Tr. at 32-33.

418. The first large MCO to provide dental care to Medicaid beneficiaries was Atlantic Dental Inc. ("ADI"). From FFY 2003 through FFY 2007, the most recent year for which there is data in the record, ADI never provided more than 23.12% of eligible recipients with any dental services. PX 14, PX 15, PX 16, PX 22. The dental participation rate peaked at 18.09% for this period. *Id.* Many ADI dentists provided even less care. Reports from individual dental providers, covering 2007 and 2008 in six month blocks, show that for each period, the majority of providers treated fewer than 15% of the children assigned to them; several provided no dental care whatsoever for the numerous children assigned to them. DX 519.

419. Testimony from providers underscores the lack of access to dental care. In the Tallahassee area, dental care is readily available to children with private insurance, but not children on Medicaid. Patients with cardiac issues must be sent to the University of Florida dental clinic in Gainesville where there is a six-month wait. St. Petery on 12/8/2009 Final Tr. at 260:19 – 261:17; 263:5 – 266:13.

420. Dr. Lisa Cosgrove, a pediatrician who practices in Merritt Island, Brevard County, Florida (Cosgrove on 5/19/2010 Final Tr. at 2550:8-9; 2525:15-25) finds that it takes six months to refer a Medicaid child enrolled in Medipass or a child enrolled in the Wellcare HMO to a dentist. Cosgrove on 5/19/2010 Final Tr. at 2573:7 – 2574:2. She had a Medicaid child with an abscess who could not get an appointment with a dentist for three months. *Id.* at 2574:3-23. In rebuttal testimony, she testified to continuing recent problems. Cosgrove on 1/31/2012 Rough Tr. at 147-152.

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421. Nancy Silva, a Brandon pediatrician, does not know any dentists who will see Medicaid kids for bottle rot or deep cavities. Silva on 5/20/2010 Final Tr. at 2768:1-2; 2794:16 – 2796:9. Nor does she know of any dentists in Hillsborough County accepting new Medicaid patients. *Id.* at 2819:20-24; 2820:1-18.

422. Dr. Tommy Schechtman is a pediatrician who practices out of three offices in Palm Beach County. Schechtman on 5/20/2010 Final Tr. at 2832:6-9,

2833:7-14. Most of his Medicaid patients do not see a dentist. *Id.* at 2845:18 – 2846:5; 2846:6-18.

423. Rex Northup is a pediatric critical care physician, regional director for Children's Medical Services for Northwest Florida, and Co-Medical Director of Sacred Heart Children's Hospital in Pensacola. Northup on 2/10/2010 Final Tr. at 1585:5-8; 1588:23 – 1589:5; 1585:17-24. There are waiting lists of "several months' time" for CMS children to receive specialized dental care at Sacred Heart's dental clinic. *Id.* at 1600:9 – 1601:6; 1602:19 – 1603:9. At the time Dr. Northup testified, the clinic had just become operable again after a "several months' period of seeing no patients" because there was no dentist available. *Id.* There is high demand for services at the clinic because it "is the only dental clinic or dental provider in the four-county area specifically seeing pediatric patients that will take Medicaid[.]" *Id.* at 1603:12-18. Other dentists in the area accept private paying children. *Id.* at 1603:19-21.

424. Dr. Northup sometimes pays dentists rates above the Medicaid rates to treat CMS children because that "is essentially the only way we've been able to obtain access to dental care for those children." *Id.* at 1605:20-22; 1606:1-4. Dr. Northup supplements the Medicaid rates paid to dentists when a child needs urgent care and cannot wait the two to three months it otherwise would take to see a dentist. *Id.* at 1607:18 – 1608:1.

425. Other PCPs also have trouble referring children on Medicaid to dentists. J. St. Petery Depo. Desig. on 11/11/2008 at 197:15-25; Testimony Dr. John Curran Depo. Desig. on 10/7/2008 at 39:21 – 41:1, 41:22 – 42:3, 42:16 – 43:5; T. Chiu Depo. Desig. on 11/25/2008 at 87:21 – 89:1; J. Ritrosky, J. Depo. Desig. on 11/10/2008 at 49:9 – 50:7.

426. Dr. Natalie Carr is a pediatric dentist who practices outside of Tampa. Carr on 8/10/2010 Final Tr. at 3787:10-13. She practiced in Texas, where 99 percent of her patients were on Medicaid. In Florida, she did not accept Medicaid because "the reimbursement in Florida was much lower than it was in Texas at the time." *Id*. at 3789:25 – 3790:2. Sometimes, parents of Medicaid children come to her offering to pay her to render services to their child because they cannot find a Medicaid dentist. *Id*. at 3791:24 – 3792:8. She has difficulty making referrals because there are so few dentists in the area who accept Medicaid, and most of those do not accept new patients. *Id.* at 3793:3-20; 3808:17-24. Dr. Carr testified that she would not accept Medicaid patients in her new practice because even with a 48% increase the gap between the fees she charges is too great. Carr on 1/23/2012 Rough Tr. at 7:2-19.

427. Dr. Robert Primosch is a Professor of Pediatric Dentistry and Associate Dean of Education at the College of Dentistry of the University of Florida in Gainesville. As Chairman of the Department of Pediatric Dentistry, Dr.

Primosch ran the dental clinic for children, 80% of whom were on Medicaid. Primosch on 8/10/2010 Final Tr. at 3721:15-20; 3722:24 – 3723:4; 3725:9-16. The clinic saw about 14,000 patients a year, and the demand for its services exceeded its capacity. *Id*. at 3732:25 – 3733:4; 3725:17 – 3726:20. When Dr. Primosch ran the clinic, there was a six-month wait for children whose dental needs required hospitalization and that waiting period has not shortened since for children whose care he has supervised. *Id.* at 3731:4 – 3732:1.

428. Dr. James Crall is a professor of pediatric dentistry at UCLA, and a former chair of UCLA's pediatric dentistry section. Crall on 11/17/2010 Final Tr. at 5069:21-23, 5070:2-3; 5071:1-13. He was director from 2000-2008 of the National Oral Health Policy Center, which is funded by the Health Services and Resources Administration (HRSA). *Id.* at 5070:11-21. Over the last 25 years, Dr. Crall has held a variety of positions with numerous national and federal government bodies dealing with oral health policy. *Id.* at 5072:21 – 5073:20. Dr. Crall has twice testified before Congressional committees and twice before state legislatures. *Id.* at 5073:22 – 5074:7. He has published 60-65 articles in peer reviewed journals, *id.* at 5075:14-19, including many on the relationship between rates and participants by dentists in Medicaid programs. I accept Dr. Crall as an expert on public policy with respect to the provision of dental care to low-income children.

429. Dr. Crall testified: (a) Children's access to dental care in Florida Medicaid program is quite low, declining and inadequate; (b) Dentists' participation in this Florida Medicaid program is low, inadequate and declining; (c) Florida Medicaid rates are low compared to market based fees charged by dentists and far below the average overhead cost of providing dental services; and (d) Medicaid rates need to be increased at least to the 50th percentile of prevailing fees charged by Florida dentists to significantly improve access. Crall on 11/17/2010 Final Tr. at 5078:15 – 5079:5; 5079:12 – 5081:14; 5081:15-23; PX 418.

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430. Dr. Crall's conclusion regarding access was based on Florida's CMS 416 reports showing that only 21-23% of eligible children received any dental care, and even fewer children received preventative care or treatment. PX 418 at p. 9; Crall on 11/17/2010 Final Tr. at 5082:8 – 5084:3; PX 447. By contrast, more than half of privately insured children receive dental care in the course of a year. Crall on 11/17/2010 Final Tr. at 5093:20 – 5094:9; 5161:9 – 5162:24; PX 452 at 13.

431. Despite Defendants' multiple attacks on the use of the form 416 data to measure access to dental care, the 416 remains the method which CMS uses to measure state performance. Crall on 2/7/2011 Final Tr. at 5208:1-22; PX 440 at 3; Crall on 1/26/2012 Rough Tr. at 155. HEDIS data are available only for managed care companies (Crall on 2/7/2011 Final Tr. at 5243:12-14) and are based on survey data while the CMS – 416 relies on all the data. Crall on 2/7/2011 Final Tr.

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at 5243:12-22. Defendants touted the role of County Health Departments and Federally Qualified Health Centers in providing dental care for children on Medicaid, and suggested those institutions were sufficient to compensate for the paucity of private dental providers. However, based on the instructions for the CMS 416, all dental care provided to children by CHDs and FQHCs are counted on the CMS 416. Crall on 2/8/2011 Rough Tr. at 82-83. So I find that the number of children receiving dental care at either CHDs or FQHCs, which ranged from about 65,000 children in FFY 2003 to about 103,00 children in FFY 2007, as shown on PX739 (last page, table 3), are included in the total number of children receiving dental care as shown on the CMS 416s for those years. And the numbers on the CMS 416 demonstrate, that notwithstanding the important role played by CHDs and FQHCs, 79% of the children on Medicaid in Florida did not receive any dental care in FFY 2007.

432. Defendants' expert Ms. Sreckovich confused dental procedures with dental visits, in an error that undercuts her credibility, as even her own back-up materials clearly showed she was counting procedures. Sreckovich 1/10/2012 Rough Tr. at 23-24, 26-27. This had a significant effect on her analysis because dentists often perform several procedures during one visit, *id.* at 23, and made it appear as if children in Medicaid were receiving twice as much care, or more, than they really were. *Id.* at 31-34.

433. Even after Ms. Sreckovich corrected that error, she computed an average number of dental visits among all patients that completely obscures the fact that the vast majority of children received no dental visits. 2/8/2011 Rough Tr. at 102-103. I conclude that Dr. Crall is justified in relying upon the CMS 416 reports, and that the figures in those reports, are more telling that Ms. Sreckovich's average dental visit analysis.

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434. Dr. Crall determined that Florida Medicaid rates were far below market rates and far below dentists' costs. He compared Florida Medicaid payment rates in each of the 14 procedure codes to the 51st and 70th percentiles of 2008 charge data provided to him by Met Life, a very large commercial dental insurer. Crall on 11/17/2010 Final Tr. at 5119:24 – 5120:13, 5122:5-22; 5126:3-4. Dr. Crall also obtained charge data from the "2008 National Dental Advisory Service Comprehensive Fee Report" (the NDAS report), which uses a system like Medicare's RBRVS system to make geographical adjustments. *Id.* at 5126:9 – 5127:20. Florida Medicaid rates equal only 22% to 41% of the 50th percentile NDAS charges and 22% to 45% of the 51st percentile of Met Life charges. *Id.* at 5131:7 – 5132:20; PX 418 (Table 5 and page E11 of the Appendix).

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435. In reaching his opinion about the adequacy of Florida's Medicaid dental rates, Dr. Crall considered the dental service component of the Consumer Price Index, and determined that since 2003, inflation had run about 40%, at a

compound rate, *Id.* at 5138:19 – 5139:15), and that the literature shows that 60-68% of dental office revenues, exclusive of any compensation to the dentists, are spent on overhead. *Id.* at 5139:17 – 5140:6.

436. Dr. Call examined not only the 50th percentile of dentists' charges, but also 70th-75th percentile of dentists' charges because of the use of that percentile as a benchmark for Medicaid rates in Indiana, South Carolina, Connecticut, and Tennessee and in connection with settlement of litigation. *Id.* at 5140:15 – 5141:20; PX 418 at 11. A sizeable increase in dentists' participation followed Medicaid dental rate increases to at least the 75th percentile of charges. *Id.* at 5141:11 – 5144:19; PX 418 at 11. Dr. Crall knows of no state which had an increase of 58% or more in dental participation without a contemporaneous increase in Medicaid rates to at least market levels. *Id.* at 5145:6-12.

437. Defendants criticize Dr. Crall's charge data. Dr. Crall used charge data rather than payment data because, among other things, reports in the literature, including a GAO report, is that dentists' collection rates are close to 95%. *Id.* at 5121:2-22; *id.* on 2/8/2011 Rough Tr. at 75:21 – 76:14. Moreover, making comparisons using payment data from commercial insurers (if it were readily available) would be problematic because co-pays and deductibles are also paid. Crall on 2/8/2011 Rough Tr. at 82:7-17.

438. Michigan had a 300% increase in dental participation within 12 months in the counties where the rates were increased. *Id.* at 5147:1-7. In those Michigan counties where the increase in dental rates was implemented, the number of children receiving a dental service increased about 32.3 % the first year, *id.* at 5148:23-25; Crall on 1/26/2012 Rough Tr. at 106-107.

439. Dr. Crall also examined the effect of the rate increases from 1998 to 2003 in Alabama, Delaware, Indiana, South Carolina and Tennessee on the number of children reported as receiving dental care on the respective states' CMS 416 reports. Crall on 11/17/2010 Final Tr. at 5147:12 – 5148:2; PX 418 at 11. The number of Medicaid children receiving any dental service over the period 1998 - 2003for these five states increased by 168% to 446%, according to these states' respective CMS-416 reports. Crall on 2/8/2011 Rough Tr. at 70-74. Those results are illustrated by the following chart in his report:

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| | FY1998 CMS 416 % with Dental Visits | FY2001 CMS 416 % with Dental Visits | 2001 vs. 1998 CMS 416 % with Dental Visits | FY2003 CMS 416 % with Dental Visits | 2003 vs. 1998 CMS 416 % with Dental Visits |
|---|---|---|---|---|---|
| AL | 41,659 | 105,522 | 253% | 151,581 | 364% |
| DE | 8,428 | 15,430 | 183% | 18,269 | 217% |
| IN | 47,730 | 160,627 | 337% | 212,909 | 446% |
| SC | 96,590 | 88,523 | 92% | 245,297 | 254% |
| TN | 148,028 | 141,140 | 95% | 249,252 | 168% |

PX 418 at 12. (The first, second and fourth columns should read "number with Dental Visits," not "% with Dental Visits.). The 2007 Connecticut settlement lead to an increase to the 70th percentile of dentists' charges and that in turn resulted in

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a tripling of dentists participating in Medicaid and an increase of 38-45% in utilization in the most recent two year period. Crall on 11/17/2010 Final Tr. at 5140:15 – 5141:10, 5150:12-24.

440. Dr. Crall concluded that in order to increase the number of dentists who participate in the Medicaid program in an amount comparable to the increases achieved in these states, it would be necessary to increase the rates Florida Medicaid pays dentists at least to the 50th percentile of dentists' charges in Florida. *Id.* at 5149:15 – 5150:7. CMS has also used the 50$^{th}$ percentile as a benchmark of the adequacy of dental fees. PX 447 at CRALL00751.

441. Ms. Sreckovich's contention that increases in dental rates do not increase dentists' participation is belied by the numerous examples Dr. Crall cited in his initial report. PX 418. Crall on 1/26/2012 Rough Tr. at 104. As Dr. Crall opines, a significant increase will induce more dentists to participate in Medicaid.

442. The most important factor in inducing dentists to participate in Medicaid is the adequacy of the reimbursement rates. Crall on 2/7/2011 Final Tr. at 5341:3-13; 5380:15-16; PX 450 at CRALL01638 ("Dentists cite as the primary reason for their not treating more Medicaid patients that payment rates are too low.") If anything, factors such as high rates of broken appointments and higher rates of dental disease militate in favor of dentists being given financial incentives

to see Medicaid children equal to or greater than the rest of the population. Crall on 2/8/2011 Rough Tr. at 77-78.

443. Dr. Crall also considered the trend line of the number of dentists participating in Medicaid. Crall on 2/8/2011 Rough Tr. at 81; PX 418 at 8-9. He concluded, based on data from the CDC and from a State of Florida website that about 1,000 active Medicaid dentists was insufficient to serve a Medicaid population of 1,600,000. Crall on 11/17/2010 Final Tr. at 5089:13 – 5099:18. In rebuttal report, Dr. Crall amplified his analysis, using the 700 Medicaid children per active Medicaid dentist benchmark developed in Tennessee Medicaid Litigation Settlement. Crall on 2/8/2011 Rough Tr. at 63; PX 439 at pp. 7-8; Crall on 1/26/2012 Rough Tr. at 188.

444. In vast majority of the counties of Florida, there are a considerable number of dentists not actively participating in Medicaid. Even if only half the dentists in each Florida county participated in Medicaid, there would 35 counties, including those with the largest population of Medicaid children, with fewer than 700 Medicaid children per participating dentist. PX 439 (Appendix A, far right column showing number of Medicaid kids per active dentist is less than 350).

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445. Defense counsel suggested that Dr. Crall failed to take into account that a number of Florida counties are designated health shortage areas. Crall's analysis is consistent with the Federal Health Resources Services Administration

(HRSA), which considers as dental shortage areas those areas where population per dentist ratio exceeds 3,000 to 1. Crall on 2/7/2011 Final Tr. at 5348:21 – 5349:17. Based on the data on HRSA's website, only 15 % of Florida population lives in an area considered underserved. Crall on 2/7/2011 Final Tr. at 5349:10-22.

446. Defense counsel also suggested Dr. Crall he should have included adults seeking dental care in his workforce analysis. Crall on 1/31/2012 Rough Tr. at 121-122. I agree with Dr. Crall that the appropriate comparison for a workforce survey is between the access for children on Medicaid and the access for children in general because he was analyzing children's access to dental care. Crall on 2/8/2011 Rough Tr. at 59.

447. Effective July 1, 2011, following an appropriation by the Florida Legislature, AHCA increased the rates paid by Florida's Medicaid Program for dental services by 48%. D.E. 962, p. 2. Dr. Crall prepared a supplemental report dated May 24, 2011, in which he assessed the impact of Florida's 48% increase in rates, PX 786, Crall on 1/26/2012 Rough Tr. at 87, and concluded that "the increase of 48% still leaves Florida dental Medicaid rates severely below adequate market-based rates" and so he continues to believe these rates must be increased. *Id.* at 88. Dr. Crall took the increased rates and compared them to two of the three measures which he used to evaluate the charges in his initial expert report *i.e.*, the 2008 NDAS comprehensive fee survey and the 2008 data he obtained from the

commercial dental plan. *Id.* at 88. The following chart shows after considering the 48% increase, Florida's dental reimbursement is still very low as compared to normal dentistry charges, even without accounting for inflation since 2001.

| Procedure Code | FL Medicaid Rates | FL Medicaid Rates vs. 2001 ADA S Atlantic %-iles | FL Medicaid Rates Based on Proposed 48% Inc | FL Medicaid Rates w/ 48% Inc vs. 2001 ADA S Atlantic %-iles |
|---|---|---|---|---|
| D0120 | $15 | 5th | $22 | 33rd |
| D0150 | $16 | <1st | $24 | 5th |
| D0210 | $32 | <1st | $47 | 4th |
| D0272 | $9 | <1st | $13 | 2nd |
| D0330 | $30 | 1st | $44 | 4th |
| D1120 | $14 | <1st | $21 | <1st |
| D1203 | $11 | 4th | $16 | 20th |
| D1351 | $13 | <1st | $19 | 3rd |
| D2150 | $41 | <1st | $61 | 4th |
| D2331 | $39 | <1st | $58 | 1st |
| D2751 | N/A | | | |
| D2930 | $68 | 2nd | $101 | 10th |
| D3220 | $50 | 3rd | $74 | 18th |
| D3310 | $148 | 1st | $219 | 3rd |
| D7140 | $27 | <1st | $40 | 1st |

D.E. 964-6. Comparing the Florida rates with the 48% increase to Southeast Atlantic Region percentiles from the American Dental Survey in 2001 shows all 14 of those new Florida Medicaid enhanced rates below the 33rd percentile and 11 of the new rates in the 10th percentile or lower. *Id.* at 92-93. PX 786, Exhibit E.

448. From 2001 to 2010 the dental component of the Consumer Price Index increased 51%. *Id.* at 93. PX 786, par. 15. Dr. Crall in his supplemental declaration therefore concluded that: "given the woeful inadequacy of the current rates, a 48% increase in Florida's Medicaid dental reimbursement rates might slow

the exodus of providers from Florida's Medicaid program, but is not sufficient to induce a significant number of providers to enter or re-enter the program, or to stimulate current providers to substantially increase the number of children on Medicaid that they are willing to treat. As I previously indicated, doing so would require raising reimbursement rates to a least the 50th percentile of dentists' prevailing charges." *Id.* at 93. PX 786 par. 16.

449. In his initial report, Dr. Crall also analyzed capitation rates. He considered three actuarial studies done in 1998, 1999 and 2004 of per member, per month (PMPM) amount necessary to cover dental care for children on Medicaid. These studies, which on average are more than a decade old, found that from about $17 to $26 PMPM was necessary. Crall on 11/17/2010 Final Tr. at 5133:7 – 5160:10, PX 418 at 6-8. By contrast, AHCA's 2009 contract with the company that acquired ADI called for a PMPM amount for children from 1-20 of between $5.53 and $7.86, depending on age and status. DX 355 at 88. Even with the 48% dental fee increase, effective as of July 1, 2011, MCNA's blended capitation rate was $11.88, Brown-Woofter on 11/10/2011 Rough Tr. at 66-67, still far below the amount necessary to provide adequate dental care for children on Medicaid, according to the three studies cited by Dr. Crall, the only such studies in the record.

450. Ms. Sreckovich has not done any analysis on the effect of the 48% increase in dental rates which Florida instituted in 2011, either for fee for service

providers or for providers enrolled with dental managed care organizations. Sreckovich on 1/17/2012 Rough Tr. at 45-46. Ms. Sreckovich's analysis of whether Florida's Medicaid rates may be sufficient to cover the variable costs of treating a Medicaid patient is largely irrelevant because: (1) she did not address the dentists' opportunity cost; and (2) did not consider whether in the real world rates above variable costs but below average costs would motive dentists to see Medicaid patients. Crall on 2/7/2011 Final Tr. at 5334:19 – 5337:6; 5342:4-6. In her analysis of the dental rates in Florida, Ms. Sreckovich reached no conclusion that the rates paid dentists by the Florida Medicaid program were adequate to ensure children had access to care. Sreckovich on 1/17/2012 Rough Tr. at 33-34.

451. The Florida legislature has authorized ACHA to expand Medicaid prepaid dental plans statewide. Brown-Woofter on 10/25/2011 Rough Tr. at 50-52. The prepaid dental plans in Miami-Dade County as well as statewide will be required to pass along to providers the 48% increase in dental fees which took effect July 1, 2011. Brown-Woofter on 11/8/2011 Rough Tr. at 126-127. Ms. Sreckovich knows of no evidence and offered no opinion regarding the likely effects of the prepaid dental plan, which Florida is putting into effect in 2012 . Sreckovich on 1/17/2012 Rough Tr. at 48. Defendants did not submit any evidence by Ms. Sreckovich or otherwise that the 48% increase in dental rates or the statewide prepaid dental plan will be sufficient (a) to raise Florida's Medicaid

dental rates to private market rates; (b) induce substantial additional numbers of Florida dentists actually to offer services to children enrolled in Medicaid or (c) increase the percentage of children enrolled in Medicaid to the 30% level, which CMS has considered a minimum threshold for compliance. *See* PX 447 at 3. Defendants did not call any dentists to testify.

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452. After reviewing the evidence and weighing the expert opinions, I find that until the recent July 1, 2011 increase, Florida's Medicaid reimbursement rate was among the lowest in the nation, and not surprisingly, Florida's Medicaid dental utilization rate was also among the very lowest if not the lowest in the country.

453. I find that while a number of different factors affect dentists' decisions as to whether to participate in Medicaid, the adequacy of reimbursement rates is the most important of those factors., and that with a significant increase in rates, will come a significant increase in provider participation, which, in turn, will lead to a substantial improvement in children's access to care.

454. Defendants have offered no evidence or opinion to contest Dr. Crall's opinion that even with a 48% increase Florida's Medicaid reimbursement rates are woefully inadequate. I find his opinion credible and accept it, especially given the utter lack of any contradictory evidence.

455. I agree with Dr. Crall's opinion, based inter alia on the fact 79% of the children enrolled in Medicaid are getting no dental services at all, that Medicaid children in Florida are not receiving dental services with reasonable promptness. Crall on 1/26/2012 Rough Tr. at 96-97. *See Health Care for All, Inc.*, 2005 WL 1660677, at *10-11 (D. Mass. July 14, 2005) (finding violation of EPSDT requirements and the reasonable promptness provision as to dental care); *Memisovski*, 2004 WL 1878332, at *50 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions); *Clark v. Kizer*, 758 F. Supp. at 575-579 (finding violation of reasonable promptness provision as to dental care).

456. It also means Florida is not in compliance with the EPSDT requirements. *See Health Care for All, Inc. v. Romney*, 2005 WL 1660677, *14 (D. Mass. July 14, 2005) (finding a violation of 43(B) and (C) as to dental care); *Memisovski*, 2004 WL 1878332, at*50-*56 (finding violation of EPSDT provisions).

457. I also agree with Dr. Crall's opinion that Florida's Medicaid dental rates failed to provide equal access in violation of 42 U.S.C. § 1396a(a)(30)(A) for Florida's Medicaid children in each of AHCA 11 regional areas, based on how few dentists participate in Florida Medicaid and on the 79% of children who get no dental service. *Id.* at 98:6-20. *See Health Care For All, Inc.*, 2005 WL 1660677, at *10-*11 (finding violation of equal access provision as to dental care); *Clark v.*

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*Kizer*, 758 F. Supp. at 575-579 (finding violation of equal access provision as to dental care).

**F. Provider Enrollment**

458. I have discussed above the issues surrounding the adequacy of the number of providers of primary, specialty and dental care for Medicaid children, and whether such providers even if enrolled limit the number of Medicaid patients they will see. I consider here the issue of whether increased reimbursement levels would likely result in increased provider participation, and hence access to care for the plaintiff class. I note that this issue already has been discussed expressly with respect to dental care. *See* Section VI. E, *supra*, and indirectly inasmuch as AHCA and others have discussed primary and specialist care problems in terms of the inadequacy of reimbursement rates.

459. While it is recipients and not providers who hold the rights provided by federal law, any analysis of their ability to access that care at all, or with the Reasonable Promptness and Equal Access, required by the Medicaid Act, must take into account the relationship between the rates at which provider reimbursement and participation by providers in the program, which reflects access to care.

460. The relationship between provider reimbursement and participation in Medicaid has been studied by academic researches, and analyzed by policymakers

at the state and federal level. There also have been certain empirical tests where reimbursement has been increased, and finally, there are legislative judgments that have been made in this area. For example, Section 30(A) itself reflects an understanding that reimbursement is directly related to access to medical care by directing that rates be set, *inter alia*, so as to insure equal access to care for Medicaid children – a statutory provision which would make no sense in the absence of a relationship between the two.

461. Plaintiff's expert, Dr. Samuel Flint, opined that "the fundamental issue that drives participation, that determines physician's decisions to participate in the program, or to limit their participation is the rate of reimbursement." Flint on 8/3/2010 Final Tr. at 2949:21 – 2950:5. Dr. Flint testified that 27 of 30 peer-reviewed studies that he reviewed supported this view. *Id*. This academic research came from different parts of the country, using different research methods, different time frames and different populations. *Id.* at 2951:5-7. While this academic research did not deny the presence of other factors, in Dr. Flint's view, the professional literature supports his opinion that doctors will "put up" with administrative hassles, patient difficulties and other concerns if they are paid a satisfactory fee. *Id.* at 2951:2-4.

462. Considerable time was spent at trial by both sides on reviewing specific studies in this rich academic literature. Defendants, to be sure can quote

certain passages from certain studies that might cast doubt on the strength or the universality of the causal relationship between fee levels and provider participation. Nonetheless, there is no question that the consensus of the academic literature reflects a causal relationship between reimbursement levels and physician participation. *See e.g.*, PX 498, PX 501, PX 504,PX 505, PX512, PX 513 and PX 524. Ms. Sreckovich admitted that she had identified no professional literature not considered by Dr. Flint. Sreckovich on 1/10/2012 Rough Tr. at 116. Reliance on peer-reviewed studies, especially from multiple studies, is the gold standard and far more reliable than non-peer reviewed work commissioned for litigation.

463. I note, as one example, the work done by Peter Cunningham, which both sides treated as authoritative. In addition to reporting that 84% of physicians surveyed identified low Medicaid reimbursement as a moderate or very important reason for not accepting new Medicaid patients, PX 512 at Flint 01123, Flint 8/3/2010 Final Tr. at 2960:4 – 2961:2. Cunningham also conducted a regression analysis that "showed that higher Medicaid fees relative to Medicare were associated with a higher probability of accepting new Medicaid patients." PX 513 at Flint 00152; Flint at 2961:16-25. A third study by Cunningham considering community norms, professional attitudes and other factors, nonetheless identified physician fees as the "driving force" in physician decision-making. PX 514, Flint on 8/3/2010 Final Tr. at 2963:3-21, 3514:11 – 3515:23. Cunningham studied a

projected 20% increase in Medicaid reimbursement relative to Medicare, and found a significant relationship among all communities studied, one of which was Miami, where he projected an increase of 11.8 percentage points in provider participation. PX 514 at Flint 00155 Flint, Flint on 1/24/2012 Rough Tr. at 173. The Cunningham study of 12,000 physicians and 60 communities also showed a statistically significant reduction in unmet medical needs of Medicaid population, increased satisfaction with choice of specialist and reduced use of emergency care, associated with higher reimbursement rates. PX 513; Flint on 1/24/12 Rough Tr. at 174-75.

464. These results are consistent with surveys and empirical relied upon by Dr. Flint. A survey of Florida physicians who were members of the American Academy of Pediatrics reported a significant number of physicians surveyed would increased their willingness to take Medicaid patients with higher reimbursement. PX 535. While this survey is methodologically limited by a small sample, it is consistent with the other evidence presented. The more providers who participate in Medicaid, the more access children on Medicaid will have to care. Flint on 8/4/2010 Final Tr. at 3348:17 – 3350:13; Crall on 11/17/2010 Final Tr. at 5106:23 – 5107:15.

465. The relationship between fees and provider participation is also illustrated by Defendants' own 2009 survey of half of Florida's physicians.

According to that survey, 46% of Florida physicians were accepting no new Medicaid patients, while only 22% were accepting no new Medicare patients, PX 742 at pp 62, 66, which pays significantly more than Medicaid.

466. In Polk County, Florida, physician reimbursement for treating uninsured patients was increased to Medicare levels during 2007-2008. The result was a substantial increase in access to care. Flint on 1/24/2012 Rough Tr. at 182-184. While this occurred among a population of uninsured individuals, I do not see that as undermining the example's relevance. Similarly, Polk County was shown to be a rather typical Florida county. Flint, Rough Tr. 1/3012 at 113-114. *Id*.

467. Even Ms Sreckovich did not opine there was no association between rates and provider participation, a point that would have been counter to common sense. Instead, she pointed to the other factors – including physician attitudes toward Medicaid patients and administrative issues – as undermining that association. Sreckovich on 1/6/2012 Rough Tr. at 83-84. Ms Sreckovich, however, could not counter that for a significant number of physicians, although clearly not all, those obstacles can be overcome by higher reimbursement levels. Indeed, she admitted as much. Sreckovich on 1/9/2012 Rough Tr. at 119-120.

468. These studies are confirmed by AHCA's own budget requests, which seek increased reimbursement for both physicians and dentists grounded in the

causal relationship between increased reimbursement rates and increased provider participation on the one hand, and increased provider participation and increased access on the other hand. *See* PX 92 ("Increasing the Child Health Check-Up reimbursement rate will increase access to services"); PX 93 (same); PX 94 (same). AHCA repeatedly observed that when AHCA doubled the reimbursement rates for child health check-ups in 1995, the participation rate doubled as well. *See* PX 734, PX 92, PX 93,PX 94, PX 95, PX 96, PX 702, and PX 703.[37]

469. In addition, AHCA, in multiple legislative budget requests over a number of years, proposed as a solution for that "specialty provider shortage" and "critical access to care problem" a fee increase for certain specialist to the Governor and Legislature. *Id.* This, too, recognizes the obvious existence of a relationship among rates, participation and access.

470. Federal CMS also recognizes the relationship between reimbursement rates, provider participation and access, declaring in a Dear State Medical Director letter: "Lack of access due to low rates is not consistent with making services

[37] At trial, defendants sought to question this relationship, even though it was repeatedly submitted to the legislature and acknowledged as correct under oath in depositions. Defendants claim there was a certain time lag before the higher rates had the observed effect. Such a time lag between raising rates and an effect on participation and rate of check-ups is not surprising. Defendants also claim that certain other steps may have contributed to increased participation rates, but no one suggests those other factors, such as educational efforts, were the principal case. *See* PX 524 and Flint on 1/24/2012 Rough Tr. at 186-193, GAO Report citing increase as example of effect of increased reimbursement rates.

available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at CRALL 00751.

471. Based on the evidence in this case, I conclude that while reimbursement rates are not the only factor determining whether providers participate in Medicaid, they are by far the most important factor, and that a sufficient increase in reimbursement rates will lead to a substantial increase in provider participation and a corresponding increase in access to care.

472. There was also substantial support at trial that the point at which physician reimbursement rates needed to be increased to have a significant effect was the level paid under the Medicare program. This was Dr. Flint's opinion and it was the level in the Polk county experience. Flint Testimony on 1/24/2012 Rough Tr. at 182-186. An increasing number of other states have pegged Medicaid compensation to, at or very near the Medicare rate *Id.* at 191-192. Moreover, Congress, in recent legislation, has required for a two-year period that primary care providers receive compensation at least at the Medicaid rate. Sreckovich on 1/12/2012 Rough Tr. at 49. It is also logical that the Medicare rate – the rate at which compensation is paid under the other large government health care program in this country – is a good indication of a competitive market price. Flint on 1/24/2012 Rough Tr. at 191-192. There was no evidence presented by the

Defendants of any different rate level. Given the record, I find that Plaintiffs have shown that achieving adequate provider enrollment in Medicaid – and for those providers to meaningfully open their practices to Medicaid children – requires compensation to be set at least at the Medicare level.

**G. Managed Care**

473. As of October 2009, there were just over 1.5 million children on Medicaid in Florida, and about 650,000 were assigned to an HMO in a non-Reform County and another 120,000 of so were assigned to an HMO in a Reform county. DX 262a.

474. Whether AHCA chooses to provide care for children on Medicaid through a fee-for-service arrangement or through a Medicaid HMO, AHCA is still ultimately responsible, as the designated agency that administers Florida's Medicaid program, to ensure children on Medicaid receive the care to which they are entitled under federal law.

475. AHCA pays HMOs on a capitated basis, and determines how much to pay Medicaid HMOs on an annual basis. Because of the formula AHCA uses to determine per capita payments for Medicaid HMOs, the amount of those payments is driven in substantial part by the amount AHCA pays providers on a fee-for-service basis through the MediPass system and historical rates of utilization. Williams on 10/12/2011 Rough Tr. at 101-103; Brown-Woofter on 11/8/2011

Rough Tr. at 124-26; *id.* at 11/9/2011 at 25. AHCA discounts aggregate payments to HMOs to account for the presumed efficiencies of HMOs.[38] Williams on 10/17/2011 Rough Tr. at 171-173.

476. "[T]he rates of capitation and the rates of physician reimbursement under capitation are a reflection of the fee-for-service rates." Flint on 8/3/2010 Final Tr. 2975:13 – 2976:2. Florida is one of the lowest paying states in terms of its managed care compensation. *Id.* at 2999:20 – 3000:4.

477. In 2005 AHCA obtained federal and state approval for a Medicaid pilot project, known as Medicaid reform, pursuant to a 1115 research and demonstration waiver. Brown-Woofter on 10/20/2011 Rough Tr. at 96-98. Medicaid Reform was instituted in July 2006 in Broward and Duval counties and expanded in 2007 to Baker, Clay and Nassau counties. *Id.* at 97. Medicaid Reform allows ACHA to use managed care almost exclusively for service provision to Medicaid recipients. Brown-Woofter on 10/18/2011 Rough Tr. at 9.

478. The Medicaid Reform pilot must be budget neutral, meaning that it does not cost more to operate with the waiver than it would have without the waiver. Brown-Woofter on 10/18/2011 Rough Tr. at 9-10.

479. Florida's Office of Program Policy Analysis & Governmental Accountability (OPPAGA) in June 2009 reported on the progress of Medicaid

[38] Typically the discount has been about 8 percent. Testimony of Mr. Williams on 10/7/2008 Depo. Desig. at 59:13 – 61:17.

Reform through December 2008 and found the data did not show Medicaid Reform had improved access, or quality of care, or saved the state money. PX 683, page 1. OPPAGA recommended the Legislature not expand Medicaid Reform until more data was available to evaluate claims of its success. *Id.* That is the most recent OPPAGA report concerning Medicaid Reform. Copa on 4/5/2011 Rough Tr. at 127-129. In September 2007, the Office of the Inspector General of AHCA made a similar recommendation, after what then-Secretary of AHCA Andrew Agwunobi called in "independent, objective and through analysis," to delay the expansion of Medicaid Reform; the Agency adopted that recommendation; Agwunobi 2/13/2009 Depo. Desig. at 183:7 – 187:1.

480. The three largest Medicaid HMO's operating through Medicaid Reform in Broad County in 2008, had approximately 50% of the Medicaid enrollment in Broward, but two years later, none of those three plans were still operating in the county. *Id.* at 182-85.

481. AHCA's application to extend the waiver for Medicaid Reform in the five counties in which it is currently operating was recently granted for three years, Sreckovich on 1/18/2012 Rough Tr. at 51-52, but Florida's application to expand Medicaid Reform statewide has not at the present time been approved by the federal government. Copa on 4/5/2011 Rough Tr. at 128.

482. Children enrolled in Medicaid HMOs suffer from the same lack of access to care as children in MediPass or fee for service Medicaid. *See* Section VI.C., *supra*. As discussed above, HEDIS reports show that children in both reform and non-reform counties on managed care do not receive adequate preventative health care. PX 689, PX 733, DX 361, DX 334.

483. Certain medical providers do not take any Medicaid HMOs; Isaac on 8/11/2010 Final Tr. at 3856:4-12; Ayala on 8/9/2010 Final Tr. at 3570:2-17; Fenichel on 10/18/2011 Final Tr. at 4301:22 – 4302:1. Others limit which HMOs they will accept. Postma on 8/4/2010 Final Tr. at 3149:1-3; J. St. Petery on 11/11/2008 Depo. Desig. at 176:8-23; Donaldson on 10/15/2008 Depo. Desig. at 78:18 – 80:18; 206: 21-25.

484. AHCA's monitoring of HMOs does not demonstrate that children are receiving the care to which they are entitled under federal law for three fundamental reasons. First, though there is extensive testimony regarding the monitoring process in the record, there is very little in the record about the substantive results of that monitoring, and nothing to indicate children are receiving timely or adequate care. Flint on 1/24/2012 Rough Tr. at 153.

485. Second, most of the monitoring focuses on process, and even if the results were in the record, they would not demonstrate the children were getting the requisite care. For instance, the fact that an HMO has no more than 1,500

children per PCP, or has a number of specialists on its panel does not demonstrate that the doctors will see the children at all, let alone promptly.

486. Third, there is virtually no evidence and certainly no systematic evidence in the record that any MCOs were hit with a substantial fine, or expelled from the Medicaid program for failure to provide care to children on Medicaid or meet any contractual requirements relating to the provision of care. Thus, there is virtually no evidence that AHCA has used its power to sanction HMOs to ensure children receive adequate and prompt care.

487. Ms. Brown-Woofter, acting assistant deputy secretary for Medicaid operations, who testified for *ten* days did not even know, for instance, whether AHCA had *ever* issued any financial sanctions to Medicaid HMOs for having a low percentage of enrollees who received a lead blood screening exam. Brown-Woofter on 10/18/2011 Rough Tr. at 116-118; Brown-Woofter on 11/8/2011 Rough Tr. at 131-132. While she testified AHCA had issued some fines against HMOs for failing to meet a state requirement for a 60 percent screening ratio for children continuously enrolled in the HMO for six months, but had no information regarding the size of the fines. *Id.* at 118. AHCA did not issue any fines against HMOs for low child health check-up screening rates until 2008, years after this action began. Brown-Woofter on 10/18/2011 Rough Tr. at 131-32. Ms. Brown-Woofter testified that a financial sanction was levied against Universal in 2011, but

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was not even sure what the sanction was for. Brown-Woofter on 10/20/2011 Rough Tr. at 60.

488. Ms. Brown-Woofter offered a lay opinion that children on Medicaid HMOs do not have trouble accessing primary care and that they do not have difficult accessing specialty care and that any trouble with specialty care are limited to a few individuals. Brown-Woofter on 10/19/2011 Rough Tr. at 38-40, 74-77. I find her sweeping conclusions unpersuasive. They conflict with testimony that she gave as a 30(b)(6) witness at the end of the discovery period and in rendering her opinion, she did not consider numerous AHCA documents regarding shortages of providers.[39] *See* Brown-Woofter on 10/25/2011 Rough Tr. at 88-97; 95-97, 100, 103-07, 109-22; 126-38; PX 205, PX 188; PX 186; PX 90; PX 101; PX 199.

489. Based on applicable statutes and case law, I find that AHCA, as the agency that administers Florida Medicaid, is legally responsible to ensure that children who obtain their care through a Medicaid HMO (or through a Provider Service Network) receive the care to which they are entitled under federal law.

[39] While her deposition testimony focused on the fee-for-service component of Medicaid, not the HMO component, there is overlap between the providers enrolled in fee-for-service Medicaid and Medicaid HMOs, testimony of Ms. Brown-Woofter on 10/25/2011 Rough Tr. at 100, and no testimony as to why Medicaid HMOs, whose per capita compensation rate is driven by the fee-for-service rates, would be able to provide better care than the MediPass program.

490. I further find that the fee-for-service reimbursement rates AHCA sets for providers is a key factor in determining the capitation rate paid to HMOs and so for determining how much HMOs can, in turn, pay their providers. Accordingly, inadequate fee-for-service reimbursement rates result in inadequate compensation by Medicaid HMOs to their providers.

491. Based on the HEDIS reports, the mini-CMS 416 reports, as well as other documents and testimony from providers, I also find that same problems that plague fee-for-service Medicaid – failure to provide well child check-ups, a paucity of specialists, excessive wait times and travel distances for specialty care, lack of dental care – infect the Medicaid HMOs, which, accordingly, fail to meet the federal requirements for providing EPSDT care, in violation of a(10); do not provide care with reasonable promptness, as required by (a)(8); do not provide care with equal access under Section 30(A); and have not complied with the obligation to provide care as established by sections 43(b) and 43(c) of the Medicaid Act.

492. There is also extensive record evidence that leads me to find that children on Medicaid HMOs do not receive equal access to specialist care, and, as discussed in these findings, capitation rates paid to Medicaid HMOs are not set with consideration of the level needed so as to provide such equal access, consistent with the other requirements of (30)(a) as required under the Medicaid Act.

**H. Outreach And Medicaid Application Process**

493. Undisputed evidence at trial established that an estimated 268,000 Florida children are eligible for but not enrolled in the Medicaid program. 2009 Florida KidCare Coordinating Council Report. PX 682 at 2. Twenty percent of Florida children are uninsured, compared to a national average of 10 percent. *Id.*

494. Between 2004 and 2006, Florida moved to a largely on-line system of applications, eliminating most of the office locations at which individuals can apply in person for Medicaid coverage. PX 238. 57% of the DCF services centers were eliminated between 2004 and 2006. Nieves on 5/17/2010 Final Tr. at 2098:20 – 2099:1. These changes, accompanied by cuts in personnel, were enacted not because they were viewed as improvements but rather due to budget cuts. Lewis on 10/20/2010 Final Tr. at 4602:25 – 4603:14.

495. In 2007, an analysis by AHCA of the revised application system reported: (a) that the on-line system will time out in 20 minutes leading to 350 lost sessions each day; (b) 25% of applicant are unable to complete their application on first attempt; (c) "often, for numerous reasons, applicants are unaware that they have not submitted the required additional information and their case is closed;" (d) that 17 to 20 percent of the applicant population due to language barriers and other factors cannot successfully complete one or all steps in the new ACCESS

Medicaid eligibility process. PX 238; Nieves on 5/17/2010 Final Tr. at 2106:9 – 2111:20.

496. If assistance is required, it is difficult to obtain with the Tampa regional center reporting 40% of incoming calls abandoned or receiving busy signals in 2007. The rate in the other two regional centers is 20% in Miami and for Jacksonville it is 19%. PX 238 at 3. At trial, Mr. Lewis testified that he believed that 40% of the incoming calls at the Tampa regional call center are *still* either abandoned or receive a busy signal. Lewis on 10/20/2010 Final Tr. at 4638:3 – 4634:8.

497. In addition, DCF data indicate that between June 1, 2004 and March 1, 2005, applications were consistently processed above the designated time standard." PX 238 at 7.

498. The Access Medicaid application, which is the principal means by which Medicaid applicants apply, purportedly has been simplified, but remains a highly formidable challenge to complete. The application, reprinted as part of the application guide (DX 160), runs for over 50 pages of screens that Medicaid applicants must navigate. Nieves on 5/17/2010 Final Tr. at 2105:2 – 2106:4. Because it is a combined application in which families may apply for multiple cash and in-kind assistance programs, there are lengthy sections requiring answers on assets and expenses not needed for determination of children's Medicaid

eligibility. Complex terms, for example, are found in questions asking about "liquid assets" and "life estates." A significant amount of records must be gathered to complete the application. And, by virtue of being an on-line application, basic computer literacy is required.

499. By contrast, the Florida KidCare application (DX 181) is a two-page application for children seeking Medicaid or SCHIP assistance, but provides sufficient information for DCF to make a Medicaid eligibility determination. Lewis on11/29/2011 Rough Tr. at 31. Although AHCA added an on-line link to the KidCare application during the course of the trial in this action, the KidCare application is an alternative to the primary ACCESS application which individuals must first find on-line – a feat that even Ms. Sreckovich, Defendant's expert witness, had difficulty accomplishing unassisted by counsel. Sreckovich on 1/17/2012 Rough Tr. at 4-18. Applicants must then indicate they want to apply solely for Medicaid for children and not other potential programs. *Id.*

500. There is no reason established why the simple KidCare application could not serve as the default application for children seeking Medicaid. St. Petery on 2/2/2012 Rough Tr. at 86-87.

501. Even though DCF's on-line application is the primary vehicle by which applicants are encouraged to apply for Medicaid, DCF does not attempt to identify individuals who start the on-line application but do not complete it, collect

demographic information on them, or determine why they do not complete the application. Poirier 10/5/2011 Rough Tr. at 3-7, 6-7 33. DCF does not even know how many people start but do not finish the application. *Id.* at 12.

502. In addition to the complex application and the difficulties in obtaining help to completing the application, Florida has eliminated its primary outreach program for Medicaid. Until 2003 Florida "had an award-winning outreach program" recognized by federal CMS as a model for other states. PX 700 at DOH10000478. Before funding was terminated in 2003 approximately $4 million a year was spent on outreach programs, more than half of which came from the federal government. *Id.* The outreach program included: Statewide multi-media campaigns in English, Spanish and Creole covering television, radio, bus cards, and billboards; free distribution of applications and promotional brochures, postures and booklets; 17 regional outreach projects charged with recruiting and training community partners; data driven market research, county level enrollment data reporting and tracking; assistance for families with enrollment and coverage issues, and statewide training and technical assistance. *Id.* at DOH10000478-479; Louis St. Petery on 12/10/2009 Final Tr. at 526:3 – 531:9. In 2003 there was $4 million in funding, more than half of which came from the federal government. In 2003, the Florida legislature eliminated funding for the program. PX 682 at 20. Mr. Snipes on 12/9/2009 Final Tr. at 452:17-22 (Less outreach now for getting

eligible individuals enrolled). Since 2003 direct outreach funding has been limited to a one-time non-recurring $1 million authorization in 2006. PX 700 at DOH10000479. As AHCA acknowledged in its 2007-2008 budget request, this level of funding "will probably not provide the amount needed to make an impact on significantly decreasing the rate of uninsurance for children[,]" even if it were recurring. PX 711 at AHCA01095027.

503. While a variety of outreach efforts exist, such as through community partners, AHCA does not even assess the effectiveness of its written materials. Boone on 10/21/2008 Depo. Desig. at 58:21 to 60:2 And there has been no showing that these ad hoc efforts are an adequate substitute for the organized statewide program that existed before funding was terminated. There are at least four strong indications that they are not.

504. First, the difference between the outreach done before the budget cuts and that performed now is stark. Before, there were statewide multi-media campaigns in English, Spanish and Creole including public service announcements (PSAs) on television and radio, as well as bus cards and billboards. PX 700 at DOH10000478-479. That is no longer the case. Anne Boone, who was AHCA's child health check-up coordinator for years when she was deposed in 2008, was not aware of any PSA being played recently anywhere in the state on either radio or television. Boone on 10/21/2008 Depo. Desig. at 65:3-67:8. Rather, all she

knew concerning whether any PSA had been aired in the last several years on radio or television is that a single PSA about lead blood poisoning "might have been on a radio station." *Id.* That is the only PSA in the voluminous record in this action. DX 492. Rather than running on the radio or television, AHCA's PSA are shown on a loop on television sets at booths at heath fairs. Boone on 8/28/2008 Depo. Desig. at 163:14-164:1; Boone on 10/21/2008 Depo. Desig. at 309:21-310:6, 311:18-312:2. Similarly, Ms. Boone knew of only one instance in recent years in which there was a child health bus billboard, and even then, the billboard was only on busses in one city. Boone on 10/21/2008 Depo. Desig. at 67: 9-20.

505. Second, the KidCare Coordinating council which has representatives drawn from a variety of governmental and private organizations interested in medical care for children stated as follows:

> Unless families learn about Florida KidCare, how to apply and where to seek assistance in they need it, the program will not fully reach the population it is intended to serve. Florida KidCare enrollment significantly declined in 2004 … Enrollment started to increase again in 2007 as a result of increased emphasis on outreach. However, except for a non-recurring $1 million appropriation to Healthy Kids for community based outreach and marketing matching grants in Fiscal Year 2007-08, other activities were undertaken within existing resources and with non-recurring funds, making a large scale and ongoing initiative unsustainable without additional resources.

The KidCare Coordinating council recommended by a unanimous vote of 22 to zero that outreach funding for programs for unenrolled children be restored. PX 682 at 20. The council has been making this recommendation for years. *See* PX

349 at DOH00078171; PX 350 at 19-20; PX 682 at 2; PX 697 at16; PX 699 at 18; and PX 700 at DOH10000478.

506. Third, the Agency for Health Care Administration has also urged that outreach funding be restored, in the form of a legislative budget request for that purpose. PX 711.

507. Fourth, the existence of over a quarter million children eligible for Medicaid but not enrolled as of 2008 is compelling evidence that outreach programs are required. Indeed, an AHCA staff analysis indicated that approximately 75% of children with incomes under 200% of the federal poverty level are "low hanging fruit" for being enrolled in existing programs by conducting outreach. PX 240. Before the outreach program was eliminated, for each kid enrolled in Healthy Kids as a result of outreach, 2 children were identified as Medicaid eligible. *Id.* at 2.

508. The convoluted history of AHCA's dental reminder letter – reminding parents who had not taken their Medicaid child to a dentist for some time to do so – is indicative of the Agency's inadequate commitment to outreach. AHCA once sent out such periodic reminder letters, but stopped doing so in 2000. Boone on 2/24/2012 Depo. Designation at 31:10-19, PX 441 at 6. It discontinued the practice because there were so few dentists participating in the program that it was hard for parents to find a dentist close to where they lived and they became upset

when they couldn't. Boone on 8/28/2008 Depo. Desig. at 33:3-12. AHCA even told federal CMS, while Mr. Sharpe who left the agency in 2004 was Medicaid Director, that AHCA had not actively marketed its dental program to recipients for four to five years because of the few numbers of dentists participating in Medicaid and because it was often difficult for those seeking treatment to find a provider close to them. Sharpe on 2/8/2011 Rough Tr. at 184.

509. Ms. Boone admitted that the letters did help increase utilization. Boone on 8/28/2008 Depo. Designation at 32: 14-19. But for years, AHCA did not send out dental reminder letters, despite its extremely low utilization rate, in what can only be viewed as in intentional effort to curtail outreach to avoid further straining an already overburdened system.

510. In February of 2008, federal CMS conducted an on-site visit in Florida as part of its decision to review states with a dental utilization rate of 30% or less on the CMS-416 report for the fiscal year 2006. PX 440 at 3. In its report on that visit, federal CMS noted that Florida had sent reminder letters until 2000 and recommended that Florida again send dental reminder letters to "parents of beneficiaries who have not received periodic dental services." PX 441 at 6-7. AHCA stated in its response that implementation of Medicaid's new fiscal agent began on July 1, 2008, but that in "the very near future" it "will work with the new fiscal agent" to send out dental reminder letters.

511. Several years later, however, when Ms. Kidder testified at trial on May 31, 2011, she acknowledged that AHCA had still not begun sending out dental reminder letters. Kidder on 5/31/2011 Rough Tr. at 107-108. She said the letter would likely go out soon. *Id.* Ms. Cerasoli, who had testified as AHCA's designated agency representative on dental issues at deposition, testified that the dental letters were not sent because the agency did not view this as a priority. Cerasoli on 8/11/2010 Final Tr. at 3980:12 – 3981:1.

512. When AHCA analyzed its claims data in May of 2011 to see how many children enrolled in Medicaid had not received any dental services in the last six months, the figure was a staggering 834,651 children. PX 790. And that did not include children enrolled in ADI, Reform HMOs, and non-reform HMOs that offered dental services.

513. Given the Defendants' limited outreach, it is, perhaps, not surprising that A.D. did not know until she became a next friend in this action that her son was entitled to dental care through Medicaid. *See supra* at ¶¶ 142-155. And S.B. did not know that she was entitled to free transportation to doctor's appointments and laboratory visits. *See supra* at ¶¶ 121-128.

514. Federal law requires states to effectively inform all EPSDT eligible individuals or their families about the availability of EPSDT services, how those services may be obtained, that those services may be obtained at no cost to the

child, and that transportation is available. *See* 42U.S.C. § 1396a(a)(43)(A); 42 C.F.R. § 441.56(a). Florida has delegated to DCF, among other agencies, certain outreach and informational responsibilities. *See* FLA. STAT. § 409.9122(2)(c) (DCF must provide "clear and easily understandable information" about Medipass and Medicaid HMOs, the plans through which most children are supposed to receive EPSDT services in Florida). I previously held and reaffirm here that "DCF, as well as AHCA and DOH, have outreach responsibilities; they are required to 'ensure that each Medicaid recipient receives clear and easily understandable information' about Medipass or managed care options. This requirement arises from the Medicaid Act's outreach provision." 9/30/2009 Order on Class Certification, D.E. 671 at 7 (citations omitted).

515. The defendants contend that 42 U.S.C. § 1396a(a)(43) does not require them to conduct outreach to children who are not enrolled but are eligible for Medicaid. The plain language of the regulations implementing this section state that "[t]he agency must [p]rovide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program." *See* 42 C.F.R. § 441.56(a)(1); *Friends of Everglades v. S. Fla. Water Mgt. Dist.*, 570 F.3d 1210, 1227-28 (11th Cir. 2009) (stating that an agency's promulgation of regulations interpreting ambiguous statutory language is entitled to deference as long as the interpretation is

reasonable). "Medicaid's implementing regulations [in specific, § 441.56(a)] . . . obligate participating States to 'effectively' inform all eligible individuals." *See Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006). The plain language of the regulations, combined with the case law supporting this interpretation, compel the conclusion that § 1396a(a)(43) and 42 C.F.R. § 441.56(a)(1) mandate that the state conduct outreach to all eligible individuals.

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516. Defendants have failed to "[p]rovide for a combination of written and oral methods designed to inform effectively *all EPSDT eligible individuals* (or their families) about the EPSDT program," and to conduct outreach in "clear and nontechnical language" that provides information about the benefits of preventative care, the services available under the EPSDT program, how those services may be obtained, that the services are available at no cost to children, and that transportation services are available. *See* 42 C.F.R.441.56(a)(1), (a)(2) (emphasis added); *see also* § 1396a(a)(43)(A).

517. I further find that the use of the Florida Access application in the circumstances in which it currently is utilized constitutes an unnecessary and impermissible barrier to the provision of the EPSDT services to children required under the EPSDT Requirements of the Medicaid Act.

## VII. PROPOSED DECLARATORY RELIEF

518. Pursuant to 28 U.S.C. § 2202, a court may issue a declaratory judgment while retaining jurisdiction to grant supplemental relief. "The purpose of [28 U.S.C. § 2202] . . . is to allow the district court to retain jurisdiction in order to grant the relief necessary to effectuate its prior judgment." *Burford Equip. Co., Inc. v. Centennial Ins. Co.*, 857 F. Supp. 1499, 1502 (M.D. Ala. 1994); *see also In re Bicoastal Corp.*, 156 B.R. 327, 331 (Bankr. M.D. Fla. 1993) ("the further relief permitted by 28 U.S.C. § 2202 was designed to carry out the principle that every court, with few exceptions, has inherent power to enforce its own decrees and make such orders as may be necessary to render them effective.) Such supplemental relief includes the issuing of an injunction. *Powell v. McCormack*, 395 U.S. 486, 499 (1969) ("A declaratory judgment can then be used as a predicate to further relief, including an injunction.").

519. I have previously decided, with the agreement of all parties, that I would reserve the issue of what injunctive relief, if any, is appropriate on those claims on which I find Plaintiffs were entitled to relief. This process will allow the proper consideration of additional evidence regarding the need for and contours of appropriate injunctive relief.

520. The findings herein do not and are not intended to question the motivation of many dedicated public servants who work for AHCA, DCF and DOH. However, in our federal judicial system, when a state program is being

operated in such a manner that it denies individuals their federally assured rights, it is the agency heads responsible for those programs who must serve as defendants in litigation such as this and who are accountable, in their official capacity, for compliance with federal law. This is consistent with the long and well-established authority of federal courts in suits under Section 1983. *See supra* at Section II, *supra*.

521. I find that the named plaintiffs and the certified class of Florida children who are or will be eligible for Medicaid have been and are being denied their legally enforceable rights under the Medicaid Act, as set forth below.

522. First, the rate-setting of reimbursement under Florida's Medicaid program, directly for most codes under the fee-for-service program, and indirectly, because those codes then serve as the basis for much reimbursement of managed care, is done on the basis of a "conversion factor" required to achieve "budget neutrality" without consideration of whether such fees are (a) adequate to assure delivery of EPSDT services required under federal law Section (a)(10), or Sections 43(B) or (C) of the Medicaid Act; (b) adequate to assure access to such required care with reasonable promptness under Section (a)(8); or (c) sufficient to enlist enough providers so that care and services are available to Medicaid-eligible children to the extent that such care and services are available to the general

population in any of the geographic areas served by AHCA as required under 42 USC § 1396a(a)(30)(A).

523. Second, the wrongful termination of children from Medicaid eligibility, the subsequent reassignment of children whose eligibility is restored to physicians other than the provider which their parents previously chose, and the denial of prompt care to newborns presumptively eligible for Medicaid, violates (a) Plaintiffs' rights to EPSDT services under 42 U.S.C. § 1396a(a)(10); § 43(B) and 43(C) of the Medicaid Act, and (b) violates Plaintiffs' rights to receive care with "reasonable promptness" under 42 U.S.C. § 1396a (a)(8).

524. Third, defendants are not furnishing EPSDT screening services to all Medicaid-eligible Florida children in violation of (a) 42 U.S.C. § 1396a(a)(10); and § 43(B); (b) or with reasonable promptness in violation of 42 U.S.C. § 1396a(a)(8). The failure to provide blood lead screening services to that portion of the Plaintiff class required to receive such services also is in violation of these requirements. The failure to set provider reimbursement at levels sufficient to ensure equal access to care in any of the AHCA areas, which I find relevant geographical regions, also constitutes a violation of 42 USC § 1396a(a)(30)(A).

525. Fourth, defendants are not furnishing required specialty care to all Medicaid-eligible Florida children in violation of (a) 42 U.S.C. § 1396a(a)(10); and § 43(C); (b) or with reasonable promptness in violation of 42 U.S.C.

§ 1396a(a)(8). The failure to set provider reimbursement for specialists at levels sufficient to ensure equal access to care in any of the AHCA geographical areas also constitutes a violation of 42 USC § 1396a(a)(30)(A).

526. Fifth, defendants are not furnishing required dental care to all Medicaid-eligible Florida children in violation of (a) 42 U.S.C. § 1396a(a)(10); § 43(b) and (c) or with reasonable promptness in violation of 42 U.S.C. § 1396a(a)(8). The failure to set provider reimbursement for dental providers at levels sufficient to ensure equal access to dental care in any of the AHCA geographical areas also constitutes a violation of 42 USC § 1396a(a)(30)(A).

527. Sixth, the current ACCESS Florida application constitutes an obstacle to the receipt of EPSDT care for Florida's Medicaid eligible children, at least as currently administered. In addition, defendants are in violation of Section 43(A) by eliminating the Florida outreach program directed at providing notice of the availability of services to children eligible for Medicaid, and by not otherwise assuring such children are notified of the availability of care and services,

528. I recognize that AHCA is the principal agency responsible under Florida law for carrying out the requirements of the Medicaid Act. Defendant Dudek is thus declared, in her individual capacity, to be operating the Medicaid program in Florida in violation of the above requirements. Defendant Wilkins, secretary of DCF is declared to be in violation solely with respect to declarations

above related to eligibility determinations and the application outreach process. Defendant Farmer, secretary of DOH, is declared to be in violation solely with respect to the care provided to children in the CMS program, which operates under the authority of the Department of Health.

## VIII. CONCLUSION

I shall enter a final declaratory judgment pursuant to 28 U.S.C. § 2202, reserving jurisdiction for further proceedings with respect to injunctive relief, the scheduling of which shall be set by separate order.[40] The court will by separate order set a status conference to determine such briefing, discovery and evidentiary hearings that are appropriate in connection with injunctive relief.

Dated: March 23, 2012

Respectfully Submitted,

By: /s/ Stuart H. Singer

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[40] I also reserve jurisdiction to consider applications for attorneys fees and costs pursuant to 42 U.S.C. §1988.

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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on March 23, 2012, I electronically filed the foregoing document with the Clerk of the Court by using the CM/ECF system and that the foregoing document is being served this day on all counsel of record identified below via transmission of Notice of Electronic Filing generated by CM/ECF.

/s/ Stuart H. Singer
Stuart H. Singer

**SERVICE LIST**

**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.**

**Case No. 05-23037-CIV-JORDAN/BANDSTRA**
**United States District Court, Southern District of Florida**

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