UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

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

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

Plaintiffs,

vs.

ELIZABETH DUDEK, et al.,

Defendants.
_____/

DEFENDANTS' 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 citations. In a few instances, facts were deleted, because of difficulty in locating record references.

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DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Summary of Defendants' Position on Issues Tried

This is a Fed. R. Civ. P. 23(b)(2) class action, where the class is defined as "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. Plaintiffs challenge the administration of the Florida Medicaid Program (FMP), as it relates to services for children. The FMP provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs. *Ark. Dep't of Health and Human Services v. Ahlborn*, 547 U.S. 268, 275, 126 S.Ct. 1752, 1758, 164 L.Ed.2d 459 (2006).

Defendant Elizabeth Dudek is the Secretary of the Florida Agency for Health Care Administration (AHCA). AHCA is Florida's single Medicaid state agency, and, as such, is authorized to make payments for medical assistance and related services in the FMP. Fla. Stat. §409.902(1) (2011). As the single Medicaid state agency, AHCA is responsible for issuing policies, rules, and regulations on FMP matters. 42 CFR § 431.10(e)(1)(ii).

Defendant David Wilkins is the Secretary of the Florida Department of Children and Family Services (DCF). DCF is responsible for making Medicaid eligibility determinations and redeterminations through its ACCESS program. It is

also responsible for establishing the policies and rules relating to Medicaid eligibility determinations. Fla. Stat. §409.902(1) (2011). However, DCF may not set policy for the FMP itself beyond the narrow area of eligibility determinations. 42 C.F.R. §431.10(e)(3).

Defendant Frank Farmer is the Surgeon General and agency head of the Department of Health (DOH). DOH administers the Children's Medical Services program (CMS) and administers its public health programs through the local county health departments (CHDs). Fla. Stat. §20.43(3)(e) and (5) (2011). Since DOH is not the single Medicaid State agency, it is also without authority to set policy for the FMP. 42 C.F.R. §431.10(e)(3).

CMS is a program which provides health care to children with special healthcare needs (CSHCN), who are on Medicaid, enrolled in the State's Children's Health Insurance Program (or SCHIP, 42 U.S.C. §§1397aa *et seq.*), or who meet other financial criteria. To be eligible for CMS' services, a child must also be younger than 21 years of age and have chronic physical, developmental, behavioral or emotional conditions and 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) and 391.029 (2011). Medicaid enrolled CSHCN are a subset of the children who are served by CMS.

Plaintiffs are two provider organizations which want their provider members

to be paid more when they provide Medicaid services, as well as 8 children (one, T.G., has passed away) who complain about isolated problems in accessing care, compared to overall rich access to Medicaid funded specialty, dental and primary care. One of the remaining 8 children, J.W., is no longer Medicaid eligible, because he is in a high risk facility. Therefore, he lacks the personal interest required to pursue these claims for prospective relief for himself or the class.[2]

Plaintiffs have three claims remaining in this case. Count I, which alleges that Defendants fail to provide covered medical assistance, including Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Services, with reasonable promptness, applies to Defendants Dudek and Farmer, but as to Defendant Wilkins, only the claims under Section 42 U.S.C. §1396a(a)(8) remain. Count II, which alleges that Defendants fail to pay high enough reimbursement fees to ensure "equal access," remains pending against Defendants Dudek and Farmer only. Count III has been dismissed. Count IV, which alleges that Defendants fail to provide effective outreach, remains pending against Defendants Dudek and Farmer only. D.E. 203-3, pp. 29-32, 35-36; D.E. 541; D. E. 40.

There are a myriad of reasons why Plaintiffs' have not proven their claims. Plaintiffs do not have representative plaintiffs who have proven any injury ever on

[2] *National Ass'n of Boards of Pharmacy v. Board of Regents of the University System of Georgia*, 633 F.3d 1297, 1309 (11th Cir. 2011) ("requisite personal interest… must continue throughout [lawsuit's] existence.").

some claims such as outreach to the uninsured, difficulties in applying for Medicaid, and issues with continuous eligibility or delays in activation of newborns. Therefore, claims predicated on these types of injury must fail.

Regarding Count I, in addition to issues about whether the statutes create any enforceable right to actual provision of services with "reasonable promptness," and the lack of meaningful guidance from Congress or CMS regarding what is "reasonable," Plaintiffs fail to prove that the named Plaintiffs have experienced waits or delays that are closely connected to a custom or policy of Defendants, or that are the types of widespread and pervasive delays needed to support both the existence of a custom or classwide liability against any of the Defendants.

Regarding Count II, in addition to the fact that 42 U.S.C. §1396a(a)(30)(A) creates no enforceable rights, if it did, Plaintiffs' proof does not establish a basis for liability either as to the individual named Plaintiffs or as to the class. Regarding the named Plaintiffs, there has not been proof that low reimbursements caused any harm to Plaintiffs; and there is no reliable proof to show the availability of the care about which Plaintiffs complain in their geographic area. Likewise, there is no reliable proof about the availability of particular care as it relates to the class, by geographic area. Plaintiffs have provided neither a quantitative analysis nor benchmarks against which the Court could compare Medicaid access with that of private insurance, but instead have relied on isolated anecdotes from fewer than

25 provider witnesses. Where statistical proof is available, it shows isolated and not pervasive issues in the availability of care. These anecdotes do not establish the availability of care in particular geographic areas, let alone establish a need for system-wide liability. Also, Plaintiffs have not proven the inadequacy of the reimbursement rates of the FMP because of various defects in Plaintiffs' analysis.

Regarding Count IV, the record shows abundant outreach by DCF, AHCA and other partner state agencies, and community partners. Measured against the abundant outreach, there is not sufficient proof that Defendants did not provide effective outreach to the named Plaintiffs. Moreover, Plaintiffs have not shown that there are pervasive issues in the class as it relates to a lack of information about EPSDT services or Medicaid. Plaintiffs have not demonstrated that those uninsured children who are eligible for but not enrolled in Medicaid would enroll in greater numbers with more or different outreach, and they have not demonstrated that children would use more health screening or dental services if there was more or different outreach.

The record in this case simply cannot support a finding of liability.

II. Relevant Principles under 42 U.S.C. §1983

"To prevail in a civil action against state actors for the deprivation of 'rights, privileges, or immunities secured by the Constitution and laws,' 42 U.S.C. § 1983, a plaintiff must show that '(1) acts by the defendants (2) under color of state law

(3) depriv[ed][him] of federal rights, privileges or immunities [and] (4) caus[ed][him] damage.'" *Thornton v. City of St. Helens*, 425 F.3d 1158, 1163-64 (9th Cir. 2005). In an official capacity suit, "a governmental entity is liable under § 1983 only when the entity itself is a "'moving force'" behind the deprivation." *Kentucky v. Graham*, 473 U.S. 159, 166 (1985). "[I]n an official-capacity suit the entity's 'policy or custom' must have played a part in the violation of federal law." *Id.* Plaintiffs must also demonstrate that the policy or custom "caused" the deprivation of rights, privileges or immunities. *Watson v. Abington Twp.*, 478 F.3d 144, 156 (3d Cir. 2007).

A custom is "a practice that is so settled and permanent that it takes on the force of law." *McDowell v. Brown*, 392 F.3d 1283, 1290 (11th Cir. 2004).

Regarding policies, the Eleventh Circuit has made a distinction between the proof required of a facially valid policy, as opposed to a facially invalid policy. If a policy itself violates federal law, or the policy affirmatively directs a government employee to violate federal law (that is, it is facially invalid), one need only determine whether there is the required causal link between the policy and the injuries suffered. On the other hand, if the policy is not facially invalid, a showing of deliberate indifference to the known or obvious consequences of the policy is required, as well as a showing of causation, which presents Plaintiffs "with a

difficult task." *Am. Fed'n of Labor and Cong. of Indus. Org. (AFL-CIO) v. City of Miami, Fla.*, 637 F.3d 1178, 1187 (11th Cir. 2011).

A close causal connection must exist between the policy or custom of Defendants and the injury to Plaintiffs. *AFL-CIO*, 637 F.3d 1178, 1187. Causation is a tort concept. "[C]ausation has two required elements, cause-in-fact and legal or proximate cause." *Jackson v. Sauls*, 206 F.3d 1156, 1168 n. 16 (11th Cir. 2000) To establish cause-in-fact, Plaintiffs "must show that except for" the custom or policy, they would not have been injured. *Id.* They must also show however, that the policy or custom was a proximate cause of their injuries (i.e., that it "was a reasonably foreseeable consequence" of the policy or custom). *Id.*

Plaintiffs must prove the requisite culpability and causation in order to support liability by the official capacity defendants. *Reynolds v. Guiliani*, 506 F.3d 183, 193-94 (2d Cir. 2007). Liability cannot be predicated on the theory that there exists a non-delegable duty to comply with the law, making official capacity Defendants liable for any violation of federal law by their subordinates.

The Supreme Court, in determining whether a policy or custom caused a deprivation of a right, has prescribed the following mandatory analysis:

> . . . Once those officials who have the power to make official policy on a particular issue have been identified, ***it is for the [court] to determine whether their decisions have caused the deprivation of rights at issue by policies which affirmatively command that it occur, or by acquiescence in a longstanding practice or custom***

> ***which constitutes the "standard operating procedure" of the [governmental entity]. (Citations omitted).*** (Emphasis supplied)

Jett v. Dallas Indep. Sch. Dist., 491 U.S. 701, 737 (1989). The existence of a custom is generally proven by evidence of pervasive and widespread practices. *See e.g. Grech v. Clayton County, Ga.*, 335 F.3d 1326, 1330 n. 6 (11th Cir. 2003) ("A custom or practice, while not adopted as an official formal policy, may be so pervasive as to be the functional equivalent of a formal policy; . . . [a] single incident would not be so pervasive as to be a custom or practice."). In other words, Plaintiffs must demonstrate that the actionable injury is "repeated, routine or of a generalized nature." Cf. *Int'l Bhd. of Teamsters v. U.S.*, 431 U.S. 324 (1977). Here, for a custom, or practice, Plaintiffs must therefore prove that there has been a denial of statutory rights throughout all or a significant part of the Medicaid system, or that Defendants repeatedly and regularly engage in acts prohibited by the statutes at issue in this case "with 'deliberate indifference' as to its known or obvious consequences." *AFL-CIO*, 637 F.3d 1178, 1187. Denial of statutory rights must be the "standard operating procedure" of Defendants. *Jett v. Dallas Indep. Sch. Dist.*, 491 U.S. at 737.

The requirement of showing deliberate indifference applies to both constitutional and statutory rights. *Bd. of County Comm'r of Bryan County, Okla. v. Brown*, 520 U.S. 397, 411 (1997). Deliberate indifference may be evidenced by an "official decision not to remedy the violation", having a "deliberate intent" not

to prevent harm, or "having in mind a gross indifference to the needs of the prospective" Medicaid beneficiaries. *Davis v. DeKalb County Sch. Dist.*, 233 F.3d 1367, 1375 (11th Cir. 2000); *Anderson v. City of Atlanta*, 778 F.2d 678, 687 (11th Cir. 1985). The Eleventh Circuit has equated deliberate indifference with recklessness. In the Fourteenth Amendment context, the Eleventh Circuit has stated: "the plaintiff must also show that with that knowledge, the defendant nonetheless knowingly or recklessly "disregard[ed] that risk by failing to take reasonable measures to abate it." *A.P. ex rel. Bazerman v. Feaver*, No. 04-15645, 2008 WL 3870697, 12 (11th Cir. Aug. 21, 2008).

Ineffective methods of preventing harm, do not necessarily amount to deliberate indifference. *Davis v. DeKalb County Sch. Dist.*, 233 F.3d 1367, 1375. Good faith, but ineffective responses, may satisfy an official capacity defendant's obligations, depending on the facts and circumstances of a case. *Doe v. Taylor Indep. Sch. Dist.*, 15 F.3d 443, 457 n. 12 (5th Cir. 1994) (en banc), cert. denied *sub nom. Lankford v. Doe*, 513 U.S. 815 (1994). *See also Sauls v. Pierce County Sch. Dist.*, 399 F.3d 1279, 1285 (11th Cir. 2005).

There must be proof of causation, as discussed above, linked to official capacity policy or custom, in order to support a violation of Section 1983. *Reynolds v. Giuliani*, 506 F.3d 183, 193-94.

III. Legal Requirements for Class Actions

A. Prospective Relief in Institutional Reform Cases

Because this is an institutional reform case seeking injunctive relief, it "raises sensitive federalism concerns." "Such litigation commonly involves areas of core state responsibility." *Horne v. Flores*, 557 U.S. 433 (2009). "Federalism concerns are heightened when, as in these cases, a federal court decree has the effect of dictating state or local budget priorities. States and local governments have limited funds. When a federal court orders that money be appropriated for one program, the effect is often to take funds away from other important programs." *Id*. at 2594.

As discussed further below, under a single umbrella program, the Florida Medicaid Program serves a diverse group of people with varied health needs through a combination of optional and mandatory coverage categories, §§409.903 and 409.904, Fla. Stat. (2011), and optional and mandatory services, §§409.905 and 409.906, Fla. Stat. (2011). The Florida Medicaid program serves healthy children, CHSCN, disabled adults and children, children and adults with autism spectrum disorders and other developmental disabilities, 19 and 20 year olds who have aged out of foster care, pregnant women, persons who are dually eligible for Medicaid and Medicare, and persons who are eligible for institutional care, such as is provided in nursing homes or institutional care facilities for the mentally retarded (ICF/MR) or developmentally disabled (ICF/DD). Additionally, outside

of Medicaid, other important programs are funded by Florida, including education and the prison system.

Plaintiffs' aim of requiring Defendants to pay higher reimbursements to physicians and dentists for certain Medicaid services would have the effect of dictating state budget priorities and would require the state to shift finite funding from other areas which are equally important (such as optional Medicaid services, education and prison administration, to name only a few priorities). Given the federalism concerns described above, liability should not be found (and Plaintiffs should be awarded no relief) in the absence of proof that **all** of the prerequisites for injunctive and declaratory relief have been clearly met, including "irreparable harm" and a "finding that the injunction would not be adverse to the public interest." *Thomas v. Bryant*, 614 F.3d 1288, 1317 (11th Cir. 2010). To obtain prospective declaratory relief,[3] Plaintiffs must "show a ***substantial*** likelihood of future injury." *Bowen v. First Family Fin. Services, Inc.*, 233 F.3d 1331, 1340 (11th Cir. 2000) (emphasis added), *citing* 13A Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 3532.1, at 114 (2d ed. 1984).

B. Class Claims Depend on Individual Plaintiffs' Claims

[3] In this "official capacity" action, Plaintiffs are limited in the relief they may seek to prospective declaratory and injunctive relief. *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 71 n. 10 (1989).

A class action trial requires a two-tiered approach to liability. Initially, the focus must be on the proof of the injuries sustained by the named Plaintiffs. The Supreme Court has found that, in the class action context, the District Court is without jurisdiction to order a remedy for alleged violations which are not found to harm the named Plaintiffs. *Lewis v. Casey*, 518 U.S. 343, 358 (1996); *Prado-Steiman ex rel. Prado v. Bush*, 221 F.3d 1266, 1279 n. 14 (11th Cir. 2000) (stating that the Eleventh Circuit requires "that the named representatives' claims share 'the same essential characteristics as the claims of the class at large.'"). Therefore, if the named Plaintiffs fail to prove that they have sustained injury as a consequence of the statutory violations they allege, the Court must dismiss those class action claims.

C. Class Action Standing for Representative Plaintiffs

The individual Plaintiff representatives of the certified class must prove their individual standing to bring the claims alleged in the Second Amended Complaint, including injury-in-fact, a causal connection between the injury-in-fact and the defendant's challenged conduct, and that "the injury will be redressed by a favorable decision."[4] *Shotz v. Cates*, 256 F.3d 1077, 1081 (11th Cir. 2001) (internal citations omitted); *Lewis v. Casey*, 518 U.S. at 357. The fact that a class

[4] The organizational Plaintiffs are not members of the certified class in this case, and, therefore, cannot be representative plaintiffs. The standing issues relating to the organizational Plaintiffs are discussed separately at Part V.A.1.

has been certified does not relieve the Plaintiffs of their burden to prove individual standing.

D. Requirements of Class-wide proof

Should Plaintiffs successfully demonstrate that at least one of the Plaintiffs has sustained the type of injury complained about for each of their claims, the next step is to demonstrate a system-wide injury. To obtain system-wide relief, Plaintiffs must show system-wide injury. *Osterback v. McDonough*, 549 F. Supp. 2d 1337, 1363 (M.D. Fla. 2008). In *Lewis v. Casey*, the Supreme Court, in the context of a challenge of denial of access to courts, found that the success of a class action systemic challenge is dependent on the ability of plaintiffs to show widespread actual injury. In contrast, isolated instances of actual injury do not support a claim to system-wide relief. 518 U.S. 349

Plaintiffs therefore must prove more than isolated anecdotes of difficulty obtaining Medicaid covered goods and services. Stated otherwise, Plaintiffs' evidence must show that any alleged problems or deficiencies represent systemic patterns or practices. *See, e.g., Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991) (requiring a "series of incidents closely related in time" or "repeated examples of delayed or denied medical care" to demonstrate "systemic and gross deficiencies" amounting to deliberate indifference to prisoners' health care needs); *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980), cert. denied, 450 U.S. 1041

(1981) (necessary to prove repeated examples of negligent acts which disclose pattern of conduct or such systemic and gross deficiencies in facilities, procedures that class members are effectively denied access to health care).

Plaintiffs may attempt to prove the system-wide pattern in several ways, such as "statistical proof, as well as individual testimony and exhibits," that a system-wide violation has occurred. *Salinas v. Roadway Express, Inc.*, 735 F.2d 1574, 1577 (5th Cir. 1984); *Boyd v. Bechtel Corp.*, 485 F.Supp. 610, 618 (N.D. Cal. 1979) (acknowledging that statistical analysis is one of the most widely used and effective means of establishing the existence of a policy and pattern of discrimination in class actions). For a large system, such as the Florida Medicaid program, proof may also involve a fully realized research design which includes a statistically adequate random sample and an objective data collection instrument, as in *L.J. by and through Darr v. Massinga*, 838 F.2d 118 (4th Cir. 1988), cert. denied, 488 U.S. 1018 (1989), *abrogated on other grounds*, *Suter v. Artist M.*, 503 U.S. 347 (1992), a case involving a challenge to the Maryland foster care system, where the plaintiffs used such a statistical study of children's case records.

Plaintiffs' evidence of system-wide injury must be reliable. To the extent that Plaintiffs rely on anecdotes to prove system-wide injury, there are fundamental scientific limitations with anecdotes. "Anecdotal reports may be of value, but they are ordinarily more helpful in generating lines of inquiry than in proving

causation." Reference Manual on Scientific Evidence, p. 217 (3d ed. 2011). Anecdotal evidence is generally less reliable than statistical analyses. *Id.* at 310. The Supreme Court recently noted the insufficiency of certain anecdotal evidence to prove system-wide discriminatory employment practices as part of a class certification determination, in *Wal-Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541, 2556 (2011):[5]

> Respondents' anecdotal evidence . . . is too weak to raise any inference that all the individual, discretionary personnel decisions are discriminatory. In *Teamsters v. United States*, 431 U.S. 324, 97 S.Ct. 1843, 52 L.Ed.2d 396 (1977), in addition to substantial statistical evidence of company-wide discrimination, the Government (as plaintiff) produced about 40 specific accounts of racial discrimination from particular individuals. That number was significant because the company involved had only 6,472 employees, of whom 571 were minorities, and the class itself consisted of around 334 persons. The 40 anecdotes thus represented roughly one account for every eight members of the class. Here, by contrast, respondents filed some 120 affidavits reporting experiences of discrimination—about 1 for every 12,500 class members—relating to only some 235 out of Wal–Mart's 3,400 stores. More than half of these reports are concentrated in only six States (Alabama, California, Florida, Missouri, Texas, and Wisconsin); half of all States have only one or two anecdotes; and 14 States have no anecdotes about Wal–Mart's operations at all. Even if every single one of these accounts is true, that would not demonstrate that the entire company "operate [s] under a general policy of discrimination," which is what respondents must show to certify a companywide class.

Dukes establishes that, while anecdotal evidence may be admissible to help establish systemic deficiencies or policies in some circumstances (typically when

[5] *Dukes* is one of the most expansive class actions ever, having "a class comprising about 1.5 million plaintiffs, current and former female employees of petitioner Wal–Mart . . ." *Wal-Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541, 2546.

combined with other statistical proof), using relatively few anecdotes to prove systemic deficiencies in a large class action may "prove nothing at all." *Id*. at 2556.

As is discussed further below, Plaintiffs rely on anecdotes from the named Plaintiffs and from certain provider witnesses that are even less reliable and much more attenuated than the insufficient examples in *Dukes*. If the types of testimonial anecdotes offered by Plaintiffs in this case were used as the basis for expert testimony on causation, that testimony would be subject to exclusion under *Daubert v. Merrell Dow Pharm.*, 509 U.S. 579 (1993), because it would not meet the standards for reliability of expert testimony. *Kilpatrick v. Breg, Inc.*, 613 F.3d 1329, 1339 (11th Cir. 2010) (finding no error in District Court's conclusion that expert dependence on anecdotal case reports to establish causation did not meet *Daubert* reliability standards); *McClain v. Metabolife Intern., Inc.*, 401 F.3d 1233, 1254 (11th Cir. 2005) (anecdotal evidence would not cure the failure of experts to offer underlying toxicological data in a scientifically reliable form); *Benkwith v. Matrixx Initiatives, Inc.*, 467 F.Supp.2d 1316, 1329 (M.D. Ala. 2006) (finding in a consumer products liability case that "uncontrolled, anecdotal reports do not meet the reliability standards of *Daubert*"); *Bradley v. Brown*, 42 F.3d 434, 438 (7th Cir. 1994). Anecdotal evidence such as that relied upon by Plaintiffs in the instant matter does not provide a reliable basis on which to predicate findings of system-

wide violations, particularly in light of the relatively miniscule anecdotes offered for a class which numbered more than 1.6 million children in September 2010. DX 262a.

It is important to remember that no system involving human endeavor will ever be perfect. *Dist. Attorney's Office for Third Judicial Dist. v. Osborne*, 557 U.S. 52 (2009) (noting that the criminal justice system, "like any human endeavor, cannot be perfect"). Congress has acknowledged this fact with respect to the Medicaid program.[6] Some level of imperfection will exist in even the best systems. The danger in relying on anecdotes to establish system-wide deficiencies is that those anecdotes may represent only statistically insignificant relatively isolated bad outcomes. Further scientific inquiry is needed to determine whether anecdotes are representative of more wide-spread deficiencies. As discussed further below, Plaintiffs have presented no scientifically reliable evidence of systemic access to care issues as it relates to Medicaid enrolled children. As such, the class claims of Plaintiffs should be dismissed.

E. Statistical Evidence

[6] Title XIX of the Social Security Act provides for appropriations to be used "as far as practicable under the conditions in such State" to furnish medical assistance, recognizing that what is practicable in one state will not be practicable in another. 42 U.S.C. §1396-1. Additionally, Congress has authorized the HHS Secretary to withhold federal funds upon a showing "that in the administration of the plan there is a *failure to comply substantially* with any such provision." 42 U.S.C. §1396c(2).

As noted above, Courts have relied on statistical evidence to prove whether system-wide violations exist. *L.J. by and through Darr v. Massinga*, 838 F.2d at 121 ("plaintiffs presented a statistical study of the case records … on children in foster care prepared by an expert in research methodology"); *Osterback v. McDonough*, 549 F. Supp. 2d 1337, 1351 n. 13 (M.D. Fla. 2008) (statistical analysis showed that DOC "was complying with the weekly mental health rounds requirement over 90% of the time in state correctional facilities).

In *U.S. v. Ark.*, 794 F. Supp. 2d 935, 946, 952 n. 16 (E.D. Ark. 2011), the District Court noted that Plaintiffs' expert failed to provide quantitative analysis comparing rates of abuse and neglect at a developmental center to rates at similar facilities or to any benchmarks, and rates of injuries at similar facilities or to any other benchmarks. The Plaintiffs had the burden to prove the type of quantitative analysis and benchmarks needed to establish patterns and practices sufficient to justify a need for relief in the action.

In the instant matter, Plaintiffs bear the burden of proving quantitative analyses and benchmarks against which the Florida Medicaid program may be measured. Statistical percentages are useful in helping to evaluate whether the problems about which Plaintiffs complain are widespread and systemic. For example, according to Defendants' answers to interrogatories (which Plaintiffs do not refute), in Federal Fiscal Year 2007, 27,665 Medicaid enrolled children under

the age of 5 had their eligibility terminated in less than one year, and this number represented 4% of the Medicaid enrolled children under the age of 5, meaning that 96% of the Medicaid enrolled children under the age of 5 experienced no termination of eligibility in less than one year, demonstrating a lack of system-wide problems with early terminations of Medicaid. Moreover, Plaintiffs have presented no benchmarks to show that these percentages represent other than an acceptable level of error. PX 739.

Significantly, this statistical data does not measure the extent to which the terminations were wrongful (because it includes all terminations, even terminations based on the fact that a child moves out of state, or passes away), but provides useful information about the extent to which children under the age of 5 have terminations of their Medicaid eligibility at all in less than a year.[7] Likewise, the extent to which children experience breaks in eligibility is a matter which may be measured using percentages, to test Plaintiffs' anecdotal evidence about the frequency of breaks in eligibility. DX 607, pg. 13.[8]

IV. The Medicaid Statutes

[7] As discussed further below, children under the age of 5 who are enrolled in Medicaid are deemed eligible for Medicaid for a total of 12 months regardless of changes in circumstances other than attainment of the maximum age (unless they move out of state or pass away). Fla. Stat. §409.904(6) (2011).

[8] The CMS-416 reports relied on by Plaintiffs throughout the case also provide statistical information. The completeness and accuracy of that statistical information is discussed further below in Part IV.C.

A. Interplay with Section 1983

Section 1983 does not provide a cause of action for every violation of federal statute. *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) ("plaintiff must assert the violation of a federal right, not merely a violation of federal law"). Historically, the Supreme Court has applied a three-factor test in determining whether a statute creates rights enforceable under Section 1983:

> 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.

Id. at 340.

In *Gonzaga Univ. v. Doe* , 536 U.S. 273, 283 (2002), the Supreme Court clarified the first factor in the *Blessing* test. "We now reject the notion that our cases permit anything short of an *unambiguously conferred right* to support a cause of action brought under § 1983. (emphasis added) .

For a statute to create such private rights, its text must be "phrased in terms of the persons benefited" and it must clearly impart an "individual entitlement." 536 U.S. at 284, 287. "We have recognized, for example, that Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972 create

individual rights because those statutes are phrased '***with an unmistakable focus on the benefited class***.'" *Id.* at 284 (emphasis added).

B. 42 U.S.C. §1396a(a)(8) & (10)

For the reasons described below, prior to changes made in 2010 to the definition of "medical assistance", Sections 1396a(a)(8) and (10) respectively obligated Defendants to make prompt payments for services and to pay for covered services. These statutes did not create an enforceable right to provision of the actual services themselves. The Eleventh Circuit has not previously determined whether and to what extent Section 1396a(a)(10) creates rights enforceable under Section 1983.[9] Defendants acknowledge that, in *Doe 1-13 By and Through Doe, Sr. 1-13 v. Chiles*, a decision rendered prior to *Gonzaga*, the Eleventh Circuit Court of Appeals determined that Section 1396a(a)(8) creates an enforceable right in Medicaid eligibles to "medical assistance" with reasonable promptness, and

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[9] Regarding Section 1396a(a)(10)(B), the Eleventh Circuit has stated:

> The precise distinction between categorically needy recipients and medically needy recipients is a technical one not relevant to the case before us today. *For present purposes, it is only necessary to understand that § 1396a(a)(10)(B) is designed to ensure that "categorically needy" recipients-who are, generally speaking, the most needy recipients-receive assistance comparable to the assistance received by other categorically needy recipients and by "medically needy" recipients*. (Emphasis supplied)

Harris v. James, 127 F.3d 993, 1012 n.26 (11th Cir.1997).

affirmed an order enjoining defendants "to provide the Medicaid *services* at issue within ninety days." *Doe 1-13 By and Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 721 (11th Cir. 1998).[10] As to Section 1396a(a)(8), below, Defendants provide a principled basis for modifying the existing case law.

Section 1396a(a)(8) requires that Florida's Medicaid State Plan provide that (1) all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and (2) that such assistance shall be furnished with reasonable promptness to all eligible individuals. Section 1396a(a)(10) provides that a state Medicaid plan must provide "for making *medical assistance* available" to certain categories of individuals.[11] Section 1396a(a)(10) also requires that the "medical assistance" include at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a)" of Title XIX. The covered services listed in paragraphs (1) through (5), (17), (21), and (28) include, among other things, physician services, and EPSDT services, as defined in

[10] The Eleventh Circuit has foreclosed the option of suits by providers under Section 1396a(a)(8). *Doe 1-13 by and Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 716 n. 13. Therefore, the arguments herein relate solely to whether Section 1396a(a)(8) creates an enforceable right to reasonably prompt services in individual Medicaid enrollees.

[11] In light of the focus of Section 1396a(a)(10) on individuals eligible for Medicaid, and not providers, it cannot be said to create any rights enforceable by providers, for the same reasons as the Court in *Doe 1-13*, determined that Section 1396a(a)(8) does not create rights enforceable by providers.

42 U.S.C. §1396d(r)), for individuals who are eligible under the plan and are under the age of 21.

Both Section 1396a(a)(8) and Section 1396a(a)(10) contain the phrase "medical assistance." Prior to 2010 changes to 42 U.S.C. §1396d, "medical assistance" was statutorily defined as "payment of part or all of the cost of [specified] care and services." 42 U.S.C. §1396d(a).[12] With medical assistance defined in this manner, Section 1396a(a)(8) required that Medicaid state plans provide that individuals who wished to make application for medical assistance (or payment of part or all of the cost of specified services), would have an opportunity to do so, and that payment of part or all of the costs of services (or coverage) would be furnished with reasonable promptness to all eligible individuals.[13] Section 1396a(a)(10) required that state Medicaid plans provide for making available payment of part or all of the costs of certain specified services (or financial assistance) for certain categories of eligible individuals. This construction of Sections 1396a(a)(8) and (10) is reasonable, because Medicaid

[12] The definitions in Section 136d are generally applicable to all of Title XIX.
[13] Although it is more common for payments to be made to third parties for services provided to Medicaid beneficiaries, federal law permits payment to certain recipients for physician and dental services consistent with a state's Medicaid plan. *See e.g.*, 42 C.F.R. §447.25.

provides health insurance coverage. *U.S. ex rel. Atkins v. McInteer*, 470 F.3d 1350, 1353 n.1 (11th Cir. 2006).[14]

In interpreting Section 1396a(a)(8), federal CMS has adopted two regulations which deal with timeliness in the context of Medicaid eligibility determinations. 42 C.F.R. §435.911 addresses the time standards for determining eligibility for Medicaid; and 42 C.F.R. §435.930(a) provides that the single state Medicaid agency must "furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." Both of these regulations are consistent with a definition of "medical assistance" meaning payment of part or all of the cost of the services, or coverage, as distinct from actual provision of services.

Prior to the 2010 changes to the definition of "medical assistance" (discussed further below), several Circuits determined that Sections 1396a(a)(8) provided an enforceable right to reasonably prompt payment, but not to services themselves. *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 n.1 (6th Cir. 2006) *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (commenting that the reference to assistance appeared to be to financial assistance,

[14] Defendants acknowledge that, in *Doe 1-13 By and Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, this construction of the definition of "medical assistance" was briefed by Defendants. However, no reference was made in the Court's opinion to either this argument or this definition of "medical assistance" contained in 42 U.S.C. §1396d(a).

rather than actual medical services, a distinction "missed in *Bryson v. Shumway*, 308 F.3d 79, 81, 88–89 (1st Cir.2002), and *Doe v. Chiles*, 136 F.3d 709, 714, 717 (11th Cir.1998)"); *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006); and *Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724, 727 (5th Cir. 2009). *See also Disability Rights N.J., Inc. v. Velez*, Civil No. 05-4723, 2010 WL 5055820, 1 (D.N.J. Dec. 2, 2010) (relying on Third Circuit case law for the proposition that "the provisions of the Medicaid Act ... deal [ ] with what are essentially financial benefits," *Newark Parents Ass'n v. Newark Pub. Sch.*, 547 F.3d 199, 211 (3d Cir. 2008)," the District Court concluded that the Medicaid Act defined medical assistance as "payment of part or all of the cost of the following care and services." 42 U.S.C. § 1396d(a)).

Both before and after the opinion in *Doe 1-13* was issued, various courts recognized that Section 1396a(a)(10) was a coverage statute (or statute regarding reimbursements to be made for medical treatment for certain costs of medical treatment for needy persons), and not a statute under which states became providers of Medicaid services.

> ***The Medicaid program was established in 1965 in Title XIX of the Act "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons."*** Section 1902(a)(10) of the Act, 42 U.S.C. § 1396a(a)(10), sets forth the basic scope of the program, which has not changed significantly from its enactment in 1965. ***Participating States are required to provide Medicaid coverage*** to certain individuals-now described as the "categorically needy"; at their option States also may

> provide coverage (and receive partial federal reimbursement) to other individuals-described as the "medically needy." These classes are defined by reference to other federal assistance programs. (some citations omitted; footnote omitted)

Schweiker v. Hogan, 457 U.S. 569, 571-72 (1982). *See also Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1144; *Westside Mothers v. Olszewski*, 454 F.3d at 540 n.1; *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 588 (5th Cir. 2004).

Thus, prior to the 2010 changes to Section 1396d, there could only be one meaning of "medical assistance" for purposes of Title XIX, the meaning set forth in Section 1396d: "payment of part or all of the costs" of specified services.

Plaintiffs will likely argue that the above-construction of Section 1396a(a)(8) is absurd or ridiculous, because the text of Section 1396a(a)(8) states that "such assistance shall be furnished with reasonable promptness to all eligible individuals," and that direct payments to eligible individuals are rare. The fact that four Circuits have held that the definition of "medical assistance" means payment (or financial assistance) in the context of Section 1396a(a)(8) suggests that this construction of the pre-2010 version of Section 1396a(a)(8) is not "absurd or ridiculous." Likewise, construing Section 1396a(a)(10) as requiring that the Florida Medicaid program make available payment of some or all of the costs of specified services for beneficiaries is not an unreasonable interpretation.

1. New Definition of "Medical Assistance"

During the trial, on March 23, 2010, the "Patient Protection and Affordable Care Act" ("PPACA") was signed into law. See Pub. L. No. 111-148, 124 Stat. 119 (2010). Section 2304 of the PPACA, "Clarification of Definition of Medical Assistance," amended 42 U.S.C. § 1396d(a), so that it now states that 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*** . . ." 42 U.S.C. §1396d(a) (2011) (emphasis supplied). In light of Congress openly acknowledging the need for "clarification" of the definition of this term, Defendants renew their argument that the pre-2010 versions of Sections 1396a(a)(8) and (10) are not unambiguously worded, as required to confer privately-enforceable rights.

The Medicaid Act is Spending Clause legislation, *see e.g., Harris v. James*, 127 F.3d 993 (11th Cir. 1997), and as such, any conditions which Congress sets on receipt of federal funding in the Medicaid Act must be imposed unambiguously. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17, (1981). In light of Congress recognizing the need to clarify the definition of the key term "medical assistance" that is incorporated into Sections 1396a(a)(8) and (10), in addition to the fact that four Circuit Courts read "medical assistance" to mean payment of part or all of the costs of enumerated services, it cannot be said that, prior to March 23, 2010, Sections 1396a(a)(8) and (10) unambiguously required actual provision of services. In light of the then existing definition of "medical

assistance" contained in Section 1396d, prior to 2010, it was reasonable to interpret Sections 1396a(a)(8) and (10) as creating, at best, only an enforceable right to reasonably prompt payment and to coverage of specified services. Hence, these Sections were ambiguous. *Medical Transp. Management Corp. v. Commissioner of I.R.S.*, 506 F.3d 1364, 1368 (11th Cir. 2007) ("Statutory language is ambiguous if it is susceptible to more than one reasonable interpretation"). Because the statues were ambiguous as to whether the state's duty to furnish "medical assistance" included the duty to actually provide services, there could be no enforceable right to actual provision of those services, prior to March 23, 2010. *See also Blessing v. Freestone*, 520 U.S. 329, 341 (to create rights enforceable under Section 1983, "the statute must unambiguously impose a binding obligation on the States").

2. New "Medical Assistance" definition is not Retroactive.

Defendants argue that the clarified definition of "medical assistance" remains ambiguous, inasmuch as the current definition refers to "payment or services" without distinguishing which is meant in which situation. Nevertheless, even assuming that Section 1396a(a)(8), as newly amended in 2010 by Section 1396d(a) is no longer ambiguous, it cannot be retroactively applied to impose liability on Defendants in this case. It would not be fair to judge Defendants'

conduct that arose before the clarification took effect based on retroactively applying statutory language that was not in effect at the time.

The question of whether a statute applies retroactively is a question of legislative intent. The presumption is that statutes are not applied retroactively absent clear legislative intent. *Hamdan v. Rumsfeld*, 548 U.S. 557, 576 (2006). The change in the definition of "medical assistance" contained in Section 1396d(a) was not expressly made retroactive, and there is nothing about the plain language of the statute which suggests intent to apply the statute retroactively. See Pub. L. No. 111-148, pg. 296, 124 Stat. 119 (2010). Also, the legislative history expressly reflects an intention that the amendment take effect on passage, and not before. H.R. Rep. No. 111-299, at 650. That being so, the amended definition of medical assistance cannot be applied retroactively to events which occurred prior to the effective date of the statute (or prior to March 23, 2010).[15]

C. Section 1396a(a)(8) and "reasonable promptness".

Defendants have argued that Section 1396a(a)(8) does not create an enforceable right to medical assistance with reasonable promptness, D.E. 9, and contend that the amendments do not render the statute enforceable. The statute is

[15] If the Court goes beyond the statutory language, the 2010 amendments affect substantive liabilities or duties in that they change what is required of a state in providing medical assistance. As a consequence, the statutes may not be applied to conduct arising before the statutory amendment was enacted. *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006).

at least one step removed from individual rights creating language, and requires only substantial compliance. Nevertheless, even if the statute has sufficient private rights creating language, it does not have sufficient guidance as to what "reasonable promptness" means in relation to services of any particular type, much less of every particular type that Florida Medicaid covers.

In this regard, the "reasonable promptness" language in Section 1396a(a)(8) is no more capable of objective and consistent judicial enforcement than the "reasonable efforts" requirements contained in 42 C.F.R. §671(a)(15)(D), which were found to be unenforceable in *Suter v. Artist M.*, 503 U.S. 347 (1992).[16] Like *Artist M*, and unlike *Wilder*, Section 1396a(a)(8) contains no objective standards to aid in determining whether medical assistance is provided in a reasonably prompt manner. This is not unlike the circumstance described in *Suter*. "This directive is not the only one which Congress has given to the States, and it is a directive whose meaning will obviously vary with the circumstances of each individual case. How the State was to comply with this directive, and with the other provisions of the Act, was, within broad limits, left up to the State." 503 U.S. at 360.

Even if Section 1396a(a)(8) contained rights creating language, *Doe v. Chiles* and other cases that have concluded "reasonable promptness" obligations may be enforced against state Medicaid programs are distinguishable from this

[16] 42 U.S.C. §671(a)(15)(D) (1992) is very similar in structure to Section 1396a(a)(8).

case in the important respect that there was no need to make subjective judgments about whether services were provided with "reasonable promptness." Instead, *Doe v. Chiles* involved a multi-year waiting list for access to residential treatment facilities that were objectively unreasonably long. *See e.g., Doe 1-13 By and Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 711 ("The complaint further averred that most of the appellees had been waiting for 'over five years' for Medicaid services and were 'languish[ing] without the training and therapies they so desperately need.'"); *Doe v. Kidd*, 419 Fed. Appx. 411, 421 (4th Cir. 2011) (reversing a grant of summary judgment for Defendants, and instead awarding summary judgment for Plaintiff regarding delays in providing services that had been requested in 2002 and 2003); and *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir. 2004) (noting that it was not disputed that plaintiffs "have languished on waiting lists for years, unable to obtain these services"). In contrast, this case has reports of wait times as short as a few days that are not facially unreasonable.

Delays in medical care have been addressed most often in the prison context. "The tolerable length of delay in providing medical attention depends on the nature of the medical need and the reason for the delay." *Harris v. Coweta County*, 21 F.3d 388, 394 (11th Cir. 1994). For example, regarding fracture care, the Court has considered whether the delay " aggravate[d] the fracture, affect[ed] the healing

of the bone, cause[d] the delayed union, or necessitate[d] surgery," *Scott v. Coleman*, No. 11–11587439, 2011 WL 3422787, 2 (11th Cir. Aug. 5, 2011). The reason for the delay must also be considered. *Youmans v. Gagnon*, 626 F.3d 557, 564 (11th Cir. 2010). In summary, in prison litigation relating to delays in medical care, the Eleventh Circuit has considered the following factors in assessing whether there was an actionable delay in providing medical care: "(1) the seriousness of the medical need; (2) whether the delay worsened the medical condition; and (3) the reason for the delay." *Goebert v. Lee County*, 510 F.3d 1312, 1327 (11th Cir. 2007).

None of the alleged delays experienced by the named Plaintiffs in this case were objectively unreasonable. See Part V.B below for the facts pertaining to Plaintiffs. Such alleged delays were each reasonable given the particular facts and circumstances applicable to each named Plaintiff. Moreover, the alleged delays pale in comparison to the timely and varied care the named Plaintiffs received for years without complaint. Having searched for years to find these representative beneficiaries, the Plaintiffs should not be heard to complain about the fact their experiences reflect that the Florida Medicaid program, as a whole, has rendered timely, adequate and quality care to those beneficiaries.

D. 42 U.S.C. §1396a(a)(10)

Section 1396a(a)(10) provides that a state Medicaid plan must provide "for making medical assistance available" to certain categories of individuals. Additionally, Section 1396a(a)(10) requires that "[a] state plan must cover the cost to eligible people" of enumerated services. *M.R. v. Dreyfus,* 663 F.3d 1100, 1103 (9th Cir. 2011). "Within this federal framework, [] states retain 'substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage.'" *M.R. v. Dreyfus,* 663 F.3d 1100, 1103 (*quoting Alexander v. Choate,* 469 U.S. 287, 303 (1985).

The "medical assistance" that states are required to cover or "make available" under Section 1396a(a)(10) should include "at least the [medically necessary] care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a)" of Title XIX.[17] Those covered services include, but are not limited to, inpatient and outpatient hospital services, services provided through rural health clinics and federally qualified health centers, EPSDT services, and physician services. Regarding EPSDT services, 42 U.S.C. §1396d(a)(4)(B) provides that "medical assistance" shall include: "early and periodic screening, diagnostic, and treatment services (as defined in [42 U.S.C. §1396d(r)) for individuals who are eligible under the plan and are under the age of 21." 42 U.S.C.

[17] Defendants are not obligated to provide services that are not medically necessary or experimental in nature. *Moore ex rel. Moore v. Reese,* 637 F.3d 1220, 1236 (11th Cir 2011).

§1396d(r) defines EPSDT services as including screening services, vision services, dental services and hearing services, all to be provided at intervals which meet standards of medical (or where applicable dental) practice.

Additionally, Section 1396d(r) defines EPSDT services to include: "Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section 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."

To prove a violation of Section 1396a(a)(10), Plaintiffs must demonstrate that Defendants Farmer and Dudek fail to "make available" to certain categories of individuals eligible for Medicaid (including most children who have been determined eligible for Medicaid) the defined medical assistance (or coverage) for certain required services, including EPSDT services. Defendants Farmer and Dudek contend that they may "make available" such medical assistance by either providing coverage (payment) for such services, or by directly providing services in those limited circumstances in which DOH directly provides covered services to Medicaid beneficiaries. *See John B. v. Goetz*, 626 F.3d 356, 360 (6th Cir. 2010) (noting that a state may still fulfill its medical assistance obligations by paying for services).

E. 42 U.S.C. §1396a(a)(30)(A)

Previously, this Court declined to follow the vast majority of circuit decisions holding that 42 U.S.C. §1396a(a)(30)(A) does not confer individually enforceable rights on either Medicaid providers or beneficiaries. D.E. 672. *See Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007) (providers and beneficiaries); *Mandy R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006) (providers and beneficiaries); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-543 (6th Cir. 2006) (providers and beneficiaries); *New York Ass'n of Homes and Servs. for the Aging v. DeBuono*, 444 F.3d 147, 148 (2nd Cir. 2006) (per curiam) (providers)*; Sanchez v. Johnson*, 416 F.3d 1051, 1059 -1060 (9th Cir. 2005) (providers and beneficiaries); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004) (providers); *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531 (3d Cir. 2002). Only one Court post-*Gonzaga* concluded that Section 1396a(a)(30)(A) created rights enforceable through Section 1983, and the judgment in that case was subsequently vacated on appeal. *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Services*, 443 F.3d 1005 (8th Cir. 2006), *cert. granted and judgment as to individual capacity claims vacated sub nomine, Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142, 127 S.Ct. 3000, 168 L.Ed.2d 724 (2007).

This Court instead relied [D.E. 672 at 4-6] on *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990), which predates both *Blessing* and *Gonzaga* and dealt with the

subsequently repealed Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), which specifically obligated states to adopt "*rates*" that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and that assured "*individuals* eligible for medical assistance have *reasonable access* . . . to inpatient hospital services of adequate quality." *Id.* at 502-03 (emphasis added).

After this Court's summary judgment ruling, the Supreme Court granted certiorari review to consider the question whether "Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law reducing reimbursement rates," in *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 131 S.Ct. 992 (2011). After the grant of certiorari review, federal CMS approved some of subject California statutes at issue, and California withdrew their request for approval of others. Rather than deciding the issue on review, the Supreme Court remanded the matter for the Ninth Circuit to address in the first instance whether Section 1396a(a)(30)(A) claims should be brought under the Supremacy Clause, in light of the fact that federal CMS had approved the rates, or whether, instead, the plaintiffs should be required to proceed under the Administrative Procedures Act, 5 U. S. C. §701. *Douglas v. Indep. Living Ctr. of S. Cal.*, Nos. 09–958, 09–1158, and 10–283, __ S.Ct. ___, 2012 WL 555204 (Feb. 22, 2012).

Douglas supports Defendants' argument that Section 1396a(a)(30)(A) does not create rights enforceable under Section 1983 and reinforces the notion that *Wilder* does not control and should not be relied upon to determine whether Section 1396a(a)(30)(A) creates enforceable rights under Section 1983.[18] The Supreme Court in *Gonzaga* emphasized that *Wilder* approved a private right of action because the Boren Amendment "explicitly conferred specific monetary entitlements upon the plaintiffs" through an "'objective' monetary entitlement to individual health care providers" *Gonzaga*, 536 U.S. at 280-81.

In contrast to the Boren Amendment, Section 1396a(a)(30)(A) does not (1) mention ***payment*** of hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of ***rates*** which take into account certain ***costs***; (2) require "findings and assurances"; (3) require the state in setting its rates for nursing home care to consider "the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter" or (4) require that the costs to be considered in setting rates be reasonable and adequate, among other things, to "to assure that ***individuals eligible for medical assistance have reasonable access*** (taking into account

[18] In *Douglas*, the Majority cited *Wilder* (and other authorities) for the sole proposition that: "Before granting approval, the agency reviews the State's plan and amendments to determine whether they comply with the statutory and regulatory requirements governing the Medicaid program." Slip Op. at 2.

geographic location and reasonable travel time) to inpatient hospital services of adequate quality."

Section 1396a(a)(30)(A) does not provide that ***individuals*** shall have reasonable access, but rather that the state plan shall provide for "methods and procedures" for utilization and rate setting as are necessary (1) to safeguard against unnecessary utilization of care and services and (2) 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**.** Clearly, since Section 1396a(a)(30)(A) makes no mention of "individuals eligible for medical assistance," it has an aggregate focus on "methods and procedures" and "***care and services*** to be unavailable under ***the plan***" at least to the extent that "care and services are available to the general population." It does not speak in terms of individuals who benefit from its terms and does not have the unmistakable focus on individual rights required by *Gonzaga*.[19]

[19] Likewise, Section 1396a(a)(30)(A) does not evidence an intention by Congress to create enforceable rights in providers. In contrast to the more direct language in the Boren Amendment, which requires payment of the Medicaid services provided in hospitals, nursing homes and ICF/MRs, taking into account the cost of providing such services, Section 1396a(a)(30)(A) requires a state plan to provide the "methods and procedures" used by the state to both control utilization and set payments for "care and services." The language of the statute is aggregate in focus. The statute only deals with providers in the context that the state's payments should be adequate to enlist ***enough*** providers (as partners in the Medicaid plan).

Additionally, Section 1396a(a)(30)(A) differs from the Boren Amendment in that its "broad and nonspecific language" is not susceptible to judicial enforcement. *Westside Mothers*, 454 F.3d at 543; *Sanchez*, 416 F.3d at 1060. It sets forth "general objectives, including 'efficiency, economy, and quality of care,'" but does not identify what standards are required by such terms. *Westside Mothers*, 454 F.3d at 543; *Long Term Care Pharmacy Alliance*, 362 F.3d at 58. Section "1396a(a)(30) is not confined to particular services; rather, it speaks generally of "'methods and procedures.'" *Westside Mothers*, 454 F.3d 532, 543; §1396a(a)(30)(A). Such broad language suggests that § 1396a(a)(30) is "concerned with overall methodology rather than conferring individually enforceable rights on individual Medicaid recipients." *Westside Mothers*, 454 F.3d at 543; *Sanchez*, 416 F.3d at 1059-60. The term "general population in the same geographic area" is also broad and vague.

Unlike the Boren Amendment, Section 1396a(a)(30)(A) is not at all connected to provider costs, leaving uncertainty as to what standards must be considered in determining whether rates are consistent with "economy and efficiency." "The interpretation and balancing of these general objectives 'would involve making policy decisions for which this court has little expertise and even less authority.'" *Westside Mother*, 454 F.3d at 543; *Sanchez*, 416 F.3d at 1060; see also *Long Term Care Pharmacy Alliance*, 362 F.3d at 58 (noting that the generality

of the goals "suggests that plan review by the Secretary is the central means of enforcement intended by Congress"). Courts are ill-equipped to make the types of policy decisions necessary to determine compliance with Section 1396a(a)(30)(A). The determination of whether the various objectives of Section 1396a(a)(30)(A) are met is better suited to policy makers, including federal CMS.

In *Douglas*, the Supreme Court acknowledged that "The Medicaid Act commits to [federal CMS] the power to administer [the Medicaid program]." *Douglas*, Slip Op. at 6. Federal CMS is the "comparative expert" in administering Section 1396a(a)(30)(A) and determining how it should be applied.

> [Federal CMS] is comparatively expert in the [] subject matter [of Section 1396a(a)(30)(A)]. And the ***language of the particular provision at issue here is broad and general***, suggesting that the agency's expertise is relevant in determining its application."

Slip Op., at 6-7 (emphasis added). "Allowing for both Supremacy Clause actions and agency enforcement 'threatens potential inconsistency or confusion,' and imperils 'the uniformity that Congress intended by centralizing administration of the federal program in the agency.'" Slip Op., at 8.[20]

Section 1396a(a)(30)(A) similarly would require the Court to make subjective judgments in balancing multiple competing objectives that Congress included in this statute. Congress has provided no definitions or other guidance for determining what Medicaid rates or procedures are sufficient to enlist "enough

[20] These comments were also echoed in the Dissent Opinion. Slip Op. at pg. 7-8.

providers" in the relevant "geographic area." Courts have recognized, for example, that the phrase "general population" is ambiguous, *see e.g. Clark v. Kizer*, 758 F.Supp. 572, 575-576 (E.D. Cal. 1990), *aff'd in part and vacated in part*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992), as is the phrase "same geographic area" in the legislative history. In *Methodist Hospitals, Inc., v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996), Seventh Circuit stated:

> "Geographic area" could mean many things, depending on what function the boundary serves. If the point of § 1396a(a)(30) is to ensure that every Medicaid recipient can obtain every medical service within walking distance, then the statute places severe constraints on a state plan, but if the law means only that every Standard Metropolitan Statistical Area has to have ample medical services (so that care is available within the reach of public transit systems), then Indiana is home free. Gary, Indiana, is in the Chicago SMSA, which offers medical services galore

Federal CMS has not issued any rules defining what "geographic area" means for purposes of Section 1396a(a)(30)(A). As the Seventh Circuit recognized, the phrase "geographic area" may have several meanings, depending upon the type of access or the type of care. *See Methodist Hosps., Inc.*, 91 F.3d at 1029).[21]

[21] In the instant matter, there is no authority to show that federal CMS is presently applying a guideline of Medicaid provider participation percentage across all of the States. Florida's approved Medicaid State Plan only requires a 50% participation rate by its primary care providers, and provider participation is measured by the extent to which providers have submitted at least one claim in the relevant time period, PX 712, Attachment 4.19-B, pg. 11. Plaintiffs have presented no evidence in this matter that federal CMS applies a minimum "full" participation rate of 50% to any provider type, and there is no evidence that federal CMS has required Florida to meet a 50% participation rate (as measured by the percentage of

In *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 931, the Fifth Circuit explained the insufficiency of the plaintiffs' proof as follows:

> Moreover, there is no evidence from the plaintiffs that focuses on geographic areas and on the access to the different types of provider services available in those areas. In order for courts to make a determination whether recipients are receiving equal access to health care, there must be evidence in the record regarding the relevant geographic area, the services offered in the area, and the recipient's relationship to that area. As the Court of Appeals for the Seventh Circuit has recognized, the phrase "geographic area" may have several meanings, depending upon the type of access or the type of care. *See Methodist Hosps., Inc.*, 91 F.3d at 1029. However, there is no evidence in the record addressing this concern; *there are only allegations of general state-wide access problems, which is not sufficient for the district court to determine whether a recipient's access will actually be affected*.

Under the *Evergreen* analysis, Plaintiffs must prove the relevant geographic area, the specific services that are available in that area to all individuals who have third party insurance in the geographic area, and how the availability of the specific services for Medicaid recipients differs. To the extent this Court decides to afford a private right of action and determine what is the relevant "geographic area," the relevant trade area for receipt of medical and dental services should be the area encompassed AHCA's eleven Medicaid area offices. This is consistent with Florida's approved Medicaid state plan ("each geographical area/district is the natural trade area for the receipt of medical services (whether delivered by

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providers who have at least one Medicaid claim in a given period) for any providers other than primary care providers (pediatricians, family practitioners, OB/GYNs).

Medicaid or not), and has at least a 50% participation rate by its obstetricians, obstetrician-gynecologists, family practitioners, and pediatric practitioners"). PX 712, Attachment 4.19-B, pg. 7a.[22]

Deference should be accorded to federal CMS's approval of Florida's Medicaid State Plan, *Douglas v. Independent Living Center of Southern California, Inc.*, 2012 WL 555204, 5 (citing *National Cable & Telecommunications Assn. v. Brand X Internet Services*, 545 U.S. 967 (2005); and *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Therefore, the Eleven AHCA Areas are the appropriate units to be applied in determining whether specific medical and dental services are available at least to the same extent as the general population in the same geographic area. Moreover, this determination must be based on the type of care at issue, whether it is primary care, a specific specialty practice, or dental care. It would be improper to make generalized conclusions about medical or dental services, as the availability of providers varies in each geographic area depending on how that area is defined and which type of medical and dental access is at issue. Moreover, the determination of how many "providers" are enough must depend on an analysis of the reasons why providers

[22]As discussed further below in Part VI.C and G, AHCA has also established by policy travel distances applicable to different types of services, subject to a waiver of those requirements in instances where there is justification for a waiver. In general terms, primary medical care must be available within 30 minutes and specialty care and other types of care must be available within 60 minutes.

may or may not be available, since monetary considerations such as Medicaid rates are certainly not the only factor why any particular type of care may or may not be available.

Plaintiffs' proof of unequal access in each geographic area of the State must be scientifically reliable. Generalized allegations of statewide access problems are "not sufficient for the district court to determine whether a recipient's access to care will actually be affected." *Evergreen Presbyterian Ministries*, 235 F.3d at 933; *Methodist Hospitals*, 91 F.3d at 1029 (the Court's responsibilities in determining the "geographic area" is similar to an antitrust determination). In the antitrust arena, the relevant economic market must be established by expert testimony, not lay testimony or opinion. *American Key Corp. v. Cole National Corp.*, 762 F.2d 1569, 1579 (11th Cir. 1985) ("Construction of a relevant economic market or a showing of monopoly power in that market cannot, however, be based upon lay opinion testimony"). Here, Plaintiffs have presented no expert testimony regarding the different geographic areas or markets for the purposes of each of the services at issue. Instead, as discussed further below, Plaintiffs present anecdotes from a relatively small and statistically unreliable sample, and without documents to back it up.

From the record, it is impossible to determine the extent to which the providers and experts who testified are sufficiently familiar with the geographic

areas (or indeed what the boundaries of the relevant geographic area should be) in which they operate to assist the Court in determining the availability of particular services in each geographic area or market. For example, we do not know from Plaintiffs' proof how many types of health insurance products (both public and private) are available in those areas of the state for which Plaintiffs produced witnesses. We do not know the extent to which there are fewer providers of specific services than may be needed given the population of the area. We know only the experiences of the relatively small number of providers who testified for Plaintiffs, regarding their ability to secure care for children who are their patients, with the particular insurance products that they accept, as opposed to all insurance products in the relevant area. Plaintiffs' proof is inadequate to provide a basis on which to make generalized findings in any particular area of the state.

F. 42 U.S.C. §1396a(a)(43)

Section 1396a(a)(43) has four components. Section 1396a(a)(43)(A) provides that a state's plan for medical assistance shall provide for informing those *who have been determined to be eligible for medical assistance of* the availability of EPSDT services and the need for age-appropriate immunizations against vaccine-preventable diseases. Federal CMS has adopted a regulation which further describes the state's responsibilities under Section 42 U.S.C. §1396a(a)(43), in 42 C.F.R. § 441.56(a). Among other things, AHCA must provide "for a combination

of written and oral methods designed to inform effectively all *EPSDT eligible individuals* (or their families) about the EPSDT program."

The phrase "EPSDT eligible individuals" in 42 C.F.R. § 441.56(a) means children under the age of 21 who ***have been determined eligible for Medicaid*** in eligibility categories which also make them eligible for EPSDT services.

Section 1396a(a)(43)(A), like any federal statute, must be phrased "with an unmistakable focus on the benefited class" to create enforceable rights in that class. *Gonzaga University*, 536 U.S.at 284. For a statute to create such private rights, its text must be "phrased in terms of the persons benefited." *Id.* at 284. Conversely, Section 1396a(a)(43)(A) lacks an "unmistakable focus" on those individuals who have ***not*** been determined eligible for medical assistance or Medicaid, and, therefore, cannot be said to create enforceable rights for such individuals.

42 C.F.R. § 441.56 does not change the conclusion regarding whether Section 1396a(a)(43)(A) creates rights enforceable by children who have not been determined eligible for Medicaid. First, the rule does not expand the scope of Defendants' (DCF and AHCA) informing duty to individuals who have not yet been determined eligible for Medicaid (i.e., the uninsured). Although it speaks of "all EPSDT eligible individuals (or their families)" in 42 C.F.R. § 441.56(a)(1), in

context, this means no more than children under the age of 21 who ***have been determined eligible for Medicaid and EPSDT services***.[23]

Section 441.56(a)(4) makes it clear that the duty under Section 1396a(a)(43) is to provide information to individuals who have been determined eligible for Medicaid within 60 days of the individual's initial Medicaid determination (and not prior to that time) and annually thereafter for families that have not used EPSDT services. In any event, the regulation cannot create an enforceable right. *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001) ("it is most certainly incorrect to say that language in a regulation can conjure up a private cause of action that has not been authorized by Congress. Agencies may play the sorcerer's apprentice but not the sorcerer himself.").

While the focus of Plaintiffs' Section 1396a(a)(43) claim is clearly on outreach (*see* D.E. 203-3, pp. 34-35), they also assert that this statute obligates Defendants to "monitor the provision and quality of services and ensure appropriate coordination of services received from different providers, and agencies." D.E. 203-3, pp. 35. 42 U.S.C. §1396a(a)(43) does not create an enforceable duty to "monitor services." Section 1396a(a)(43)(B) requires only that Defendants "provid[e] or arrang[e] for the provision of such screening services in

[23] Some children will not be eligible for the full complement of EPSDT services, because their Medicaid eligibility category entitles them to a narrower group of services. For example, see instructions to the CMS-416 report regarding children to be excluded from reporting requirements. PX 25, pg. 2.

all cases where they are requested." Section 1396a(a)(43)(C) requires Defendants make provision for "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." Section 1396a(a)(43)(D) contains a reporting requirement on services provided, including a requirement for reporting on goals set by federal CMS. None of the provisions of Section 1396a(a)(43) create an enforceable right to "monitoring of services," or "appropriate coordination of services." Thus, there is no enforceable right to "monitoring" and "assuring appropriate coordination of services."

G. The Elements/Substantive Standards for the Statutes

Undoubtedly, the Medicaid Act sections at issue are "broad and general," as the Supreme Court noted with respect to Section 1396a(a)(30)(A) in *Independent Living*. *Slip Op., at 7.* If the Court concludes that Plaintiffs have a right of action under these statutes, then it will have to determine, on a class-wide basis, whether:

(1) the class has received medical assistance with "reasonable promptness" under Section 1396a(a)(8);

(2) Defendants have made available the "medical assistance" which it is required to make available under 1396a(a)(10), including EPSDT services;

(3) The FMP, in light of its approval by federal CMS and its determination that the plan complies with "the statutory and regulatory requirements governing

the Medicaid program" (*Independent Living*, Slip Op., at 2), nonetheless provides "such methods and procedures relating to . . . care and services 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*" under Section 1396a(a)(30)(A); and

(4) the plan provides for informing regarding EPSDT services and immunizations for individuals who have been determined to be eligible for medical assistance under Section 1396a(a)(43)(A).

The language of each of section is so ambiguous and general that any attempt at an objective standard, without making assumptions as to legislative history and without considering the experiences of each beneficiary at issue, is futile. *See, e.g., Clark v. Richman,* 366 F. Supp. 2d at 645 ("the legislative history suggests that 'particular' geographic areas within a state should be considered . . . which implies that regional geographic areas within a state, rather than the state as a whole, should be the proper focus….").

H. 42 U.S.C. §1396a(a)(43)

1. Outreach

Pursuant to 42 C.F.R. § 441.56(a)(2), the information about EPSDT services must be clear and non-technical, and cover:

> (i) The benefits of preventive health care;
>
> (ii) The services available under the EPSDT program and where and how to obtain those services;
>
> (iii) That the services provided under the EPSDT program are without cost to eligible individuals under 18 years of age, and if the agency chooses, to those 18 or older, up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy recipients; and
>
> (iv) That necessary transportation and scheduling assistance described in § 441.62 of this subpart is available to the EPSDT eligible individual upon request.

42 CFR § 441.56(a)(2). "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." *Rosie D. v. Romney*, 410 F.Supp.2d 18, 27 (D.Mass. 2006).

42 CFR § 441.56(a)(4) provides that AHCA must:

> Provide assurance to CMS that processes are in place to effectively inform individuals as required under this paragraph, generally, *within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter*. (Emphasis supplied)

Therefore, to state a cause of action under Section 1396a(a)(43)(A), Plaintiffs must show that DCF and AHCA have not "effectively informed" them of the availability of EPSDT services, providing the detail about those services described

in 42 CFR § 441.56(a)(2). Such information may be made available orally or in writing, and should be provided within 60 days of the individual's initial Medicaid eligibility determination, and annually thereafter, for families who have not utilized EPSDT services. 42 C.F.R. § 441.56.

2. Screening Services

Assuming *arguendo* that Plaintiffs have pled a claim under 42 U.S.C. §1396a(a)(43)(B), it requires that Florida's Medicaid State Plan provide for "providing or arranging for the provision of such screening services in all cases where they are requested." "Screening services" are defined in 42 U.S.C. §1396d(r)(1), and are to be provided at appropriate intervals, and shall include at a minimum:

> (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 the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,
>
> (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
>
> (v) health education (including anticipatory guidance).

Under Section 1396a(a)(43)(B), Plaintiffs must prove that they requested screening services (as defined in Section 1396d(r)(1)), that Defendants were aware of the request, and the agencies did not "arrange for or provide" for such services.

3. Corrective Treatment

Assuming *arguendo* that Plaintiffs have pled a claim under 42 U.S.C. §1396a(a)(43)(C), it requires that Florida's Medicaid State Plan provide for "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." Thus, Plaintiffs must identify a corrective treatment the need for which was identified during a health screening service, which Defendants did not arrange to be provided (either directly or by referral to a third party).

V. The Named Plaintiffs[24]

A. Individual and Organizational Standing for the Named Plaintiffs

1. Individual Standing

The case law regarding individual standing is set forth above in Part 3.C. Prior to trial, and without a fully developed record, the Court found which named

[24] Citations to record references are made as follows: Final Trial Transcripts are referenced with the abbreviation "TT" followed by page numbers (TT 249-250); rough trial transcript testimony and deposition testimony are referenced by day, followed by the initials of the witness, followed by page numbers (1/30/12 SF 3). A key is attached as Exhibit "B", which provides the full names that correspond to initials. Plaintiffs' exhibits are referenced using the designation "PX" and Defendants' exhibits are referenced using the designation "DX".

plaintiffs have standing to pursue which claims against which official capacity defendants. D.E. 541, D.E. 671. T.G., now deceased, is the named plaintiff with standing to bring Counts I and II against DOH. S.M. is the named plaintiff with standing to bring Counts I and IV against DCF and AHCA. J.S. is the named plaintiff with standing to bring Count II against AHCA.

There are clear differences in the type of conduct challenged and the type of injury suffered by T.G., S.M., and J.S, as compared to each other, as well as compared to the other named plaintiffs and absent class members. "Because these injury claims target different defendant conduct, the type of proof required for each claim necessarily will differ." *Prado-Steiman v. Bush*, 221 F.3d 1266, 1281 (11th Cir. 2000). Even if these named plaintiffs prevailed on their individual claims, therefore, it would be insufficient to impose class wide liability on any defendant for other challenged conduct that is unrelated to those claims.

Accordingly, it would be inappropriate to impose class wide liability on DOH unless there were proof that DOH's conduct caused T.G. injury in terms of timely access to his orthopedic surgeon. Similarly, AHCA and DCF cannot be liable for alleged deficiencies in making outreach to children before they are enrolled in Medicaid or the Florida Medicaid application process, unless there were a named plaintiff with proof of injury caused by that conduct. Here, there is no evidence that any of the named Plaintiffs was unable to apply for or maintain

Medicaid eligibility, because of difficulties in the application process or a lack of awareness about Medicaid itself.

In short, while the Court has found that three of the named plaintiffs have standing to pursue certain claims against defendants on behalf of the class, any liability finding must be tethered to the claims of those named plaintiffs, and proof of conduct unrelated to those claims cannot support a finding of class wide liability. Otherwise, defendants could be sued for conduct in the absence of a plaintiff with standing to sue, which would violate Constitutional standing rules.

2. Organizational Standing

As a threshold matter, this Court has already determined that the Organizational Plaintiffs cannot serve as class representatives. A class representative must suffer the same injury as the class members in order to satisfy the typicality requirement of Rule23(a)(3). *Vega v. T-Mobile USA, Inc.*, 564 F. 3d 1256, 1275 (11th Cir. 2009). As recognized by the Court, "[t]he organizational plaintiffs' injury of depletion of resources due to energy spent advocating for children improperly denied care under the Medicaid Act is distinct from the children's injury of improper denial of care." D.E. 671 at 7; D.E. 671 at 7; D.E. 613 at 28-29.

Furthermore, the Organizational Plaintiffs previously abandoned any claims that they were purporting to assert in this case for themselves as organizations or

for their member-providers. FPS and FAPD explained that they only seek to advance "third party" claims for Medicaid recipients. *See* D.E. 572-73 at 41-45. To sue on behalf of third parties, an organizational Plaintiffs must demonstrate an "injury in fact," that gives him or her a "sufficiently concrete interest" in the outcome of the dispute; the litigant must have a close relation to the third party; and there must exist some hindrance to the third party's ability to protect his or her own interests. *National Alliance for Mentally Ill, St. Johns Inc. v. Board of County Com'rs of St. Johns County*, 376 F.3d 1292, 1295 (11th Cir. 2004). Regarding the claims of Medicaid recipients (as opposed to the uninsured) FPS and FAPD cannot sue for the putative class of Medicaid recipients because at trial they failed to demonstrate any hindrance to the class of Medicaid recipients' ability to sue for themselves. (*See* discussion *infra*). This fact presents an independent hurdle to third-party standing that is insurmountable for FPS and FAPD. *See Powers v. Ohio*, 499 U.S. 400, 409-12 (1991); *Knight v. Alabama*, 14 F.3d 1534, 1554 (11th Cir. 1994); *cf. Pennsylvania Psychiatric Society v. Green Spring Health Services*, 280 F.3d 278, 293 (3d Cir. 2002).

Regarding the ability of FPS or FAPD to sue on behalf of persons who are uninsured (because they are unaware of Medicaid or have difficulties applying for Medicaid), Plaintiffs have not proven that they meet the first or second factual hurdles necessary for third party standing. They have neither demonstrated that

any of their members are harmed by the fact that uninsured patients are unaware of Medicaid or have difficulties applying for Medicaid, nor have they demonstrated that they (or their members) have a close relationship – or even, for their provider members, a doctor patient relationship with individuals who are uninsured because they do not know about Medicaid or have difficulty applying for Medicaid. Their closest proof came from Dr. St. Petery, the Executive Vice President of FPS, who testified that members of FPS "treat children who are not currently on Medicaid, but subsequently gain or regain eligibility for Medicaid." However, such testimony is not sufficient to show harm to either FPS (we do not know for example whether those providers were paid for their services by the Medicaid program), or that the individuals with whom the physicians have this doctor patient relationship are not on Medicaid because of a lack of awareness of Medicaid or difficulty in applying for Medicaid (as opposed to other issues). TT 279.

B. Named and Organizational Plaintiffs

L.C.: L.C. lives in Polk County, Florida, and is a former foster child who was adopted. He has been with his family since 1999 and does not allege any gaps in his Medicaid coverage. D.E. 692, pg. 11, ¶¶ 25, 26; TT 1319-20, 1322.

Between his adoption and 2003, L.C. was on his father's commercial insurance. When his father lost his job, his parents enrolled L.C. on Medicaid, rather than adding him to his mother's commercial insurance. TT 1324-26.

L.C.'s parents kept L.C. on Medicaid for health insurance coverage, even after his father was hired in his present job with Polk County. L.C.'s parents have added L.C. to his father's family dental insurance plan provided by his employer. From January 1, 2004 through March 24, 2011, the Medicaid system paid $44,008 for the care provided to L.C. TT 1311, 1379-80; DX 582.

Dr. Wehle has been L.C.'s pediatrician both while L.C. was covered by his father's health insurance, and after L.C. was on Medicaid. L.C. has received regular care from his pediatrician and his immunizations are up to date. L.C. has also received care from the following types of specialists: urologist, neurologist, cardiologist, auditory therapist, developmental pediatrician, psychologist, psychiatrist, mental health therapist, and four years of occupational and speech therapy. D.E. 692, pg. 11, ¶¶ 27-29, 31; TT 1324, 1327; DX 94 (Peace River 30-31); DX 102; DX 102c.

Since 2004, L.C. has received regular mental health therapy services from Elizabeth Craig, who is not a Medicaid provider, without interruption. In 2004, L.C.'s mother, S.C., called AHCA looking for a Medicaid mental health therapist for L.C.. Medicaid referred S.C. to Peace River Center (PRC). D.E. 692, pg. 12, ¶31; TT 1333, 1336-37, 1377; 1/19/12 ES 91; DX 98.

On September 2, 2004, S.C. and L.C. met with PRC therapist, Christy Bishop, MSW, for "Triage/Orientation." On September 9, 2004, S.C. and L.C. met

with PRC licensed therapist, Jackie Reycraft, LMHC, and a treatment plan for L.C. was completed and signed by S.C. Under that plan, L.C. was offered twice monthly therapy from Christy Bishop. TT 1372-73; DX 94; Peace River 6-8).

S.C. chose not to pursue the therapy services at PRC, but instead to obtain services for L.C. with Ms. Craig. TT 1333, 1345; DX 94 (Peace River 6-8); DX 91.

On January 12, 2005, S.C. was notified that PRC would pay for L.C.'s prior sessions with Ms. Craig, and future sessions until June 1, 2005, at which time L.C. was to transition back to PRC for services. DX 92; DX 94 (Peace River 26).

After June 1, 2005, S.C. continued to take L.C. to Ms.Craig for therapy, rather than taking him to PRC. S.C. later asked DCF to pay for Ms. Craig's therapy services for L.C., which DCF did, as well as reimbursing S.C. for any out-of-pocket expenses S.C. had incurred with Ms. Craig. TT 1333, 1350-51, 1382-83.

Since 2005, L.C. has been prescribed various drugs and was never without a physician to manage those drugs. Medication management has been provided first by Dr. Hubbard and then by Dr. Winny, who practices with the Behavioral Health Division of Winter Haven Hospital. TT 1351-52, 1358-61; DX 97; DX 104c.

Dr. Hubbard and Dr. Winny routinely called in L.C.'s prescriptions to the pharmacy, when S.C. called to request it, and did not require L.C. to be seen in the office. This was Dr. Hubbard's routine practice for all prescriptions, except for Focalin (a Class III narcotic), prescribed by Dr. Hubbard for the first time on

March 5, 2007. TT 1355, 1378; DX 97 (Hubbard 1); DX 104c (Winter Haven 259, 261, 263).

S.C. took L.C. to PRC on February 19, 2007, to obtain a psychiatrist to continue to provide medication management for L.C. According to L.C.'s medical records, Dr. Hubbard had seen L.C. just three weeks earlier on January 30, 2007. Medical records for both Dr. Hubbard and Dr. Wehle show that, at the time that S.C. took L.C. to Peace River in 2007, L.C.'s was prescribed Lamictal and Advair (L.C. was not taking Provigil, a drug previously prescribed by Dr. Hubbard). DX 94 (Peace River 1-2); DX 97 (Hubbard 15); DX 102 (Wehle 8, 26, 35-37).

L.C. was not taking Depakote when he was taking Lamictal, because both are anticonvulsants. S.C. explained, "Depakote…was put in place of the Lamictal, because it didn't do what it was supposed to do." The first time that Dr. Hubbard prescribed Depakote for L.C. after she saw him on January 30, 2007 was not until March 2, 2007. TT 1351-52; DX 97 (Hubbard 1).

L.C.'s medical records do not indicate that, as of February 19, 2007, he needed refills for any of his medications or that he was not doing well with Lamictal. PRC's records also do not reflect that S.C. ever advised PRC that L.C. needed to be seen on an urgent basis. Instead, the appointment was characterized as routine, such that it could occur within 5 days. PRC left a message for S.C. on February 26, 2007, which was not returned. DX 97 (Hubbard 15); DX 94 (Peace

River 41, 47); 1/19/12 ES 102; DX 98 (Craig 20, 21).

Plaintiffs' expert, Dr. Sarkis, offered opinions that are based on S.C.'s testimony, even when that testimony was inconsistent with L.C.'s medical records. He did not evaluate L.C., and did not speak to any of the doctors actually involved in L.C.'s care. None of L.C.'s doctors testified at trial. The requirements of FRE 701 for lay opinions and FRE 702 and 703 for expert opinions have not been satisfied and the Court should not admit Dr. Sarkis' opinions. 1/19/12 ES 13-14, 62-64, 66-70, 72-78, 80-83, 86-87, 89-91, 104.

Dr. Sarkis testified that it would have been reasonable for L.C. to wait for a psychiatric appointment at PRC if L.C. was not at risk of running out of medications. He admitted that Dr. Hubbard's medical records of the drugs that she prescribed for L.C. at different times contradict information that S.C. gave PRC about the drugs that L.C. was taking in early 2007. Dr. Sarkis conceded that none of the PRC records showed that PRC staff was informed that L.C. was running out of medications. 1/19/12 ES 92-93, 104; DX 97 (Hubbard 1, 15).

L.C. has been a patient of Dr. Bopp, a dentist, since 2001. He has never been without a dentist. L.C.'s dental records show that, from July 2001 until March 2008, L.C. saw Dr. Bopp once a year, except in 2005 when L.C. saw Dr. Bopp twice, in October 2005 and November 2005. Although S.C. testified that, in 2007, L.C. was placed on a waiting list for dental services, the dental records do not

show that he received dental services less often than had previously been the case (with the exception of in 2005). After L.C. was added to his family's dental insurance, L.C. continued to see Dr. Bopp with the same once-a-year frequency. DX 96 (Bopp 8-11, 12); TT 1363-64, 1379-80.

Plaintiffs have not proven that L.C. is likely to experience any future difficulties in obtaining therapy services, medication management services or dental services, and, in fact, there are Medicaid providers available in Area 6 to provide all of these services, either at Peace River (for mental health services) or elsewhere. 10/6/11 LC 90-91, 106-107, 109-110.

T.G.: T.G. passed away on August 14, 2011. T.G. lived in Palm Beach County, Florida, with his parents, R.G. and L.G., who appeared as his next friends. T.G was determined eligible for Medicaid in 1998 and alleges no problems with his Medicaid coverage. There is no evidence that T.G. experienced a problem accessing dental care or primary care (PC). D.E. 1026; D.E. 692 at ¶75 & 76.

T.G. was a CHSCN. Therefore, T.G. participated in CMS. As such, he had a CMS Network Care Coordinator (CMS NCC), who is a nurse, assigned to help his mother schedule medical appointments and obtain medical services. D.E. 692 pg. 15 ¶77.

During his lifetime, T.G. received extensive specialty care and numerous surgical procedures. Between January 1, 2004 and March 24, 2011, the Medicaid

system paid $1,145,367.71 for the medical services that T.G. received. DX 582.

By ten years of age, T.G. had already undergone 17 surgeries. Moreover, T.G. received medical care from a cardiologist, a dentist, a pediatric endocrinologist, an Ear Nose and Throat physician (ENT), a pediatric gastroenterologist, a genetics clinic, a nutrition clinic, a pediatric neurologist, an ophthalmologist, a pediatric pulmonologist, and a physical medicine and rehabilitation specialist. Plaintiffs have not proven that T.G. had any problems obtaining care from these specialists. TT 2319; DX 27, DX 37; D.E. 692 at ¶78.

T.G. also received extensive orthopedic care and treatment from at least three orthopedic surgeons and had at least seven surgeries on his spine and two surgeries on his hips. DX 37; DX 27 p PBOI 51; 231-232).

Plaintiffs allege that T.G. experienced approximately a year wait time in 2004 to receive a spinal surgery, after one of his orthopedic surgeons, Dr. Brett Baynham, stopped staffing CMS clinics. However, R.G. acknowledged that T.G. never had back surgery scheduled in 2004, and medical records show that in January 2004 R.G. told T.G.'s CMS NCC that she had decided with Dr. Baynham that T.G. "will have no more spine surgeries." [25] The medical records also indicate

[25]R.G. has acknowledged that she has difficulty remembering all of her seven children's doctor appointments. This is understandable given the number of doctor visits her seven children have. For instance, in 2009 alone, her children had 109 doctor visits. TT 2352.

that when T.G. visited Dr. Baynham in his office (not in a CMS clinic) in January 2004, Dr. Baynham recommended that T.G. have surgery on his hip and that he continue to wear his back brace to manage his scoliosis.[26] Dr. Baynham did not recommend that T.G. have back surgery in January 2004 as R.G. had previously indicated. TT 2355-57, 2388; 1/24/12 BB 106-108; DX 37 TG_CMS 542, DX 27 PBOI 45.

Dr. Baynham always considered T.G. to be his patient. 1/24/12 BB 116.

Dr. Baynham performed 12 orthopedic surgeries on T.G. First, in 2002 and 2003, Dr. Baynham performed three surgeries on T.G.'s spine, consisting of the insertion of corrective growth rods into T.G.'s spine, the adjustments of the rods and the removal of the rods after a persistent infection developed. In 2003, Dr. Baynham also operated on T.G.' hip. D.E. 692 p16, ¶80; 1/24/12 BB 39-40; DX 27 p PBOI 82-86; DX 37 p TG_CMS 568).

There is no evidence in the CMS NCC's records that R.G. requested an orthopedic consult for T.G. for his spine, his left hip or any other orthopedic issues after this visit with Dr. Baynham in January, 2004, and no evidence that T.G. encountered a problem receiving an orthopedic consult when later requested. In fact, the medical records indicate that the CMS NCC gave T.G. an appointment to

[26] T.G. regularly had appointments in Dr. Baynham's office as opposed to in the CMS clinic. In fact, T.G. visited Dr. Baynham's office at least 22 times. DX 27; TT 2357.

be seen at the CMS orthopedic clinic on July 9, 2004, but R.G. brought only N.G., T.G.'s brother, to the clinic. DX 37 p TG-CMS 740; DX 43 p NG_CMS 431.

Furthermore, there is no evidence that R.G. had to wait for T.G. to see Dr. Baynham when she next telephoned his office in 2005 about T.G.'s orthopedic issues. Dr. Baynham's medical record and R.G.'s testimony both show that T.G. saw Dr. Baynham in his office (not in a CMS clinic) on April 14, 2005. Dr. Baynham had not yet returned to staffing CMS orthopedic clinics. At this point, Dr. Baynham stated that all treatment options for T.G.'s spine remained on the table. TT 2385-86; 1/24/12 BB 97; DX 27 p PBOI 49-50.

T.G. returned to Dr. Baynham's office for a follow-up visit on May 5, 2005. At that time, T.G.'s hip was a priority over his spine. On August 22, 2005, Dr. Baynham performed surgery on T.G.'s left hip. In 2006, Dr. Baynham performed two additional surgeries on T.G.'s spine. DX 27 p PBOI 51, 99-102, 231-32.

Following these surgeries, R.G. decided that T.G. would not have any more orthopedic surgeries, including spinal surgeries. 5/18/10RG 2379, 2401-02.

T.G. also required supervision because of his G-tube. Medicaid paid for T.G. to receive 16 hours of home nursing supervision every weekday and 8 hours every night on the weekend. TT 2318, 2403.

N.G.: N.G. currently lives in a group home in Palm Beach County, Florida. His parents, R.G. and L.G., appear as his next friends. N.G. was determined

eligible for Medicaid in 1998 and has not experienced any gaps in eligibility. D.E. 692 p 15 ¶83, 84.

N.G. suffers from chronic health problems, is a CSHCN, and a client of CMS. As such, N.G. has a CMS NCC assigned to him that helps him schedule medical appointments and obtain medical services. D.E. 692 p15 ¶85.

There is no evidence that N.G. experienced a problem accessing dental care or pediatric preventative care. In fact, there is no evidence that N.G. has been denied any medically necessary treatment of his extensive medical problems. Between January 1, 2004 and March 24, 2011, the Medicaid system paid $329,100.78 for the medical services that N.G. received. Record; DX 582.

N.G. has required and received extensive specialty medical care from a variety of specialists, including a pediatric pulmonologist, a cardiologist, a hematologist, an ophthalmologist, an orthopedic surgeon, an allergist, a pediatric endocrinologist, a pediatric otolaryngologist, a pediatric gastroenterologist, an ENT, a pediatric immune deficiency specialist, an infectious disease specialist, a neuropsychologist, and a physical medicine and rehabilitation specialist. TT 2418-23; DX 41, DX 43.

Plaintiffs allege only one problem relating to ENT care in 2005, when N.G. received an ENT appointment five days (three business days) after requesting it. The medical records show the appointment was timely. On Wednesday, July 13,

2005, N.G. had an appointment with his pediatric pulmonologist, Dr. Jorge Sallent. Dr. Sallent's records from that visit don't indicate that N.G. was experiencing pain. N.G. was described as "alert, active, and playful." Dr. Sallent recommended "an ENT evaluation in "the near future." DX 43 p NG_CMS 678.

The CMS NCC notes also do not indicate that N.G. was in pain on July 13, 2005. Rather, the records indicate that his mother called CMS on July 13, 2005 requesting an ENT appointment for N.G. "asap."[27] CMS scheduled N.G. for an appointment on July 21, 2005 at 9:00 a.m. at the CMS ENT clinic. That appointment did not work for R.G. because she had to take N.G. to a neurology appointment on July 21. The next day, R.G. called CMS to request an appointment at the CMS ENT clinic for N.G. on ***July 21,*** at 8:00 a.m. However, Dr. Jeffrey Alperstein, the ENT, did not start the clinic until 9:00 a.m. CMS offered R.G. another appointment for N.G. at the ENT clinic scheduled on July 25, 2005 ***and*** called Dr. Alperstein to see if he would see N.G. in his office rather than the CMS ENT clinic. TT 2410-18; DX 43 p NG_CMS 754-56.

On July 18, 2005, Dr. Alperstein saw N.G. in his office, just five days after Dr. Sallent recommended that he see an ENT in the "near future" and three days earlier than requested by R.G. That day, N.G.'s "ears [were] unremarkable" and

[27] R.G. acknowledged that she does not typically schedule appointments for her children because they are regularly scheduled for various CMS clinics. She said: "I have only in my life requested this one appointment for ENT for N.G.." TT 2350.

Dr. Alperstein recommended that N.G. obtain a CT scan, which was done on July 20, 2005. When Dr. Alperstein saw N.G. on July 25, 2005, he noted that the "sinus x-rays are unremarkable." DX 39 p Alperstein 2; D.E. 692 p 16 ¶90.

Plaintiffs' expert, Dr. Marie Becker, a Tallahassee ENT, acknowledged that the treatment provided on and after July 18, 2005 was appropriate. However, Dr. Becker opined that N.G.'s 5-day wait for an ENT appointment was unreasonable. Her opinion was based only on the fact that N.G.'s mother testified that N.G. was in pain at the time that she tried to make the ENT appointment on July 13, 2005. However, there is no mention in any medical record from July 13, 2005 to July 18, 2005 that indicates that N.G. was experiencing pain (or that CMS was notified that he was in pain). 2/1/12 MB 38, 40-49; DX 42, DX 43.

Moreover, Dr. Becker did not evaluate N.G, or contact any of the doctors actually involved in N.G.'s care, or any ENTs in Palm Beach County. None of N.G.'s doctors testified at trial. She did nothing to determine wait times for available ENT appointments in Palm Beach County and could not opine on the average wait times for an ENT appointment in Palm Beach County in 2005. For the reason's stated in Defendants' Motion in Limine and related Reply (D.E. 694 and D.E. 765), the Court should not admit Dr. Becker's opinions over defense objections. 2/1/12 MB 32-33, 53-54.

Since 2005, N.G. has continued to receive regular and periodic ENT

services. Plaintiffs have offered no evidence to suggest that N.G. will have any future difficulty obtaining ENT or other specialty care. DX 43p NG_CMS 629-630, 645-646, 659-661, 676; DX 43c; Record.

K.K.: K.K., a resident of Lee County, Florida, is the eight year old son of his next friend, A.D. K.K. has received regular PC, preventative care and follow-up care from the same pediatric group, and is current with his immunizations. Plaintiffs offered no proof that K.K. was ever improperly terminated from Medicaid or that he did not receive his continuous eligibility. At trial, A.D. testified that it was initially difficult to use the on-line application for Medicaid, but no proof was offered that this difficulty actually affected K.K.'s eligibility. D.E. 692 p 14 ¶64, 67; TT 4052-53, 4078, 4094-95.

K.K. also has received regular dental care. K.K. began receiving free dental care from the Family Health Centers of Southwest Florida as part of the Head Start Program. After leaving the Head Start Program, K.K. has continued to receive dental care from the Family Health Centers of Southwest Florida paid for by Medicaid. TT 4065-66, 4099-100, 4107-08.

In the past, K.K. has had ear problems and often visited pediatricians and ENTs for that reason. In fact, A.D. states that K.K.'s doctor visits were so regular that the doctor's office was like A.D.'s "second home." D.E. 692 p14 ¶66; TT 4079.

A.D. reports a single instance when K.K. allegedly experienced difficulty seeing an ENT, after A.D. voluntarily changed K.K.'s Medicaid plan from MediPass to Staywell, a Medicaid Health Maintenance Organization (HMO). On January 5, 2005, A.D. called Medicaid to change K.K. from MediPass and enroll him in Staywell. K.K.'s voluntary change to Staywell was effective March 1, 2005. TT 4056-406, 4074-76; DX 49 p Defendants 10106; DX 54 p Defendants 10125.

Less than two weeks later, on Sunday night, March 9, 2005, K.K. went to the emergency room (ER) at Cape Coral Hospital because his ear had started to bleed that night. The ER physician characterized K.K.'s ear as "non-urgent" and treated him. The ER physician consulted with Dr. Liu, the ENT who previously put tubes in K.K.'s ears, and noted that Dr. Donaldson, Dr. Liu's partner, "will see the patient tomorrow. . . to suction out the ear canals and evaluate the tympanic membranes." K.K. was discharged from the hospital in the early morning hours on March 10, 2005. DX56 p Cape Coral 6, 9-10; TT 4082-83.

K.K. was treated by Dr. Donaldson on March 10, 2005. The medical records indicate that Dr. Liu couldn't see K.K. on March 10, 2005 because he "was operating that day." Dr. Donaldson received payment from the FMP for treating K.K. on March 10, 2005. DX 61; TT 4085-86; 2/1/12 MB 57, 60-62; DX 414.

While Dr. Becker opined that Staywell should have had ENTs on its panel in

the Fort Myers area on March 10, 2005 (and she infers that they did not), the only basis for this opinion was A.D.'s testimony. Dr. Becker did nothing to confirm whether there were ENT providers available on Staywell's panel at the time in question. For the reason's stated in Defendants' Motion in Limine and related Reply (D.E. 694 and D.E. 765), the Court should not admit Dr. Becker's opinions. 2/1/12 MB 54-57.

Plaintiffs offered no evidence to show that K.K. is likely to experience any difficulty in the future obtaining primary pediatric care, ENT care, or dental care. Regarding ENT care, Staywell had at least seven ENTs on its panel in the Fort Myers area accepting new patients as of 2008. DX 65a.[28]

Between November 2010 and January 2011, K.K. was only eligible for Medicaid in the coverage category known as medically needy, an optional Medicaid coverage category. In this Medicaid category, the family income exceeds established limits; however, family medical expenses may be deducted from income to determine eligibility. Essentially, medical expenses are tracked, and if they reach a point where when deducted from income the family meets established income thresholds, Medicaid will pay for needed services. Children who are eligible for Medicaid in the "medically needy" program are not assigned

[28] Fran Nieves, Field Office Manager for AHCA's Area 8 which includes Lee County, testified that Lee County currently has ENTs that accept Medicaid fee-for-service as well. TT 2168-69.

to Medicaid managed care plans, including MediPass. Fla. Stat. §§409.904(2) and 409.9122(2)(a) (2010); 1/25/12 AD 68-70; TT 472-73.

When K.K. became eligible for "regular Medicaid" again, he had to choose a managed care provider. K.K. was enrolled in Staywell, effective April 2011. His mother called, and he was assigned to a MediPass provider, effective May 1, 2011. 1/25/12 AD 70-73.

On April 19, 2011 K.K.'s pediatrician prescribed him Vyvanse, an attention deficit hyperactivity disorder (ADHD) medication. Staywell, required prior approval for Vyvanse, which was initially denied. On April 19, 2011, K.K.'s pediatrician pursued an appeal with Staywell to request Vyvanse for K.K. and prescribed K.K. Adderral, another medication used to treat ADHD. DX 55c p Associates in Pediatrics 68-77.

While the appeal was pending, K.K.'s mother changed him to MediPass in May 2011, and he promptly received Vyvanse. Plaintiffs have offered no evidence to suggest that K.K. will not be able to continue receiving Vyvanse or any other requested medications. 1/25/12 AD 72-73.

S.M.: S.M. is the five year old son of his next friend, S.B., who lives in Tallahassee, Florida. Since August 9, 2011, however, S.M. has not lived with S.B. but rather with his father, T.M. S.B. has no involvement in arranging S.M.'s medical and dental care since he went to live with his father. Furthermore, there is

no date by which S.B. expects S.M. to return to live with her. SEALED 12/6/11 SB 89-90, 98-99, 131, 152-153.

S.M.'s challenges with Medicaid-coverage and services have causes that are unrelated to the policies and practices of defendants' agencies and are outside defendants' control. For example, S.M. had a gap in Medicaid eligibility between September and October 2011. This gap arose after S.B. applied to DCF for benefits without including S.M. on her application, using an outdated address that she knew was incorrect. Nor did S.B. inform the Medicaid program that S.M. was living with his father, either during the application process or thereafter. 11/28/11 NL 93-95; SEALED 12/6/11 SB 90-92, 101-104, 107.

Before this Medicaid eligibility gap, S.M. had at least 16 pediatrician visits with the Dr. Simmons, his pediatrician, including well-child visits, and S.M.'s immunizations were up to date. S.B. was satisfied with S.M.'s pediatrician, and Tallahassee Pediatric Foundation ("TPF") Primary Care Program was providing S.M. with primary care coordination management (PCCM) services. Nevertheless, despite Dr. Simmons and TPF's reminders, S.B. never took S.M. to have lead blood screenings that were ordered as part of S.M.'s well-child visits. Although in February, 2011, S.B. told TPF that she was taking S.M. for the blood work "tomorrow", she never did. D.E. 692 p 12 ¶ 34-36, 39; TT 1783, 1797; SEALED 12/6/11 SB 107-115; DX 69c p Simmons 56-69; DX 71c p TPF 2410.

In March 2011, Dr. Simmons refused to keep S.M. as a patient, due to S.B.'s repeated failures to bring her children for scheduled appointments, before and after she was warned to "avoid no shows." Thereafter, in May 2011, TPF terminated S.M. because S.B. did not pick another TPF-affiliated pediatrician. TT 1792-93, 1797-99; SEALED 12/6/2011 SB 121-122; DX 69c p Simmons 58, 73, 76; DX 71 p TPF 2331, 2339; DX 71c p TPF 2405.

S.B. also failed to bring S.M. for scheduled well-child visits several times, in addition to other no shows. S.B. did not bring S.M. to his two-month well-child visit and also skipped S.M.'s two-year well-child visit. These visits were each rescheduled for two months after the milestone age. These "no shows" were not due to any problem with S.M.'s assigned Medicaid plan, or any other factor within the defendants' control. S.M. also had his 18-month well-child visit rescheduled for April 18, 2008, which was also two months after the milestone age. S.M. did have a Medicaid plan assignment issue on this one occasion. Nevertheless, Dr. Simmons never advised S.B. of any health concerns because the 18 month well child visit (or indeed the other two visits) occurred two months later than recommended by the guidelines of the American Academy of Pediatrics (AAP). Besides this one occasion, S.M. never had another Medicaid plan assignment issue, and on this occasion, TPF covered S.M. "immediately" once the Medicaid plan assignment issue was brought to TPF's attention. Thus S.B. testified that, if there

was a need to see Dr. Simmons, since he was part of TPF, it could be arranged. D.E. 692 p 12 ¶38; TT 1808-19, 4168; DX 69c p Simmons 58, 73, 76; DX 71 pTPF 2315, 2317, 2331, 2339.

S.B. has moved residences often, but did not always inform AHCA. As a result, there have been times when S.B. could not receive mail from AHCA. TT 1807-09; SEALED 12/6/11 SB 100-104.

Although Plaintiffs alleged that there were gaps in Medicaid eligibility before September, Ms. McCormick (from TPF) admitted that TPF records are contradictory and inconclusive about any prior gaps. TPF's executive vice-president, Dr. St. Petery, also reviewed the TPF records and testified he was unaware of any gaps for S.M. In fact, there were no gaps in S.M.'s Medicaid eligibility until September 2011. 11/28/11 NL 93-95; DX 73 p Defendants10901; TT 638-40, 1786-88, 4132-37, 4183-85, 4190-92.

TPF's Ms. McCormick explained that TPF has particular individuals at the defendants' agencies whom TPF can contact with Medicaid eligibility and Medicaid plan assignment issues, to the extent they still arise. Ms. McCormick's experience with the frequency of these issues is that: "There are not nearly as many as there were during [summer and into the fall of 2008]." TT 4188-90.

All the same, there is no reasonable likelihood that S.M. will have another Medicaid plan assignment issue (what plaintiffs have termed "switching") now that

he lives with his father.

Below in Part VI.B, the general issue of switching is discussed, along with the efforts made by Defendants to prevent it from occurring.

N.A.: N.A, a resident of Leon County, Florida, is the five-year old adopted son of C.R., who appears as his next friend. N.A. has lived with C.R. since he was an infant, first as a foster child and later as her adopted son. N.A. regularly visits his pediatrician, whom he has seen at least 39 times. N.A. is current with his immunizations. There is no evidence that N.A. has experienced any difficulty receiving dental care. DX 20; DX 19c; D.E. 692 at ¶104, 109; 1/14/08 CR 18-19.

N.A. has been a client of TPF since days after his birth. He has been enrolled in CMS since March 1, 2007. N.A. has a TPF PCCM coordinator who helps him schedule medical appointments and obtain medical services, as well as a CMS NCC. DX 20; D.E. 692 at ¶106, 107; 1/14/08 CR 31.

Plaintiffs allege that N.A. once experienced difficulty seeing his pediatrician. But, on that occasion, N.A. was able to see his pediatrician only two hours and fifteen minutes after his mother called the pediatrician's office for an appointment. 1/14/08 CR 66.

On January 1, 2007, N.A. was assigned by AHCA to Buena Vista, an HMO that covered Medicaid recipients in N.A.'s area, because plan assignment correspondence went to his natural mother, rather than to his foster care

caseworker. DCF policy required that the caseworker responsible for the removal of N.A. from his mother apply for "child in care" Medicaid at the time of removal, but the worker failed to do so. Had the worker followed policy, notices about plan assignment choices would have been sent to the caseworker, for appropriate follow-up. D.E. 692 at ¶110; 11/28/11 NL 96-99; 1/14/08 CR 26-27.

On January 19, 2007, C.R., called the pediatrician's office at 7:45 a.m. and learned that Buena Vista would not cover N.A at the pediatrician's office to which C.R. planned to take N.A. Even so, N.A. was seen at that pediatrician's office ***two hours and fifteen minutes later*** at 10:00 a.m. Plaintiffs' expert, Dr. Robert Middlemas, a retired pediatrician from Tallahassee, acknowledged that N.A. did not experience an unreasonable delay in getting pediatric care. Nevertheless, Dr. Middlemas opines that N.A. had greater difficulty accessing medical care than patients with private insurance. Dr. Middlemas offers no foundation or reliable data to support his opinion and, for the reasons in Defendants' Motion in Limine and related Reply (D.E. 695 and D.E. 766), the Court should not admit his opinions over defense objections. 1/14/08 CR 66; 1/31/12 RM 20-22; D.E. 692 at ¶ 111.

On January 19, 2007, C.R. also alleged difficulty in getting Medicaid coverage for a prescription for N.A. This occurred on a Friday, and on the following Monday, C.R. was reimbursed by the pharmacy for the money spent on the prescription. 1/14/08 CR 29-30; D.E. 692 at ¶ 112.

On January 24, 2007, N.A was reassigned to the Medicaid PCP designated by his foster mother, C.R. DX 26 (DEFENDANTS001517-000005).

N.A. has not experienced any other problems receiving PCP care. Plaintiffs have offered no proof that N.A. is likely to experience future difficulty obtaining PC. 1/14/08 CR 19-21, 68.

N.A. has received specialty medical care from a pediatric allergist and an ophthalmologist. Plaintiffs do not allege that N.A. has experienced or will experience any problems receiving this specialty medical care. DX26c; DX26d.

J.S.: J.S. is a sixteen-year old girl who resides in Jupiter, in Palm Beach County, Florida, with her mother, K.S., who appears as her next friend. J.S. has been on Medicaid since birth and does not allege any interruption in Medicaid coverage. She has no complaints of "switching." D.E. 692 at ¶ 55, 56, 63; TT 1959, 1981-82; DX 127c (Alonzo 12, 25-28); DX 584.

J.S. has regularly received PCP care, including wellness care, from Pediatric Partners since at least the age of two. Between the age of two and twelve, she was seen for PC 150 times. She is current with her immunizations. When J.S. has needed to see Medicaid specialists, her PCP usually has helped K.S. find them. In fact, K.S. has not identified an occasion on which her PCP was not able to find Medicaid specialists for J.S. PCPs at Pediatric Partners are available to do whatever it takes 24 hours a day, 365 days a year, to arrange the care that their

patients need. Patients are specifically informed by Pediatric Partners about the assistance they will provide to locate needed specialist care. TT 1959, 1983-89, 2873-76, 2883-85; 1/26/12 TS 82-84; DX 128.

J.S. regularly sees a dentist, Dr. Alonzo. Although on May 17, 2010, K.S. testified that Dr. Alonzo would no longer see J.S. once she turned 14, J.S.'s dental records prove that Dr. Alonzo has continued to see J.S. after her 14th birthday, including on June 22, 2010 for a check-up with x-rays. D.E. 692 at ¶ 55, 56, 63; TT 1959, 1976-77, 1981-82; DX 127c (Alonzo 12, 25-28); DX 584.

J.S. has received care from a number of different specialty providers. For a common variable immune deficiency condition, she has received injections once a month in her home, has received blood work done every three months at a clinic in Palm Beach County, and has seen a specialist, Dr. Gary Kleiner, every six months at the University of Miami, a tertiary care facility. J.S.'s pediatrician referred her to Dr. Kleiner. For ruptured cysts, in addition to her pediatrician, J.S. has seen a gynecologist in Palm Beach County, Dr. Berto Lopez, and another gynecologist at the University of Miami. For vision problems, she has seen an ophthalmologist in Palm Beach County, and a specialist in vision loss at the Bascom Palmer Eye Institute at the University of Miami. For sinus problems, in addition to her pediatrician, she has seen an allergist and a pediatric ear nose and throat specialist for care that included a CT scan, x-rays, and surgery, all taking place in Palm

Beach County. J.S. also has seen a cardiologist, dermatologist, and oncologist, as well as a chiropractor and a podiatrist, all without any issue. From January 1, 2004 to March 24, 2011, the Medicaid system had paid $95,887 for care rendered to J.S. D.E. 692 at ¶ 57-62; DX 128 (Pediatric Partners 13-16); DX 582; TT 1997-2001, 2009-11.

The only times that K.S. recalls having difficulty finding a specialist for J.S. were the few occasions she did not contact Pediatric Partners. First, in or around 2000, K.S. used "the phone book" to find an orthopedist to evaluate J.S.'s ankle, because the orthopedist to which J.S. was referred by Jupiter Medical Center (JMC) did not accept Medicaid. K.S. cannot recall and there are no medical records identifying how long it took her on that occasion to find an orthopedist by using the phone book. TT 1961-62, 1992.

Second, in 2003, J.S. injured her ankle at a Winn-Dixie supermarket. K.S. took J.S. to JMC and was referred to an orthopedist for a follow-up evaluation of J.S.'s ankle in two days with x-rays. Nevertheless, J.S.'s medical records prove that she was seen at JMC on a Saturday, and on Monday, had received follow-up care from an orthopedist, Dr. Simon. On that Monday, K.S. had retained an attorney to sue Winn-Dixie for J.S.'s ankle injury and he arranged "within an hour" for Dr. Simon to see J.S. Because Dr. Simon worked with the attorney, K.S. paid nothing for Dr. Simon's orthopedic care. K.S. cannot recall how many

orthopedists she called that Monday before retaining the attorney to sue Winn Dixie. On this occasion, K.S. did not contact Pediatric Partners for help to find an orthopedist. TT 1962-70, 1992-97; DX 130 (Simon 1); DX 120 (JMC 146-157).

In 2007, J.S. injured her wrist playing on a trampoline. K.S. took J.S. to JMC for treatment, on Saturday, March 3, 2007, and was instructed to take J.S. to a particular orthopedist for follow up. K.S. testified that she called this orthopedist on Monday, March 5, 2007, and understood that for J.S. to be seen, K.S. would have to pay cash for the visit. K.S. made other phone calls to locate an orthopedist accepting Medicaid, and by the next day, Tuesday, March 6, 2007, J.S. was seen by an orthopedist Dr. Danko. K.S. did not contact Pediatric Partners for help to find an orthopedist on this occasion either. TT 1971-75, 2001-04; DX 120 (JMC 21-29); DX 111 (Danko 5-9).

In 2007, Dr. Danko practiced at Coral Springs Medical Center (CSMC). The estimated distance between Jupiter and CSMC is between 54 and 58 miles, and the estimated travel time is about an hour and 3 or 4 minutes. D.E. 1127-27.

On other occasions, K.S. acknowledges it was not an issue to locate an orthopedist for J.S. J.S. injured her wrist playing on a trampoline, and K.S. took her to JMC, on May 23, 2006. J.S. was referred to be seen by an orthopedist within a day or two, and, on May 25, she saw Dr. Acosta without any alleged issue. It is not clear whether or not K.S. received help from Pediatric Partners to locate

Dr. Acosta. TT 2007-09; DX 120 (JMC 33,-34, 40); DX 131 (Acosta 1-2).

Pediatric Partners did provide an orthopedic referral for J.S., on September 30, 2005. J.S. injured her knee in a Tae Kwon Do class. On October 4, 2005, J.S. was seen by Dr. Bret Baynham (who also treated T.G.), pursuant to a referral from "Pediatric Partners." Plaintiffs do not allege any problem for J.S. to access specialty care on this or any other occasion where K.S. consulted with Pediatric Partners. As discussed below, in Part VI.C., as a MediPass provider, Pediatric Partners is responsible for managing all needed specialty referrals for its patients. DX 128 (Pediatric Partners 142); DX 124 (PBOI 21, 32); TT 2004-07.

K.S. testified that she took J.S. for counseling sessions for four months with "a friend's counselor," and paid out of pocket . There are no medical records identifying who this counselor was, or what care was provided. K.S. did not try to identify a counselor for J.S. who accepted Medicaid and only called the one counselor that J.S. saw. K.S. did not contact Pediatric Partners or anyone at the FMP for help locating mental health services for J.S. TT 1975-76.

Plaintiffs have not proven that J.S. will be unable to secure medical care in the future, particularly with the assistance available from Pediatric Partners and the local Medicaid office. Notably, the only occasions on which K.S. claims to have had a problem to access orthopedic care for J.S. were those that she did not consult Pediatric Partners. Even in those instances, moreover, the medical records show

J.S., in fact, received the care within the time frame that the attending physician at PBOI had specified, *i.e.*, within two or three days. Further, William Albury, the Field Office Manager for Area 9, which includes Palm Beach County, testified that his office is available to assist parents to find specialists, and explained the steps that AHCA takes to inform parents and Medipass PCPs of this available assistance. Mr. Albury, a long time employee of Area 9, is not aware of any child with Medicaid for whom that office could not find an orthopedist, when requested to assist in this regard. 11/15/11 WA 95-105; 11/16/11WA 3-22, 93-95.

N.V.: N.V., a resident of Volusia County, Florida, is the eight-year old son of K.V., who appears as his next friend. N.V. was determined eligible for Medicaid in 2005 and since then has been continuously eligible for Medicaid. Plaintiffs do not allege that N.V. has ever experienced "switching". D.E. 692 at ¶41-42.

N.V. has not encountered any problems receiving PC treatment and N.V.'s immunizations are up to date. Plaintiffs have not proven that N.V. will not be able to continue receiving regular and follow-up care from his pediatricians at Orlando Regional Medical Center (ORMC). TT 4244, 4256; D.E. 692 at ¶49.

Between 2005 and March 24, 2011, FMP has paid $106,107.24 for the medical services that N.V. has received. DX 582.

N.V. has received extensive specialty care and numerous surgical procedures

from a pediatric urologist, a pediatric nephrologist, a pediatric gastroenterologist, a pediatric hematologist/oncologist, a pediatric neurosurgeon, a pediatric cardiologist, a pediatric ENT, and a pediatric geneticist. N.V. has not experienced any issues accessing specialty care at any time from these numerous specialists. D.E. 692 at ¶43; TT 4249-56, 4274-77.

During Plaintiffs' rebuttal case, K.V. alleged that she had difficulty finding a neuropsychologist for N.V. in September 2011. This is the only alleged instance where she has experienced difficulty accessing specialty care for N.V. K.V. testified that N.V.'s neurosurgeon, Dr. Greg Olavarria, suggested that K.V. be seen by a neuropsychologist, Kara Lyons, PsyD., before the school year started. Thereafter, K.V. testified that N.V. saw Dr. Lyons in November 2011 – "four or five" days after Dr. Olavarria actually called Dr. Lyons office requesting an appointment for his patient. Medicaid paid Dr. Lyons for K.V.'s November 2011 visit. 2/1/12 KV 72-78.

K.V. did not call the AHCA Area Office for help trying to find a neuropsychologist for N.V. In fact, K.V. had not called the AHCA Area Office since 2007, at which time K.V. called to change N.V.'s PCP. 2/1/12 KV 79-80.

Plaintiffs have offered no evidence to suggest that N.V. will not be able to continue receiving the specialty health care that he currently receives, including neuropsychology care.

N.V. currently receives regular dental care paid for by Medicaid. N.V. was not yet three years old, when he was first seen by a dentist at Greenberg Dental Associates, on January 17, 2007. The dental records reflect that N.V. was "uncooperative" (a fact disputed by his mother), and he was referred by Greenberg Dental to Dr. Charles Robbins. DX 82; DX 82c; DX 83 (Greenberg 2); DX 79 (Robbins 1); TT 4258.

Dr. Robbins initially saw N.V. three times in about a month in order to treat N.V.'s gum infections. On the last visit, on September 6, 2007, Dr. Robbins advised K.V. that he no longer did white fillings for children. N.V. was then referred by Greenberg Dental Associates to Dr. Howard Schneider, a pediatric dentist in Jacksonville, Florida because that is where Greenberg Dental was referring all patients that need dental work for tooth decay like NV required. DX 79 (Robbins 3); TT 4267.[29]

N.V. first received dental care from Dr. Schneider on October 27, 2007. Since that point, N.V. has regularly received dental care from Dr. Schneider. DX 82 (Schneid 12-13, 22-23, 32-33, 37-39, 41); DX82c (Schneid 45-52).

Since N.V. started seeing Dr. Schneider, his mother has not looked for

[29] According to N.V.'s records, as of October 2006, there were eleven dental offices in Volusia County (eight accepting new patients) that would treat children on Medicaid, as well as a number of other dentists in Florida Medicaid's Area 4. This list includes all three dentists who saw N.V. – including Dr. Schneider – all of whom are in Area 4. DX 77 (N-Val 5-7).

another dentist, and has not called the Medicaid Area office to help find another dentist.[30] K.V. likes the personal care that N.V. receives from Dr. Schneider. TT 4244, 4245, 4271-72 ; DX 82c (Schneid 52).

None of K.V.'s dentists testified at trial. Plaintiffs have offered no evidence to suggest that N.V. will not be able to continue receiving regular dental care from Dr. Schneider. Moreover, Plaintiffs have offered no evidence that K.V. presently could not find a dentist to treat her now 8-year old son closer to her home.

J.W.: J.W. is the seventeen year old grandson of his next friend, E.W. Since J.W. is incarcerated in a high risk facility, he is no longer Medicaid eligible. Prior to his incarceration, J.W. had Medicaid coverage without interruption, since February 2005. In 2005, E.W. received written information about Medicaid health plan options for J.W., and chose Healthease, a Medicaid HMO. DX 5 (Defendants 597); D.E. 692 at ¶ 91-93; 11/28/11 NL 95-96.

J.W. was assigned to Healthease from April 1, 2005 to February 28, 2007. E.W. also called DCF to request Healthease for J.W. on March 19, 2007. As a result, J.W. was enrolled in Healthease as of April 1, 2007, and remained in Healthease until 2009, at which time, J.W. was assigned to MediPass. J.W.'s

[30] N.V. has not required sedation for his dental procedures since 2007. Regardless, there was a dentist in Volusia County, Dr. Brown, who treated young children that require sedation. According to N.V.'s records, in October 2006, Dr. Brown was accepting new patients with severe dental problems. DX 77 (N_Val 6); 6/2/2011 BK 140.

medical records do not evidence any delay or any out-of-pocket expense for J.W.'s medical or dental care when he was not assigned to Healthease. DX 5 (Defendants 620); DX 7 (Defendants 817); 6/16/10 EW 82, 113-14.

While J.W. had Medicaid coverage, he had numerous appointments with a variety of specialists at Nemours Children's Clinic in Escambia County, including orthopedic surgeons, oncologists, and a pediatric surgeon. E.W. never had any difficulty getting J.W. in to see these specialists. D.E. 692 at ¶ 94; 6/16/10 EW 108-10, 132-33.

J.W.'s medical records prove the following: an orthopedic surgeon, Dr. Stanton, operated on J.W. to remove a tumor from his leg in December 2004, and saw him for follow up in January 2005. In January 2005, an oncologist, Dr. Assanasen, saw J.W., reported: "… [N]o evidence of any other infected areas. We will plan to see him again in July of this year with annual follow up thereafter." DX 2 (Nemours 163-164).

Dr. Stanton next saw J.W. for follow up in March, 2005, and instructed that J.W. should: "Return for x rays in two months." E.W. returned with J.W. in May 2005, at which time x-rays were performed and reviewed with E.W. by another orthopedist at Nemours Children's Clinic, Dr. Pike. Dr. Pike reported: "The patient requires AP and lateral x-rays of the left femur with Dr. Stanton in 2 months." DX 2 (Nemours 160-162).

On July 20, 2005, J.W. next saw Dr. Stanton, who reviewed the x-rays and reported: "[N]o evidence of any progressive disease or weakness. I believe [J.W.] can be confidently released for normal participation in childhood sporting activities with minimal risk. I have recommended a 1-year follow-up visit for re-x-ray in 1 year." That same day, however, J.W. saw Dr. Assanasen, as was planned back in January 2005. Dr. Assanasen reported "newly noted neck pain" and further reported: "At present, there are no neurological symptoms of spinal cord compression or perturbation, however, after discussion with Pediatric Radiology, definitive study of his cervicothoracic spine is indicated." Dr. Assanasen advised E.W. that he would contact J.W.'s insurance provider to authorize a CT scan, and directed her that J.W. should: "Return if symptoms worsen or fail to improve, or on 8/24/2005, approximately 5 weeks." DX 2 (Nemours 157-159).

Meanwhile, on August 10, 2005, J.W. was seen by Dr. Murray, his PCP, who, pursuant to the Healthease Members Handbook, was responsible to arrange for or approve specialist care. On this occasion, Dr. Murray recommended the CT scan for J.W., which J.W. received on August 24, 2005. D.E. 692 at ¶ 99, 100; 6/16/10 EW 165-66; DX 1 (Murray 1-2); DX 13 (Defendants 834).

E.W. knew that Dr. Murray was J.W.'s PCP at the time that authorization was being sought for the CT scan. E.W. is satisfied with the care that J.W. received over the years from Dr. Murray, including well child care, and she

acknowledges that the authorization process started to resolve itself after she spoke with Ms. Laura Johnson of Dr. Murray's office. Dr. Murray continued to see J.W. after he was assigned to MediPass, as did J.W.'s other providers. 6/16/10 EW 102-104, 178-80; DX 8.

On August 10, 2005 when J.W. was first evaluated by Dr. Murray, he was an "Alert, active YM in no distress," and with respect to his neck pain, a "Heating pad is all that is usually needed to make it go away." Likewise, it is undisputed that E.W. did not seek to move up J.W.'s next visit with Dr. Assanasen to a date earlier than August 24, 2005, even though Dr. Assanasen said to do so if J.W.'s "symptoms worsen or fail to improve." DX 1 (Murray 1-2); DX 2 (Nemours 157-159); 6/16/10 EW 139.

It is unknown how long after J.W. had his August 10, 2005 office visit with Dr. Murray that the CT scan authorization was in place. J.W. received his CT scan on August 24, 2005, and it was available for review by Dr. Stanton when he saw J.W. the next day. Based on his review, Dr. Stanton reported: "The current level involvement should not produce significant instability of the cervical spine and there is minimal risk to cord integrity… Surgical intervention and radiation treatment is unnecessary, ..." J.W. also was evaluated at this time by oncologists, Dr. Kelleher and Dr. Schwartz, and was not seen by Dr. Assanasen again until September 8, 2005, when J.W.'s treatment was underway. Stipulated Fact 100;

DX 2 (Nemours 143-154, 157-59, 223-225). DX 1 (Murray 1-2); 6/16/10 EW 200.

On September 8, 2005, Dr. Assanasen wrote Dr. Murray: "We would highly recommend that the Infusaport be obtained in order to prevent further complications in this young man." That same day, Dr. Murray referred J.W. for a central line placement and faxed Healthease authorization. On September 15, 2005, J.W. received the infusion port (also called a central line). D.E. 692 ¶103; DX 1 (Murray 1-2); DX 2 (Nemours 143-147); DX 3 (Sacred Heart 117-119).

From August 2005 through the time that E.W. last testified in this action on June 10, 2010, J.W. was continuing to have regular follow-up visits at Nemours Children's Clinic every six months, including CT scans either every six months or annually, and E.W. is not aware of any problem to get these CT scans. J.W. received an additional six CT scans and two MRIs, 34 specialist visits; and 15 PC visits – all without any issue – over the 30 months between August 25, 2005 and February 19, 2008, according to J.W.'s medical records. There is no evidence that any of J.W.'s providers, E.W., or any other person complained to AHCA about the time it took for Healthease to authorize care for J.W. 6/16/10 EW 165; DX 1 (Murray 2-17); DX 2 (Nemours 1-153).

J.W. had four dental visits between May 2005 and March 2006 with Dr. Rogers, a dentist who saw J.W. at the Escambia CHD, and another eight dental visits between May 2007 and June 2009 with Dr. Wright, a dentist who saw J.W. at

the Sacred Heart Pediatric Dental Clinic, all without reported issue in the medical records. DX 17; DX 410.

Plaintiffs' expert, Dr. Middlemas, agreed that Medicaid served J.W. well during multiple primary and specialty care visits from July 20, 2005 forward. Nevertheless, Dr. Middlemas never treated J.W. or any other patient with J.W.'s condition, never contacted any of the doctors actually involved in J.W.'s care, or Healthease to learn the facts relating to the authorization process in the case of J.W. He also conceded having no basis to know whether Healthease as a matter of course timely approves imaging studies. Accordingly, and for the reasons in defendants' motion *in limine* and related reply (D.E. 695 and D.E. 766), the Court should not admit his opinions. 1/31/12 RM 3, 7-8, 26-27, 30-31, 33, 36.

FAPD: FAPD has not proven that its organization has been injured by any of the Defendants. Dr. Primosch, a past president of FAPD and its current executive director, has acknowledged that FAPD is not looking to achieve anything for itself as an organization through the Medicaid lawsuit, but rather, seeks to increase Medicaid reimbursements for dentists. 3/14/08 PC 205, 211; TT 3740-43, 3776.

There is no evidence that any of FAPD's members have been injured by any of the Defendant agencies. FAPD does not even know how many of its members accept Medicaid; and has not attempted to determine the extent to which Medicaid

reimbursement rates have affected the ability of its members to provide quality care. 3/14/08 PC 42, 69, 211-13.

Moreover, Plaintiffs have offered no evidence that Florida Medicaid has reimbursed ***any*** FAPD member at rates that fail to cover the marginal costs of providing that dental care. Plaintiffs only had two of its members testify in court during this trial: Dr. Robert Primosch and Dr. Natalie Carr. Plaintiffs submitted deposition testimony from two other FAPD members, Dr. James McIlwain and Dr. Peter Claussen.[31] None of these individuals testified that Medicaid reimburses him or her at rates that failed to cover the marginal costs of providing that dental care.

Dr. Primosch is a professor of pediatric dentistry at the University of Florida, and has never practiced dentistry in a private practice. His salary is determined by the University of Florida. Dr. Carr, a past president of FAPD, has never accepted Medicaid in her dental practice in Florida. TT 3721, 3735, 3758, 3789, 3799.

Dr. McIlwain, a past president of FAPD, similarly has not accepted Medicaid in his private practice since at least 1984. 11/13/08 JM 4, 10.

Dr. Claussen, a past president of FAPD, treats Medicaid patients. In fact, about half of his patients are on Medicaid. Dr. Claussen did not testify that Medicaid reimbursed him at rates that failed to cover the costs of providing dental

[31] Dr. Claussen was not deposed in his individual capacity but rather as FAPD's corporate representative.

care to his Medicaid patients, but rather speculated: "I feel that the low reimbursement rates offered by Medicaid would be harming to my annual net income if I allowed my practice to grow past 50 percent Medicaid." 3/14/08 PC 14-15, 69, 110.[32]

FPS: There is no evidence that FPS as an organization has been injured by any of the Defendants.

FPS has not analyzed whether, in general, the marginal cost of treating patients on Medicaid is greater than the reimbursement paid by Medicaid. FPS does not know if any of its members refuse to treat Medicaid patients as a result of allegedly inadequate reimbursement rates. FPS does not even know which of its members accept Medicaid. TT 1436, 715-17, 711.

Moreover, Plaintiffs have offered no evidence that Florida Medicaid has reimbursed ***any*** FPS member at rates that fail to cover the marginal cost of providing that health care. Plaintiffs only had six of its current members testify in court during this trial: Dr. Louis St Petery, Dr. Rex Northrup, Dr. Lisa Cosgrove, Dr. Nancy Silva; Dr. Tommy Schechtman, and Dr. Jerome Issac.[33] None of these

[32] Dr. Claussen is reimbursed about $10,000 per week for treating Medicaid patients. 3/14/08 PC 171.

[33] While Plaintiffs also called Dr. Duncan Postma, a ENT, Dr. Ricardo Ayala, a pediatric nephrologist, Dr. Adam Fenichel, an orthopedic surgeon, and Dr. Tamer, a pediatric cardiologist, none of them are members of FPS. TT 3224, 3627, 4535. Plaintiffs also called Dr. Baynham but, given his testimony, it is unknown as to whether or not he is a member of FPS. Regardless, Dr. Baynham did not testify as

individuals testified that Medicaid reimburses him or her at rates that fail to cover the marginal costs of providing treatment.

Dr. Cosgrove, a pediatrician, testified that she has not analyzed how the costs of treating Medicaid patients compare to what Medicaid reimburse her private practice for providing services to Medicaid patients. TT 2614.

Dr. Silva, a pediatrician, could not testify as to whether Medicaid reimbursement rates cover the cost of providing care to patients on Medicaid, because she is only an employee of HealthPoint Medical Group. She has no ownership interest, but is paid a salary based on how many patients that she sees. Her practice is not at capacity, so she makes incrementally more money for each and every patient that she sees, including Medicaid patients. TT 2824-26.

Dr. Schectman, a pediatrician who testified during trial on three separate occasions, never compared Medicaid reimbursement rates to his marginal cost of providing care to those Medicaid patients. Rather, Dr. Schectman included all of his practice expenses –salaries, 401K, automobile expenses (including mileage reimbursements, gasoline, and insurance), collections expenses; rent, travel, entertainment, and immunization purchases – and divided that number by patient to arrive at a cost per patient visit. Clearly, however, the cost associated with providing care to Medicaid patients does not include many of these expenses,

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to whether Medicaid reimbursed him at rates that would cover the actual cost of providing that health care. 1/24/12 BB 71-72.

particularly immunizations which are provided for free for Medicaid patients. Moreover, Dr. Schectman continues to take more and more Medicaid patients and hire more and more doctors to service them. It is not reasonable to conclude that he is losing money on Medicaid patients. TT 2887, 4438, 4472-81, 4487; PX 145A.

Dr. St. Petery similarly included both fixed and variable practice costs to determine an average cost per patient. He admits that his analysis did not compare the marginal cost of treating a child on Medicaid with the Medicaid reimbursement rate. TT 1429-36.

Dr. Isaac could not know whether Medicaid reimbursement rates cover the cost of providing care to patients on Medicaid because he has never calculated the average or marginal cost of seeing any patient. TT 3921.

Plaintiffs submitted deposition testimony from other current FPS members: Dr. Richard Bucciarelli, Dr. Mark Didea, Dr. Weber, Dr. Donaldson, Dr. Jonathan Phillips, Dr. Paulino Milla-Orellana, Dr. Julia St. Petery, Dr. Gerold Schiebler, Dr. William Knappenberger, Dr. Thomas Chiu, Dr. John Curran, Dr. John Ritrosky, and Dr. Mary Elizabeth Seay. None of the deposition testimony submitted by Plaintiffs established that any of these individuals are reimbursed by Medicaid at rates that failed to cover the costs of providing treatment to a child on Medicaid. Record.

Dr. Milla-Orellana has never analyzed whether Medicaid covers the costs of certain medical procedures. He only claimed that Medicaid does not cover the cost of purchasing certain injectables. He based his testimony on documents that are hearsay and not in the record. 11/23/08 PO 90-91, 106, 35.

VI. Proposed Class-wide Findings of Fact and Conclusions of Law

A. Proposed Findings of Fact

1. Florida's Medicaid State Plan (FMSP)

To qualify for federal funding also referred to as either federal financial participation (FFP) or federal medical assistance payment (FMAP), Florida must submit a state plan, for approval by federal CMS. "The state plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX, the regulations in this Chapter IV, and other applicable official issuances of" federal CMS. 42 C.F.R. §430.10. Amendments are required to the FMSP when "necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation." PX 712, §7, pg. 86 at FL-MED 08196

The FMSP must contain all information necessary for federal CMS to determine whether the plan can be approved to serve as a basis for Federal

financial participation (FFP) in the State program. 42 C.F.R. §430.10. The state plan consists of required preprinted material dictated by federal CMS, as well as "individualized content that reflects the characteristics of the particular State's program." 42 C.F.R. §430.12.

42 U.S.C. §1396a sets forth the items which must be contained within a valid state plan. 42 U.S.C. §1396a(a). The FMSP, approved by federal CMS, addresses the requirements of Section 1396a(a). Certainly, no record evidence has been presented that federal CMS has ever determined that the FMSP does not comply with the provisions of 42 U.S.C. §1396a(a), as it pertains to the issues in this case. PX 712.

The FMSP contains the required assurances, approved by federal CMS, that its "payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." PX 712, §4, pg. 65 at FL-MED 08141

2. Funding for the Medicaid Program

For federal fiscal year 2011-2012, the FMAP for Florida is 56.04%. 75 Fed. Reg. 69082-01 (November 10, 2010). This means that Florida is required to pay or "front" 43.96% of the funds necessary to reimburse Medicaid providers, and the remaining 56.04% is provided by the federal government.

Between 2005 and 2011, Florida's total Medicaid spending grew from

$13,882,000,000, to almost $20 billion. 10/21/11 PW 152. This represents a 44% increase in spending in the Medicaid program. DX 249 at 20.

In June 2008, there were 1,306,942 children enrolled in Medicaid, and on November 29, 2011, there were approximately 1,700,000. This represents a 30% increase in enrollment over just this period. PX 291-292; 11/29/11 NL 48-49.

Florida's Constitution requires that the state operate under a balanced budget. *Chiles v. United Faculty of Fla.*, 615 So.2d 671, 676 (Fla. 1993); Fla. Const., Art. 7, §1(d). Nonetheless, in 2009-2010, the projected deficit for the FMP was $1.3 billion, and for 2010-2011, it was $2.6 billion. TT 465-66, 2520-21.

3. Florida Medicaid Reimbursement Rates (Fee for Service)

a. EPSDT Services

By state law, providers of EPSDT services shall be reimbursed using an all-inclusive rate set by AHCA in a fee schedule. Providers of the visual, dental and hearing components of the EPSDT services shall be reimbursed at the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by AHCA. Section 409.908(6), Fla. Stat. (2011).

The “all-inclusive” rate” set by AHCA in the Medicaid physician fee schedule for CHCUPs is $71.58, if the screening is provided by a PCP, and $88.77, if provided by certain specified specialists. PX 572, 781.

As noted above, Section 409.908(6) provides that dental services for

children are reimbursed at the lesser of the billed amount or the Medicaid maximum allowable fee, as established by AHCA. Effective July 1, 2011, AHCA increased all of the fee-for-service reimbursement rates for dental services for children by 48.63%. 5/31/11 BK 100-103; D.E. 1011-3; D.E. 1012.

Over the life of this lawsuit, the fee-for-service appropriations for EPSDT services have grown by 90%:

Laws of Florida	**Line Number**	**Amount**
Ch. 2005-70, Laws of Florida	183	134,029,664
Ch. 2010-152, Laws of Florida	182	175,486,167
Ch. 2011-69, Laws of Florida	170	254,420,635

Included within the 2011 appropriation for EPSDT services was $56,071,086 for the above-mentioned increase in the Medicaid dental reimbursement fees. §3, Line 170, Ch. 2011-69, Laws of Fla.

Although physician services are generally adjusted annually, using a resource-based relative value scale (RBRVS) process described further below, CHCUPs (CPT codes 99381-99385 and 99391-99395) are not subject to the RBRVS process. 10/17/11 PW 18.

In the years leading up to the filing of this lawsuit, there were two fee increases which resulted in increases to the amounts paid to PCPs for child health checkups (CHCUP). In 2000, there was a 4% increase in reimbursement rates for physician services generally. Chap. 2000-166, §3, Line Item 229, Laws of Florida.

Effective April 1, 2002, there was a second 4% increase in reimbursement rates for physician services, for services to children ages 0-21. Chap. 2001-253, §3, Line Item 266, Laws of Florida.

Plaintiffs' exhibits show that AHCA requested additional funding for CHCUPs each year between 2006 and 2008. PX 92, 95, 707, 734.

Some earlier CHCUP LBRs stated: "Increasing the reimbursement for a CHCUP *will* help meet the state and federal participation goal of 80 percent." (emphasis supplied). There is no record support for this prediction. While AHCA's participation ratio, as reported on the CMS 416 report increased from 32% to 64% between federal fiscal year (FFY) 1995 and 1996, and the reimbursement rate for CHCUPs was increased from $30 to $64.82, effective January 1, 1995, other important changes were also made in Medicaid's CHCUP program, which also helped increase the participation ratio. AHCA implemented an optional medical records form, for use by practitioners, to make it easier to document the elements of a CHCUP; and there was better reporting by Medicaid HMOs regarding the CHCUP requirements. Further, federally qualified health centers (FQHCs) began reporting their services. PX 92, 686 at 2, *** [34]

Moreover, the FFY 1995 rate increase was implemented January 1, 1995 and in effect for most of that FFY. Yet, a comparison of the difference in the

[34] In 2001, Florida reported these concurrent initiatives to the Government Accountability Office. 1/6/12 CS 106-107; 1/30/12 SF 92-93.

participation year between FFY 1994 (no increase) to FFY 1995 reveals that there was only a 3 percentage point increase in the participation ratio, from 29% to 32%. If reimbursement rates were a significant contributing factor in increases to the participation ratio, there should have been more than a 3 percentage point increase between FFY 1994 and FFY 1995. PX 686. 1/6/12 CS 108-109.

The CHCUP LBRs also state that "[a]n increase will also more accurately reflect the cost of providing and documenting this comprehensive, preventive service." AHCA does not collect information about the costs of physicians providing services. It, therefore, has no way of validating statements about the relationship between reimbursements and provider costs. Further, Dr. St. Petery's testimony showed that, for the pediatric practices within TPF, CHCUP reimbursements are enough to cover costs. PX 92; 10/13/11 PW 38-39; TT 1432; compare with PX 781.

Notwithstanding AHCA's repeated and unsuccessful efforts to increase fees for CHCUP services, federal CMS has never found that AHCA is not in substantial compliance with the requirements of Title XIX of the Social Security Act as it relates to AHCA's reimbursement rates for CHCUP services. Likewise, federal CMS has never threatened to withhold or recoup federal funding as a result of perceived problems with the Child Health Check-Up program. TT 1224-25.

b. Dental Services

Prior to July 1, 2011, when the rates were increased by 48.63%, dental reimbursement rates had not been increased since 1998. However, as Plaintiffs must acknowledge, for many years, AHCA submitted LBRs in an effort to increase dental reimbursement rates. *See e.g.* PX 78, 109, 80, 82, 83, 102 at 168-169, 109, 707, 716; 10/13/11 PW 50-52; TT 3951.

For an LBR to be effective in achieving its purpose (securing new or additional funding), the LBR must show a need for the new or additional funding. Nonetheless, some statements in the LBRs have been shown to be without support or erroneous. In part this is due to the short turnaround time for staff to prepare LBRs each year. TT 1078-79; 10/3/11 BK 113-14.

For many years, in creating the LBRs, staff copied over information from prior LBRs. That this was done was not evident unless a review was done of prior year LBRs, going back more than one year. This type of review wasn't typically done. For dental LBRs, AHCA staff reported every year for a 7 year period that there had been a 15% decline in active provider participation in the prior five year period. However, the participation data in the LBRs did not support this. Instead, active participation stayed fairly constant, after a modest increase in 2003, and even went up in 2007. Plaintiffs' own witness, Bob Sharpe, a lobbyist and former Medicaid Director, did not know why AHCA would indicate that there was a decrease in active providers, under these circumstances. The percentage changes

reported in the LBRs were "very inconsistent" with the provider participation data being reported in the same documents. TT 5006-7; 6/1/11 BK 124-25; c*ompare* PX 78 to PX 109 at 25, PX 726, 10/3/11 BK 157; PX 78, 80-85, 109, 715, 726.

The statements in the dental LBRs did not include dentists who provided services through County Health Departments (CHDs) and Federally Qualified Health Centers (FQHCs). 6/1/11 BK 125. Between October 2002 and September 30, 2007, the FQHCs and CHDs provided services to the following numbers of children enrolled in Medicaid:

Federal Fiscal Year	Number of Children obtaining Dental Services at County Health Department	Number of Children obtaining Dental Services at Federally Qualified Health Center	Total
2002-2003	47,897	17,959	65,856
2003-2004	57,268	18,545	75,813
2004-2005	69,046	23,274	92,230
2005-2006	77,223	25,647	102,870
2006-2007	75,659	26,825	102,484

PX 739, Table 3.

The dental LBRs also contained estimates regarding the relationship between AHCA's dental reimbursement rates and provider costs. AHCA does not collect dental practice cost data from Florida dentists. Thus, AHCA has no way to validate estimates of the relationship between dental practice costs and Medicaid

dental reimbursements. Certainly no evidence has been presented that AHCA has ever collected scientific evidence of provider costs in Florida, such that it could reliably determine the relationship of those costs to Florida Medicaid fees. *See e.g.*, PX 78, 80-84, 706, 726; 10/13/11 PW 38-39, 53-55; TT 4991; *Record*.

The LBRs also typically compared the Medicaid reimbursements for select dental procedures to "usual and customary fees" as reported in a 1999 American Dental Association Survey of dental fees. The "usual and customary fee" is a charge, and not what a provider would necessarily be paid for a service. It can have different meanings in different contexts. Plaintiffs' expert, Dr. Crall, characterized "usual charge" as the fee that a particular dentist normally charges for a particular service, and "customary charge" as the most commonly charged in an area. Based on these definitions, for a charge to be both usual and customary, it must be the normal charge for the particular dentist for a particular service, which charge does not exceed the customary charge in the area. *See e.g.*, PX 78; TT 5417.

AHCA has done no auditing to determine whether self-reported "usual and customary charges" are in fact the practitioners' actual usual and customary charge. TT 1125; 10/13/11 PW 66.

AHCA does not have access to information about what private or commercial insurance plans pay for either dental or physician services, and

therefore is not able to compare its rates to what private or commercial insurance pays for services. TT 2655-56; 6/2/11 BK 151.

In 2008, Plaintiffs' expert, Dr. Crall, compared Florida's Medicaid reimbursement rates for dental services to charge data from the American Dental Association (ADA), a WebMD claim database purchased by the ADA, charge data from the National Dental Advisory Service (NDAS) and charge data form MetLife, a commercial dental insurance plan. *See* PX 418at 5 and Appendix E.

In 2011, Dr. Crall performed a similar comparison of the increased Florida Medicaid reimbursement rates against just charge data from the National Dental Advisory Service and MetLife. PX 786.

The ADA data consisted of percentile charge data obtained through a 2003 survey of dentists. The total sample size for the 2003 ADA survey was about 5% of dentists in the U.S., and the response rate was about 30%. Thus, the responders to the survey represented about 1.5% (5% X 30%) of U.S. dentists. Notwithstanding this low response rate, according to Dr. Crall, in the ADA survey, staff "do look to see whether or not their sample varies from what they know about dentists in general, on the basis of age, size of practice, years in practice, et cetera." From the ADA survey results, Dr. Crall compared the ADA charge data at the 50th

percentile[35] for a list of 15 dental codes. Dr. Crall presented no reliable evidence of the relationship in 2008 between charge data from the ADA 2003 survey and third party reimbursement rates (or indeed in 2003, when the survey was done). TT 5112-13, 5420, 5427; PX 418, pg 5.

As noted above, Dr. Crall also used a claims database from WebMD, from 2004, which contained charge data in his analysis of Florida Medicaid rates. Using the WebMD data, Dr. Crall compared 50th and 75th percentile charges to Medicaid reimbursements, for the same 15 dental codes he used in the ADA comparison above. Dr. Crall used the 75th percentile charges, because that is "what the ADA recommends," and not because he has done any analysis of the impact that rates at lower percentiles have on utilization. Dr. Crall presented no proof of the relationship between third party reimbursements in 2008 (or 2004), and the WebMD percentile charge data. TT 5113, 5116-17, 5119-20, 5199; *see* PX 418, pg. 5.

As noted above, Dr. Crall also used 2008 NDAS percentile charge data in his rate comparison. The 2008 NDAS charge data is reportedly based on confidential mail fee surveys of dentists about what they charge; however, Dr. Crall was not able to review the survey methodology used by NDAS. NDAS information about rates of nonresponse (needed to assess the reliability of the

[35] The 50th percentile charge would be the point at which 50% of dentists charge an amount at or less than the stated charge.

survey data) is considered "proprietary information", which Dr. Crall did not review. Likewise, Dr. Crall did not review response rates for the NDAS survey. According to the NDAS, "[c]omplete confidential surveys are deemed reliable, but accuracy cannot be guaranteed." The NDAS report reflects that it is not to be used to set fees, or as a recommended fee schedule, and "should not be used for Medicare or Medicaid pricing." TT 5426-27. As with the ADA and WebMD charge data, Dr. Crall presented no proof regarding the relationship between the reported NDAS fee percentiles, and what third party payors in Florida pay dentists for dental services. TT 5108, 5414-18, 5420-21, 5423-24.

Dr. Crall also analyzed Florida's dental Medicaid reimbursement rates against data from MetLife. Dr. Crall sits on an advisory board for MetLife. Notwithstanding his involvement on MetLife's advisory board, Dr. Crall presented no evidence regarding their actual dental reimbursement rates. Instead, he relied on percentile charge data, which he made no effort to validate. Rather, he "took the data as it were, as they were provided." TT 5395; 1/26/12 JC2 133.

Before relying on the MetLife data (or indeed the WebMD or NDAS data), Dr. Crall did not take necessary steps to validate it, including determining the minimum number of respondents before a particular percentile is reported, what is done with outliers, and what data is included or excluded in determining the percentiles. It is important, for example, to know if percentile data may be

reported based on a single respondent, or whether a minimum number of respondents is required. 12/14/11 CS 69.

The Metlife data included information about what purported to be 51st, 70th, 80th percentile charges by the three digit zip code prefix for all areas in Florida. TT 5396; 1/26/12 JC2 133, 135-36.

Dr. Crall did not know the number of dentists who participated in MetLife in Florida, although he asked for this information. Dr. Crall acknowledged that MetLife has a lot of competitors in Florida (as it relates to dental insurance), but that he used MetLife because they were "the largest commercial dental provider" nationally. He did not know MetLife's market share in Florida, or who MetLife's competitors in Florida were, and did not ask MetLife's competitors for data on charges or reimbursements. Dr. Crall did not conduct any independent research to test the reliability of the dental participation information forwarded to him at MetLife. TT 5404-6, 5408-10, 5412.

Although Dr. Crall looked at multiple data sources in analyzing Florida's reimbursement rates, as noted above, the data were not all for the same time period. The ADA data was from 2003, the WebMD data was for 2004, and the NDAS data and MetLife data were from 2008. All four data sets differ in the amount of the reported percentile charges (and the MetLife data reports on 51st percentile charges which are still typically lower than the 50th percentile NDAS

data provided by Plaintiffs). None of the data provided illuminates what dentists in Florida are actually paid by third party payors.[36]

Dr. Crall did not use commercially available databases which provide actual payment information for commercial payors in Florida, in testing the adequacy of Florida Medicaid dental reimbursement rates. 1/26/12 JC2 137; 12/14/11 CS 62.

Dr. Crall did not ask member dentists of the Florida Academy of Pediatric Dentistry about what they were paid for dental services by commercial insurers. He also did not determine the extent to which FAPD member dentists participated in MetLife. He said there were time constraints to his project, and he didn't know who to contact. TT 5399-400.

Data about charges does not reliably show what dentists get paid for services provided to privately insured patients, and Dr. Crall has not presented credible evidence on this issue. He testified that what dentists are paid is close to what they charge, and cites to a 2000 GAO report entitled, "Factors Contributing to Low Use of Dental Services by Low Income Populations." The 2000 GAO report relied on a 1998 ADA survey to state:

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[36] Dr. Crall's analyses of Medicaid reimbursement rates to charge data also do not consider the impact of behavior management fees which Medicaid dentists may bill Medicaid when a child presents a management problem that must be controlled by extraordinary means. Behavior management may be up to three times a year for that patient, at a rate of $36.67 per visit, in addition to whatever other services are provided. TT 5382-83, 5392-93; D.E. 1011-3, pg. 6; 10/3/11 BK 15; DX 264 p. 2-5; PX 418.

as root canal), and surgical services.[12] For dentists, the fees they charge are fairly representative of the amounts they generally collect. According to a 1998 survey by the American Dental Association (ADA), dentists collect about 95 percent of the amount that they bill.

PX 450, pg. 12. However, data which was 10 years old at the time of Dr. Crall's initial analysis would not be reliable for the purposes of determining the relationship between charges and reimbursements for dentists in 2008 or presently. Since 1998, there has been increased availability of employer sponsored dental insurance, and more coverage of dental services through managed care plans. The payors have had more negotiating power, obtain higher discounts on dental services. Even the 2004 ADA document which Dr. Crall attached to his declaration, filed as PX 786, reflects that at that time: "The experience of commercial dental preferred provider networks in heavily competitive dental markets indicates that some providers may accept fee discounts in the range of 15 percent to 20 percent off of their usual fees." PX 450; TT 5121; 12/14/11 CS 60; D.E. 964-5, pg. 2.

Dr. Crall also looked at provider costs. According to a 2004 ADA survey overhead represents 60.5% of the general practitioners practice revenues. Another article cited by Dr. Crall reported that overhead was about 68% of practice revenues. However, none of the data sources cited by Dr. Crall evaluate the reasonableness of the overhead expenses included within these percentages.

Further, Dr. Crall did not dispute an observation by Mr. Levin (someone who Dr. Crall relied upon in his initial report), that "general overhead in most practices is approximately eight to ten percent too high." Dr. Crall has provided no evidence of the percentage that reasonable practice expenses are of practice revenues for general dentists. TT 15-16, 22-25, 31-33; PX 418, pg. 4

Dr. Crall did not examine provider costs for any Florida dentists, including the dentists who provided services to the named Plaintiffs. Based on the fact that Dr. Crall has not compared Florida Medicaid reimbursements to Florida dental practice costs, Plaintiffs have not shown that Florida Medicaid reimbursement rates (as increased) are not adequate to cover dental practice costs. TT 5338-40.

Also, Dr. Crall has not analyzed the amount that the FMP would need to pay dentists who are not currently participating to join those who are. Nor has this Court been given enough evidence to make this determination on its own. FAPD's past president, Dr. Claussen, stated that it "requires speculation on my part" to believe increasing FMP dental rates would lead to a significant shift in the willingness of dentists to serve Medicaid clients in Florida. Dr. Primosch offered nothing more than "hope" that it would affect dentists' decision making on Medicaid participation. TT 3741; 3/14/08 PC 254-55.

Comparing what Florida Medicaid actually pays to what dentists charge is also problematic because charge-based fee schedules are inflationary; providers

have an incentive to inflate their charges because they will be paid higher fees under a charge-based reimbursement system. The Medicare program moved away from a charge-based payment system for physicians and other practitioners in 1992, citing the inflationary nature of charge-based reimbursement as one of the reasons for the change. 12/5/11 CS 34-35, 50; 12/14/11 CS 81-82; DX 612, ¶ 41, p. 21.

Finally, Plaintiffs' proof is insufficient to demonstrate that higher dental rates will achieve higher percentages of children receiving a dental service, as determined by using the CMS 416 report. Significant to this determination is the fact that Delaware, a state which Dr. Crall touts as paying at the 85th percentile of usual and customary charges had the same percentage of children receiving a dental service as Florida in FFY 2007, or 21%. PX 440, pg. 52; 2/8/11 JC2 72.

c. Physician Services

The methodology used to set physician services' fees, in the fee-for-service context, is described in Section 409.908(12)(b), Fla. Stat. (2011), which requires that Florida adjust its fee schedule, using resource-based relative value scale (RBRVS) data.

In 1997, Florida submitted certain of its pediatric service reimbursement rates to federal CMS as part of its Medicaid State Plan, and received approval of those rates. Since that time, the reimbursements for the services covered in the

approved plan have increased. There is no record evidence that Florida has been required to further update its reimbursement rates for physicians, that federal CMS has ever disapproved Florida's reimbursement rates for physicians, or that federal CMS has determined that Florida's physician reimbursement rates are not in substantial compliance with the provisions of Title XIX of the Social Security Act. Federal CMS has never sought to withhold federal funding as a result of any inadequacy of physician service rates in Florida. PX 712, Attachment 4.19-B, Page 8-10 (FL-MED 08952-57); co*mpare* PX 781; 1/8/10 DS 1224-25.

Annually, the FMP complies with Section 409.908(12)(b) by obtaining from federal CMS' website a relative value file created by the American Medical Association (AMA), which is used to adjust physician service reimbursement rates. 10/12/11 PW 57-58; TT 4351.

The RBRVS data available on federal CMS' website includes relative values for physician practice expense, excluding physician salaries, physician time and malpractice expenses. "Relative value units" (RVUs) are established for each CPT (Current Procedural Terminology) code by the AMA. CPT codes which have a higher overall relative value (considering physician time, practice expenses and malpractice costs) will reimburse at a higher level than CPT codes with lower overall relative value. *See e.g.*, DX 595; TT 4351.

The FMP's application of the RBRVS process is budget neutral, and results

in the redistribution of appropriated funds, based on changes in relative values that occur year to year. The resultant adjustments do not increase overall spending, but do not account for any changes in utilization. 10/13/11 PW 37-38; TT 359-60.

Medicare also uses an RBRVS methodology to set Medicare physician services rates. The Medicare RBRVS process has elements of budget neutrality. Apart from action by Congress, if RBRVS changes to the Medicare physician services rates cause spending to vary by more than $20 million (across the entire Medicare program), then adjustments must be made. U.S.C.A. § 1395w-4(c)(2)(B)(ii)(II). Federal CMS has never advised Florida that it may not use budget neutrality in its RBRVS adjustment process for physician services. 10/13/11 PW 35- 37; 12/5/11 CS 57-58.

Over the life of this lawsuit, FMP appropriations for physician services have grown by 62%:

Laws of Florida	**Line Number**	**Amount**
Ch. 2005-70, Laws of Florida	203	758,671,629
Ch. 2010-152, Laws of Florida	203	1,178,665,357
Ch. 2011-69, Laws of Florida	191	1,226,838,768

Between 1999 and 2004, AHCA was able to secure several rate increases for physician services for children. In addition to the general 4% increase for all physician services obtained in 2000 and the 4% increase in 2002 for services to children (referenced in Part VI.A.1.a), effective January 1, 2000, AHCA obtained

funding for targeted increases for PC services provided to children aged 0-19, billed under CPT codes 99212, 99213, and 99214. At the same time, AHCA obtained funding for a fee increase, for certain services provided to children by physicians who are board-certified in pediatric surgery or urology. TT 165, 173; Chap. 1999-226, §3, Line Item 259, Laws of Florida.

In 2004, the Legislature appropriated funding for a 24% increase in reimbursement rates "for services provided to individuals under the age of 21 with emphasis on pediatric specialty care for those services deemed by the agency to be the most difficult to secure under the current reimbursement methodology." This 24% increase in rates was applied to services provided by a number of specialist provider types.[37] Chap. 2004-268, §3, Line Item 215, Laws of Florida.

The 24% increase is in addition to the 4% increase in reimbursements for services provided to children under the age of 21. So for example, while the reimbursement rate for a service for an adult billed under CPT code 99201 would be reimbursed at $31.20, the same service if provided to a children under the age of 21, by a PCP would be reimbursed at $32.45, and by a specialty provider at

[37] These specialist provider types are: allergy, anesthesiology, cardiovascular disease, dermatology, endocrinology, gastroenterology, hematology, infectious diseases, neoplastic diseases, nephrology, neurology, child neurology, oncology, ophthalmology, otolaryngology, pediatric allergy, pediatric cardiology, pediatric oncology, pediatric nephrology, child psychiatry, pulmonary, rheumatology, cardiovascular surgery, general surgery, neurosurgery, orthopedic surgery, plastic surgery, and trauma surgery. PX 128A, pg. 981414.

$40.24. PX 781.

Since 2004, AHCA has continued to seek rate increases for physician services, albeit unsuccessfully. In 2006, the Governor issued Supplemental Budget Recommendations, seeking another 10% fee increase for pediatricians and pediatric specialists. In the Fall of 2007 and again in the Fall of 2008, AHCA submitted LBRs for increases in the following specialty areas: dermatology, neurology, neurosurgery and orthopedic surgery. PX 707, pg. 2; PX 89; PX102, pg. 166-67.

Regarding the statements made in Plaintiffs' exhibits 89 and 90 that the "Medicaid offices have identified physician specialty shortage and critical access to care problems" for neurology, neurosurgery, dermatology and orthopedic surgery, the LBR documents contain no statements specific to any access issues for children. TT 1070.

That children have better access to these physician services is shown by the named Plaintiffs who have most typically received an array of specialty care. See Part V.B. above.

The specialty physician services' LBRs submitted by AHCA in the Fall of 2007 and 2008 contained statements regarding the increase needed to bring reimbursement rates for these specialty services half way to Medicare, and estimated that a 40% increase would be needed for that purpose. Such estimates

did not apply to child services, because for dermatology, neurology, neurosurgery and orthopedic surgery, there was a more than 28% (4% and another 24%) increase for specialty services provided to children over what was paid to adults, and as a consequence, a 40% increase in rates for services to children would bring them in some instances over the Medicare rate. TT 1070-72; 10/13/11 PW 125; PX 128A.

Historically, it has been more difficult to do global comparisons between Medicaid and Medicare for services to children, because of the various rate differentials, and because for some services for children, there is no published Medicare rate. The following rate differences for 99212-99214 illustrate the problems:

CPT Code	Adult services	Children 0-19, PC Services	Children 19-20, PC services (adult rate + 4%)	Children 0-21 Specialty Care Services (adult rate +4% + 24%)
99212	21.84	26.45	22.71	28.16
99213	26.61	32.56	27.67	34.32
99214	41.46	48.27	43.12	44.84

PX 781.

For certain services, like the CHCUP codes, 99381-99385 and 99391-99395, there are no published Medicare rates, and, therefore, it is necessary to calculate a rate using the Medicare methodology and the published data on CMS' website.

Historically, AHCA has not calculated the rates for the CHCUP codes. As a result, any comparisons of Medicaid and Medicare rates for children in the past have not included the CHCUP rates. 10/13/11 PW 17.

Nonetheless, a review of the calculated CHCUP rates between 2003 (the earliest date on which the necessary data is presently on federal CMS' website) and 2011 shows some variability over time in what the pricing would be using the Medicare methodology:

	2003	2004	2005	2006	2007	2008	2009	2010	2011
99381	97.44	99.78	100.94	100.60	91.52	87.84	89.04	91.11	94.29
99382	104.93	107.54	108.81	108.46	98.62	94.58	96.86	99.00	102.05
99383	102.84	105.42	106.67	106.34	97.20	93.15	96.19	98.65	101.72
99384	111.84	114.71	116.09	115.74	105.87	101.57	104.97	107.50	110.93
99385	111.84	114.71	116.09	115.74	105.87	101.57	104.97	107.50	110.93
99391	73.82	76.01	76.92	76.69	71.52	70.09	74.16	76.66	79.66
99392	82.82	85.30	86.34	86.09	79.81	78.51	82.94	85.51	88.65
99393	81.78	84.24	85.27	85.03	79.10	77.80	82.60	85.16	88.32
99394	90.66	93.06	94.21	93.95	86.92	85.30	90.77	93.40	96.41
99395	91.70	94.12	95.27	95.01	87.62	86.01	91.11	93.75	96.75

The 2011 calculated rates for services in the 99381-99385 series were lower than the rates that existed in 2003. The calculated rates for all of the CHCUP services hit a low point in 2008, which is coincidentally the year covered by Plaintiffs' expert's analysis of rates. The 2011 calculated rates for services 99391-99395 were typically about $5 more than they were in 2003. For CPT code 99395, this amounts to an average increase of .7% per year ($96.75-$91.70/$91.70= 5.5%; 5.5%/8=.69%). Further, given the up and down nature of the rates, it is difficult to

predict whether the rates will begin to slide again, as they did between 2006-2008. D.E. 1127-25.

In their rebuttal case, for the first time, Plaintiffs presented evidence of the relationship between Medicaid reimbursement rates for CPT codes 99381-99385 and 99391-99395 and the Medicare calculated reimbursements for the same codes in 2012. St. Petery Demonstrative A. These are the same calculated rates that Plaintiffs referred to as imaginary, during their case in chief. Supposedly, the reason why Plaintiffs' expert did not compare the reimbursement rates for CPT codes 99381-99385 and 99391-99395, in his initial analysis, was that he made a mistake, and was unaware that the information needed to calculate a rate for these CPT codes using the Medicare methodology was posted on federal CMS' website. However, the very document which Dr. Flint purported to use to calculate the Medicare reimbursement rates for the other CPT codes used in his analysis contained the relative value information for CPT codes 99381-99385 and 99391-99395. TT 3048-51; DX 595; 10/13/11 PW 3-6; 10/12/11 PW 133-39; 1/24/12 SF 127.

In his initial analysis here, Dr. Flint compared 2008 Florida Medicaid reimbursement rates for PCPs and specialty care physicians to 2008 Medicare reimbursements for **20 CPT codes**, using the Medicare rates for Miami, Ft. Lauderdale and Rest of Florida. The selection of these **20 codes** was not supported

by data analysis. In contrast, in *Memisovski ex rel. Memisovski v. Maram,* No. 92 C 1982, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004), Dr. Flint relied upon data analysis to support his selection of **22 CPT codes** used when testifying to the adequacy of Illinois' Medicaid rates. In *Memisovski*, data analysis showed that the 22 codes used were those most frequently billed in the Illinois Medicaid program. PX 495, Attachments A1, A2 and A3; 8/3/10 SF 3041, 3043.

The reason Dr. Flint had no data analysis to support his code collection in this case is because he requested it, but Plaintiffs' counsel decided not to provide it. Dr. Flint's request is understandable, because obtaining information about the frequency with which the selected CPT codes are billed (for PCPs and specialty physicians) is the only way of knowing whether, by virtue of the volume of their use, those CPT codes are representative of Medicaid reimbursements. TT 3041-42; 1/9/12 CS 78.

In *Memisovski*, Dr. Flint selected 22 CPT codes to analyze reimbursement rates for just pediatrician services. However, here, he selected a total of 20 CPT codes to analyze reimbursement rates for both specialty and pediatrician services. In *Memisovski*, Dr. Flint included in his analysis the CPT codes for both new and established patients for both preventative care (99381-99384, 99391-99394) and office visits (99201-99203, 99212-99214) , but here, he excluded the CPT codes for new patients for both preventative care and office visits (99381-99384, 99201-

99203). TT 3041, 3043; 10/13/11 PW 16; PX 495, Attachments A1, A2 and A3.

By limiting his analysis to 20 CPT codes for PC and specialty care, from which all new patient codes are excluded, without data analysis to support his code choices, Dr. Flint provides no reliable basis to measure the adequacy of Medicaid reimbursement rates for services provided to children by PCPs or specialty care physicians for any CPT codes not included in his analysis, and his analysis is incomplete. 1/9/12 CS 78; 10/13/11 PW 16.

Dr. Flint presented no evidence regarding the relationship between Florida Medicaid rates and private insurance rates. To fill this gap in proof, in their rebuttal case, Plaintiffs presented members of FPS' leadership, Dr. St. Petery, Dr. Cosgrove and Dr. Schechtman to testify to their reimbursements for certain services from certain of the commercial insurance plans for which they are participating providers. However, from the evidence presented, the Court cannot determine whether the evidence presented reliably (1) represents the relationship between Medicaid and commercial insurance reimbursements in their own practice, for codes not included in their testimony; (2) represents the reimbursements other providers in their area receive for services billed using the same codes for the same commercial insurance plans; or (3) represents the reimbursements for other commercial insurance plans that provide coverage in their geographic area. 12/7/09 LS 83; TT 2588, 2881.

Dr. Cosgrove and Dr. St. Petery provided reimbursement information for fewer than all of the insurance plans in which they participate. Nonetheless, Dr. Cosgrove and Dr. Schechtman's testimony shows instances where commercial insurers pay less than the Medicare rate. 1/31/12 LC2 125, 138, 140; *compare with* St. Petery Demonstrative B; 1/26/12 TS 47-48.

There is simply no reliable proof regarding the relationship between Florida Medicaid reimbursement rates and private insurance rates in Florida as a whole, or in any geographic area.

Dr. Schechtman complained about insufficient reimbursement for vaccine administration for Medicaid children. Providers are reimbursed $8 or $10 for administering vaccines; however, providers participating in the federally funded Vaccines For Children program (discussed in Part VI.C below) receive the vaccine for free. The FMP vaccine administration fee varies depending on whether the vaccine is administered by a nurse or a physician. TT 4441-43; 11/7/11 CA 46-47; 1/26/12 TS 53-54.

Dr. Schechtman also testified on rebuttal to different requirements of the VFC program, which he contends have attendant costs. He did not quantify those costs, and there is no reliable testimony that current administration fees are inadequate to cover costs. If the vaccine administration reimbursement rate was not adequate to cover costs, it is reasonable to expect more widespread complaints

on the issue, rather than from a single witness provider. 1/26/12 TS 55-57.

In addition to the foregoing problems of proof, there is no evidence of Congressional intent that the FMP should be required to increase its reimbursement rates to Medicare or any other metric at this time, and certainly not for all physician provider types (even if the relief is limited to services for children). Rather, Congress's intent as expressed in 2010, is that Medicaid reimbursement rates only be increased to Medicare levels for certain PC services and then only effective January 1, 2013. Congress has not otherwise expressed its intention that providers have an entitlement to any particular reimbursement rate, including either reimbursement rates set at Medicare reimbursement levels or at other reimbursement levels.

Pursuant to Sec. 1202 of the Health Care and Education Affordability Reconciliation Act of 2010 (Reconciliation Act), payment for PC services in 2013 and 2014 by a physician with a specialty designation of family medicine, general internal medicine or pediatric medicine shall essentially be at Medicare rates. Primary care services are defined as evaluation and administration services and immunization administration. For payments made for PC services between January 1, 2013, and December 31, 2014, the amount of money needed to increase the reimbursement rates to the Medicare rate, from where they were as of January 1, 2009, is subject to FMAP of 100%. §1202, Pub. Law 111–152, 124 STAT.

1029 (Mar. 30, 2010).

Congress has not required the states to increase their reimbursement rates for PC services to Medicare rates until January 1, 2013. The enhanced FMAP is not available for rate increases prior to January 1, 2013.

Further, it will be up to federal CMS to determine how this statute should be implemented as it relates to those CPT codes for which there is no published Medicare rate, like the CPT codes 99381-99385 and 99391-99395. Specifically, federal CMS will have to determine whether those CPT codes are subject to the provisions of Section 1202 of the Reconciliation Act.

Moreover, Florida has a case pending in the United States Supreme Court regarding the constitutionality of the various Medicaid provisions of what is referred to as Obama Care, including Section 1202 of the Reconciliation Act. *Fla. v. Dep't of Health and Human Services*, 132 S.Ct. 604 (2011).

As discussed further below, there is no scientifically reliable evidence that the Florida Medicaid reimbursement rates are not adequate to make services available to Medicaid recipients to the extent that they are available to the general population in the same geographic area. Likewise, there is no scientifically reliable proof that there are widespread or systemic issues of untimely care. That being the case, Plaintiffs' claims predicated on inadequate rates must fail.

One last point should be made about DOH and CMS. AHCA is the single

Medicaid state agency, as described above. By both federal regulation and Florida statute, only AHCA may set or change Medicaid reimbursement policy and rates. *See e.g.*, Fla. Stat. §409.908(12)(b) (2011) ("*the agency* shall adopt a fee schedule"); Fla. Stat. §409.908(6) (2011) (EPSDT providers "shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by *the agency*"; 42 C.F.R. §431.10(e)(3). DOH and CMS have no the authority to set Medicaid physician reimbursement policy and rates. In fact, the Legislature has stated that CMS shall reimburse services using the Medicaid reimbursement rate to the maximum extent possible. Fla. Stat. §391.045(1) (2011).

Dr. Northup testified that there were instances where, in order to secure particular provider types for CMS clients, it was necessary for CMS to pay a provider an amount that was more than the established Medicaid reimbursement rate. However, this alone cannot provide a basis for suing Dr. Farmer in his official capacity as the agency head for DOH. In addition to the fact that DOH has no authority to make policy in this area (and therefore causation does not exist), there is no individual Plaintiff who has been harmed in those instances where DOH pays more than the Medicaid reimbursement rate for services. TT 1598, 1606.

B. Newborns, Continuous Eligibility & "Switching"

DCF determines eligibility for most of the Medicaid recipients in Florida. Currently about 90% of Medicaid applications are submitted on-line either from an

individual's home, work, a library, one of DCF's community partners, or a DCF storefront location. If additional information is requested by DCF, it can be faxed, emailed, or brought to a DCF office or one of DCF's community partners. Face to face interviews are rarely required. Over time DCF has made improvements to the online application to make it easier to use. Recently, DCF implemented the "Pick-a-Benefit" option, which allows a person to choose only to apply for Medicaid benefits, if they want. Also, a parent has the option of choosing to apply for Medicaid benefits for their child only, in which event they will be redirected directed to a simple two page application from the FHKC. TT 4604; 11/28/11 NL 138-40, 143-44, 146-47.

DCF's computer system, the FLORIDA system, processes eligibility for applicants. This computer system stores the eligibility information and there are a total of 80 to 100 different eligibility categories. Children normally have a review of their Medicaid coverage conducted annually, although a change in circumstances, such as change in income, could cause this to occur at any time. Changes in family circumstances may result in the need to change coverage categories. TT 4686, 4649; 11/28/11 NL 91-93, 102, 107-10.

Eligibility information is communicated to AHCA's FMMIS (its computer system) by DCF nightly. TT 4760-61; 11/28/11 NL 108.

AHCA is responsible for processing assignments to managed care plans.

DCF has no responsibility for that. The requirements of the plan assignment process are described in Section 409.9122, Fla. Stat. (2011). Individuals normally have 30 days after enrollment within which to choose participation in one of the available managed care plans, either AHCA's own Medipass program, or one of the HMOs operating in that particular county.[38] *Id.* Once DCF sends basic demographic information to AHCA, it is AHCA's responsibility to provide information about plan choices to recipients, and process plan assignments. AHCA stores the information as to an individual's eligibility, plan selection, medical providers, etc. in FMMIS. TT 4651, 4760-62.

Plaintiffs' primary witness on these issues was Dr. Louis St. Petery, both a fact and expert witness who has been employed by FPS since 1981. At trial, the Court withheld ruling on the admissibility of his expert report, marked as Plaintiffs' exhibit 580, pending a ruling on whether Dr. St. Petery was qualified to testify as an expert. TT 83, 211-15, 614-15.

Dr. St. Petery practices in Tallahassee as a pediatric cardiologist, in the same office as his wife, a pediatrician. The geographic area of his practice is Tallahassee east to Perry, west to Panama City, and south to the Gulf of Mexico. Dr. St. Petery has been a previous board member of the FHKC, a current board

[38] In addition to the five Medicaid Reform counties, HMOs and capitated PSNs also operate in about 34 "non-reform counties." Thus, Medicaid HMOs and capitated PSNs are not yet an available managed care option in 28 Florida counties. 10/18/11 MW 46-50.

member for the Kid Care Coordinating Council, the Executive Director of TPF, and member of the CMS Network Advisory Council. TT 81, 86-88, 90.

Plaintiffs withdrew certain of Dr. St. Petery's opinions in his expert report. Nevertheless, he is not qualified to render opinion testimony as an expert on the other matters covered in his expert report (and testimony), for the reasons argued in Defendants' motion in limine, D.E. 696, and because his opinions are not sufficiently reliable. Dr. St. Petery is an advocate for children's health care issues. As the court observed during trial, many of Dr. St. Petery's opinions went well beyond his area of expertise, and were not confined to his area of practice, his group, the patients monitored by his group, or his geographical area. Dr. St. Petery must be restricted to lay opinions related to his personal experience in Tallahassee, and his geographical area and his practice. See TT 211. Any other "lay opinion" testimony must be excluded. TT 201-02, 204, 207-09.

1. Presumptive Eligibility for Newborns

FMP policy provides that when a pregnant woman is receiving Medicaid benefits, her unborn child is presumptively eligible to be a Medicaid recipient as of the moment of birth, if the woman or someone else notifies DCF of her pregnancy (either through the application process or later). Thus, coverage for these unborn children is not automatic – someone must notify DCF of the pregnancy. Additionally, someone must inform DCF when the baby is born. DCF and AHCA

work together to encourage mothers to register their unborn children for Medicaid, and require HMOs, PSNs and providers to notify them of pregnancies so that the coverage process can be initiated. These efforts with providers by DCF and AHCA have improved the chances that they will be put on notice of the birth. AHCA has sanctioned a number of health plans from 2004 to 2009 for failure to utilize the unborn activation process on each pregnant enrolled member. 10/18/11 MW 32-34; 11/8/11 MW 111; 1/6/12 CS 36-37; TT 4649-50.

Despite registration of the unborn child, the benefits must be activated at birth. As Dr. St. Petery noted during his testimony, once the child is born, "[t]he mom is supposed to notify her DCF caseworker and let them know of the child's birth." However, the HMO or the PCP can also notify DCF of the birth. TT 602-03, 2584-85; 10/18/2011 MW 31-34.

Despite the mother's obligation to register her unborn child, and to notify DCF of the birth, Dr. St. Petery advocated a court enforced procedure whereby the mother has to do nothing, and, DCF would both automatically complete the registration process for the mother, and somehow also keep track of whether and when the baby is born, in order to activate the benefits for the mother. TT 610-11.

Plaintiffs put on some provider testimony regarding "delayed activation" of Medicaid benefits even though notification of the birth was provided. Plaintiffs

did not, however, put on evidence as to how often this occurred,[39] and how many children were affected. They have not presented a named Plaintiff who had an issue in delay in activation of their Medicaid. The Court has not been provided with the kind of widespread, systemic evidence needed to determine that classwide liability is appropriate. TT 2585-86,3891-92.

Nonetheless, if there is a delay in activation and if DCF is notified, eligibility can be made retroactive, and medical bills for the prior three months can be covered. Also, in the situation where AHCA sanctioned a number of health plans from 2004 to 2009 for failure to utilize the unborn activation process, the children were still able to get their needed medical services. 11/28/11 NL 135-36; 11/8/11 MW 112.

Before July 2008, DCF created separate "cases" or files for the pregnant woman and her unborn child. After being born, the child would have his Medicaid activated under the separate case. However, DCF realized that having the child outside the mother's case had the potential of resulting in multiple personal identification numbers to be assigned to a single child, which caused file errors to occur when that information was sent to AHCA, and medical services potentially

[39] Dr. St. Petery's original report contained statements of frequency, but when he testified at trial about the issue of activation of newborns, he did not testify about frequency. Based on the parties' agreement that expert reports are only admitted to the extent that the witness was examined on an issue, Dr. St. Petery's statements about frequency in his expert report do not come into evidence. 1/31/12 JM 71-75.

not being provided as a result. After July 2008, in an effort to correct that problem, DCF incorporated the unborn child into the mother's case, rather than giving the child his own separate case. TT 4786-87; 10/5/11 SP 39-41; DX 174.

DCF employees in Tallahassee monitor cases on a monthly basis in an attempt to further minimize situations where separate cases are established. If any errors are found, communications are made to DCF local offices to remedy what occurred in that particular case, and to re-train staff on the proper procedures. At the local DCF level, case workers are responsible for entering the information in the FLORIDA system, which creates the unborn child's registration for Medicaid. Additionally, AHCA instituted a training session with DCF staff, agency staff, and required members from each managed care plan to attend. The importance of the unborn activation process was addressed, and the process was explained. Feedback was given about additional ways to improve the process. TT 4787; 10/18/11 MW 40-41; 10/5/11 SP 44-45.

2. Continuous Eligibility

In Florida, the policy regarding continuous eligibility is that children under the age of five, once determined eligible, receive 12 months of continued or protected coverage so that changes in household circumstances such as income or household composition would not affect the child's eligibility during that period of time. Fla. Stat. § 409.904(6)(2011). For newborns, it ends up being 13 months of

continuous eligibility because it is 12 months from the birth month. For children 5 through 18, the continuous period of time is reduced to 6 months. Fla. Stat. §409.904(6)(2011). During the continuous eligibility period, eligibility is only affected by the death of the child, or the child moving out of state. However, if the child becomes eligible for private insurance, Medicaid would become the secondary payor (although for EPSDT services, the FMP must pay for the services, if a claim is filed, and then seek reimbursement from the third party payor). TT 4654, 4763; 1/6/12 CS 9; 42 U.S.C. §1306a(a)(25).

After the period of continuous eligibility ends, the child Medicaid eligibility must be redetermined, and eligibility may affected by such things as family assets or income, resulting in an appropriate termination of eligibility. If additional information is needed to redetermine eligibility, a notice is sent to the family regarding the information needed. If AHCA requests required information at the end of the eligibility period that is not supplied, termination can be appropriate, with the child reinstated only after the information is supplied. A new eligibility determination of Medicaid coverage would trigger a new period of eligibility. TT 4661; 1/6/12 CS 8; 10/1/08 FL 20.

No evidence was presented at trial to show that any of the named Plaintiffs did not receive their continuous eligibility. However, despite the continuous eligibility policy, evidence presented through several witnesses by Plaintiffs

showed that some children had an interruption to eligibility prior to the end date of their continuous eligibility. Nathan Lewis, a bureau chief for the DCF ACCESS program, acknowledged that this has happened in the past. 11/28/11 NL 94-95, 104, 110-11; TT 2586-87, 2804, 3915-16, 4658; DX 460.

Around the time of his deposition in 2008, Mr. Lewis discovered that certain communications from the FLORIDA system to the FMMIS system might be misconstrued by FMMIS as breaks or gaps in Medicaid eligibility even though the DCF computer system did not have information reflecting breaks or gaps. For example, if a change in household circumstances resulted in a change in Medicaid coverage categories, if the closing of one coverage category and the opening of another was not communicated at the same time, there was the possibility that FMMIS might construe the closing of a coverage category as a termination of eligibility (as opposed to the first step in a change to a new coverage category), and when the report came that the new coverage category was opened, FMMIS might construe this as a new eligibility determination. This would be so even if one coverage category ended on the last day of the month, and the new coverage category began the very next day. 11/28/11 NL 94-95, 104, 110-11; TT 2586-87, 2804, 3915-16, 4658; DX 460.

To address these circumstances, DCF issued a procedure memorandum with instructions that were designed to minimize the possibility of FMMIS

misconstruing eligibility actions by DCF as breaks in eligibility. For newborns, DCF determined that they should be maintained in their presumptively newborn coverage category until they were 13 months old.[40] By doing this, there would be no need to change any coverage categories in the first 13 months of life. For older children, so there could be no mistake on the part of FMMIS, DCF procedure was that notifications that one coverage category was ending should wherever possible be accompanied by notification of the new coverage category. One additional procedure was also implemented regarding social security numbers. DX 178; TT 4648; 11/28/11 NL 111-12.

Although not an issue identified by Dr. St. Petery, Mr. Lewis found that missing social security numbers (SSN) in an update to FMMIS, may cause the update not to be accepted. To ensure that this is not a problem, AHCA has reminded staff to conduct timely follow up and get SSNs for each Medicaid enrollee. DCF also monitors compliance with this requirement. 11/28/11 NL 117-18, 127-128; 10/5/11 SP 52, 54; *see* DX 178; TT 4712-13.

DCF is actively working to improve its processes to ensure continuous eligibility. Training for all staff reminds workers of the policies that provide for 6, 12, or 13 months of continuous coverage, depending on the age of the child. DCF also has a quality management team that samples cases across all of its programs to

[40] This coverage category cannot be used past the first thirteen months of life. So a change in coverage category is required at that point. TT 4763-64.

analyze the extent to which there are denials of continuous eligibility for newborns. This team conducted a review of over 1,400 randomly sampled cases to look for any erroneous breaks in coverage for newborns. The result was published in a federal fiscal year 2010 report. Errors were found in less than 7% of the cases, and some of the "errors" were not the fault of DCF. These percentages show that there is not a widespread or systemwide problem with continuous eligibility. TT 4659, 4779-80; PX 580 at p. 5; DX 169A at p. 1-2.

In addition to full quality management team review, DCF has organized several groups of people who go out and actually look for children who don't appear to have received the appropriate amount of continuous service. If any such cases are found, communication is made with the local DCF office for education and resolution. Also, DCF organizes regular telephone calls between staff in Tallahassee and the local offices to discuss continuous eligibility issues, and discuss any necessary corrective measures. Furthermore, DCF does operational management reviews at all DCF sites annually, and the monitors check whether the recipient was given continuous Medicaid coverage for the appropriate time period. TT 4780-81; 10/27/11 JF 39-50.

Although, Mr. Lewis is unhappy if even one child's case is decided incorrectly, it is unreasonable to expect any system that involves humans to be perfect. Nonetheless, in addition to the steps taken above, DCF also reinforces the

procedures in discussions with staff to ensure compliance, and Mr. Lewis' staff has regularly looked at the issue of continuous eligibility for newborns. 11/28/11 NL 118, 124; 11/29/11 NL 42-43.

In July 2010, DCF did another review to determine the extent to which babies had their 13 months of continuous coverage interrupted. This reflected an improvement. In that review, when DCF examined 147,000 infants, it found that only 900 (or 0.6%) had lost their eligibility prior to the end of the 13th month. That review covered the prior year, thus demonstrating that DCF's corrective measures were beginning to have a significant effect on the number of infants particularly whose eligibility was interrupted and providing rebuttal to Dr. St. Petery's statements in his report that eligibility is inappropriately terminated "frequently" and "often." 11/28/11 NL 125; PX 580 at p. 5; TT 4772.

At times, older children must be moved from one coverage category for which they are no longer eligible to another. Sometimes, DCF can make this move without the need for additional information from the family. However, after the change, the recipient is likely to get notice that a change has been made. At other times, DCF may believe that the family of an older child has had a change in income. Even if the information supports that, before taking action DCF evaluates whether the child has received his full continuous coverage. If not, the change in income cannot affect the child's eligibility. In that situation, DCF will keep the

child in his coverage category but move other family members into whatever categories are appropriate for their income change. TT 608, 4764-65, 4768-70.

Once a child is outside of the applicable continuous coverage period, DCF may have to close the child's Medicaid case if necessary income information is not received from the family. Even so, DCF will send the child's information to the FHKC where an application for other, non-Medicaid coverage is created, so that the child has the opportunity for continuous medical coverage. TT 4770-71.

Although DCF does not have a computer system that is completely automated for the 6 or 12 month continuous eligibility periods, DCF has developed systems technology that helps. Changes have recently been made to DCF's computer screens so that workers are reminded that closure of one benefits category may mean that the Medicaid benefits should remain open. TT 4748-49.

Dr. St. Petery testified from Defendant George Sheldon's (the predecessor to Defendant Wilkins) answers to interrogatories, Plaintiffs' Exhibit 737, to the raw numbers of children under the age of five whose Medicaid was terminated in less than a year, between FFY 2003 and FFY 2007. From Plaintiffs' Exhibit 737 it is impossible to determine the actual number of "improper" terminations that may occur, because the document includes all terminations for whatever reason as that

is what was requested.[41] Nonetheless, even considering this caveat, the terminations themselves amounted to no more than 3.5% to 5% of all children under the age of five on Medicaid during each federal fiscal year. TT 1503; PX 737, pg. 10.

Outside of Plaintiffs' Exhibit 737, it is impossible to say that all terminations of Medicaid for children are improper. Proper terminations occur because of failure to supply required information, a finding of ineligibility during the redetermination period, and relocation of the recipient outside of Florida. Particularly for children over the age of 1, one cannot simply look at the numbers of children who have a break in eligibility and determine which are improperly terminated. Further analysis is required. PX 580 at p. 5; 1/18/12 CS 43.

Similarly, it cannot be assumed that every interruption in eligibility caused an interruption in medical services, because this assumes that medical services were needed during the brief period that eligibility was interrupted. Accordingly, Dr. St. Petery does not provide any factual support for the conclusion in his report that as a result of a lack of continuous eligibility "many children [are] experiencing significant delays in receiving needed care," and that "often checkups, immunizations and sick visits are missed entirely." Ms. Sreckovich rebutted this when she testified that by looking at the children who suffered a temporary break

[41] Children under 5 may be terminated from Medicaid if they move out of state or pass away. TT 4783.

in eligibility, one would not know whether there was any problem with continuity of care during that break, because you wouldn't be able to tell whether the child needed medical services during that time. 1/18/12 CS 43-44; PX 580 at 5.

Loss of eligibility for medical coverage is not unique to Medicaid. Patients with private insurance lose their coverage. Because of this situation, providers have their offices check coverage eligibility for all patients before they come in for their appointment, regardless of whether it is Medicaid or commercial insurance. TT 2576; 1/19/12 NS 170, 173-174.

Interruptions in coverage don't necessarily mean interruptions in services or payment. For example, Dr. St. Petery testified that Dr. Julia St. Petery was able to treat K.P. during an instance of eligibility interruption and receive payment from general revenue "safety net funds," made available for K.P. until his eligibility was restored. Also, as noted above, retroactive eligibility may also allow payment for services provided during the period (providing the child was otherwise eligible). TT 651-52.

During their rebuttal case, Plaintiffs presented testimony from a few providers that loss of eligibility continues in their practice. However, this anecdotal testimony is not reliable to determine whether there are widespread or systemwide problems with continuous eligibility. These witnesses did not (and lacked the foundation to) address the frequency and circumstances of interruptions

in Medicaid either in their geographic area or on a state-wide basis. Additionally, it was from witnesses with a strong bias toward the Plaintiffs' position. For example, Dr. Silva, a pediatrician from Hillsborough County, is a board member of FPS and has made financial contributions to support the FPS' efforts in this lawsuit. Despite testifying that loss of continuous eligibility occurs in her practice for children under one year old, she has not reported this to AHCA, or asked anyone in her office to do so. 1/19/12 NS 150, 165-166, 174.

Significant to the issue of whether DCF is deliberately indifferent to the problems with continuous eligibility, Ms. Sreckovich thought it was notable that DCF is monitoring cases to become aware of situations where termination might occur to reinstate the child or deal with systems issues before the impact of a termination actually affects a child's eligibility status. She also noted the continuous training of workers, the willingness to address these issues as soon as they occur, the policy reinforcement, and the quality control projects, all of which was, in her opinion, designed to reduce the number of incorrect terminations. 1/18/12 CS 44-46, 49.

3. Switching

As defined by Dr. St. Petery, a phenomenon of "switching" occurs when without the parents' knowledge or consent, and without the provider's office's knowledge, a child has been "switched" to a different Medicaid plan, frequently a

plan for which that doctor is not a provider. The switch is commonly from Medipass to an HMO; however, the child can also be switched to a different provider within the same plan. TT 548, 550.

According to Dr. St. Petery, the triggering mechanism for switching is a temporary loss of Medicaid eligibility, regardless whether that loss is appropriate or inappropriate. The information regarding loss of eligibility is sent by DCF to AHCA. Upon reinstatement by DCF, and the communication of that reinstatement by DCF to AHCA, the parents get a letter from AHCA regarding plan assignment, but do not respond to it. As a result of the failure to respond, the child is assigned to a plan, or a provider, that is different than what the child had before the loss of eligibility. The parents' failure to respond causes AHCA to automatically assign the child to a plan or a provider that could be different. TT 565-66, 641-46.

As with loss of continuous eligibility, at trial DCF acknowledged that switching has occurred. In fact, it has done some investigation into the reasons behind it, in an effort to minimize the chances that anything it does may trigger the process. TT 4645.

Since the "triggering mechanism" for the switching phenomenon is a loss of eligibility, as indicated above, there are ways in which the family can be the cause of the loss of eligibility. At trial, Dr. Rex Northup testified that after switching events were explained to him, he concluded that there were situations where the

families were clearly at fault for the switch, such as where the family did not follow through on their paperwork for plan selection, or where there was a misunderstanding by the family. As also indicated above, although AHCA sends out notification regarding the plan assignment, if the recipient loses, misplaces, or fails to respond to the notification, they would be unaware of the request for a plan selection, and thus be unaware of the subsequent automatic assignment of a plan or provider. Also if a recipient moves and doesn't update his or her address, the plan assignment notification won't be received, as was the case with S.B., described above. TT 4875-76.

Furthermore, there was substantial evidence produced at trial to demonstrate the many approaches by DCF and AHCA to reduce the instances of an interruption of continuous eligibility. Since switching starts with a loss of eligibility, these approaches would be expected to have a similar remedial effect on switching.

Although Dr. St. Petery stated that AHCA "frequently" switches children, his conclusion as to frequency was not supported by any studies or factual data. Instead, it was supported by hearsay statements received as a result of his experience in Tallahassee with TPF, discussions with his wife, and with others. When Dr. St. Petery said switching occurred frequently, he meant "often," but he admitted that it is difficult to know the exact number of cases that are switched, and he can't be more specific as to how often it occurs other than his use of the

words "frequently" and "often." TT 561-62, 786-88; PX 580 at 5.

Ms. Sreckovich explained that Dr. St. Petery relies primarily on anecdotal information for his conclusions regarding switching, and that Dr. St. Petery does not include information on the circumstances of the switching, the reasons for it, or whether it is a state-wide problem. Neither do Plaintiffs' other provider witnesses provide the type of reliable evidence needed to support a finding of widespread or system-wide problems with switching. 1/6/12 CS 10.

Other than Dr. St. Petery, Plaintiffs presented testimony from a number of pediatric providers who described the frequency of switching in their practice as a result of inadmissible hearsay statements. Even with the use of the hearsay foundation, the testimony from Plaintiffs' providers as to frequency was inconsistent. Dr. Lisa Cosgrove, who practices in Brevard County, testified that it occurs on a daily basis; however, Dr. Jerome Isaac, who practices in Sarasota, testified that it happens from time to time, is not an everyday occurrence, and that he has about two patients affected every month, and Robert Sharpe, a former deputy secretary of AHCA called by Plaintiffs, testified that he received a low number of complaints about switching when he was Medicaid director. *See e.g.*, TT 2552, 2577, 2579, 2797, 3853, 3893-94, 3914, 4985.

Defendants have not studied how often it occurred. However, an AHCA area office manager testified that it was not a frequent occurrence in Broward

County, and that it occurred a small number of times. TT 4645; 5/31/11 RC 76-77.

The steps described above to minimize the likelihood of FMMIS misunderstanding updates and transmissions from the FLORIDA system are also intended to help prevent unnecessary plan changes by AHCA. TT 4645-46.

If a child's Medicaid plan is switched, the policy is that they may be reassigned back to the original plan (and provider) without any need to explain why, so long as they request the change within 90 days. A notification letter of the plan assignment is sent to the parent, so that (assuming they keep their address current and open their mail) they will know they have 90 days to change back to the original plan. Fla. Stat. 409.9122(2)(i) (2011); 10/18/11 MW 39.

Sometimes the prior provider, to whom the recipient presented for care, will assist the recipient in contacting the plan representative. However, even after the 90 day period for no-cause changes ends, a beneficiary may request to change back to his original provider if good cause is shown. Fla. Stat. 409.9122(2)(i)(2011); TT 2625-26.

It is also important to note in the context of auto-assignment of children to a plan (triggered because no selection has been made), AHCA will try to reenroll the child in the same MCO and PCP to whom they had originally been assigned. Matching returning children once they are back on the Medicaid roles with their former MediPass provider is AHCA policy. Fla. Stat. 409.9122(2)(f)2 (2011).

That having been said, it is possible that a child will be prohibited from being reassigned to their original provider without AHCA being at fault. There are instances where MediPass providers have since reached their maximum capacity of patients (discussed further below) or are restricted providers. A restricted provider is a provider who, by contract, must agree before a particular child is assigned to his panel. If either circumstance is present, AHCA would not auto-assign a child back to that MediPass provider. While Dr. St. Petery testified that TPF would take children back under these circumstances, without prior approval, there is no record that TPF's position is representative of all restricted MediPass providers. 2/2/12 LS 133-34; 10/24/11 MW 46; 11/14/11 MW 30; 12/7/11 CS 38-39, 44.

It has been asserted that switching poses a problem with respect to the continuity of care of a child. However, it is not always true that switching results in continuity of care issues such as denial of access. Children can seek care from the county health departments (CHDs) without prior authorization for well-child visits even if they have been switched. The CHDs can also provide immunizations to such children. Further, even when a child is switched, or if the child is actively trying to become enrolled in a new program or be transferred to a different provider, the HMO or PCP to which they have now been assigned has a duty to provide access to care to the child. DX 474; 11/7/11 CA 23-24; 12/7/11 CS 46-47; 12/13/11 CS 107; TT 2799.

Additionally, the issue of switching and the problems presented in the continuity of care context are not unique to Medicaid eligible children. Even individuals with private insurance or employer sponsored health insurance may, at times, be enrolled or assigned with a particular PCP and will subsequently be dropped from the MCO or reassigned to another PCP without their knowledge. Sometimes this results because, for example, their employer changes insurance plans, but other times it happens with no apparent reason. 12/7/11 CS 47-48.

4. Additional Efforts To Minimize Administrative Errors

To ensure that administrative errors are minimized, DCF conducts a variety of reviews at least annually at all DCF storefronts, processing centers, customer service centers, case maintenance units, and customer call centers. These reviews include an examination of recipient files, surveys of recipients who are present at the sites or who can be reached by telephone, interviews of local advocacy groups that work closely with, or on behalf of, Medicaid recipients, and interviews of staff. If any mistakes are found, DCF initiates plans of correction, and provides additional employee training. 10/27/11 JF 34-39, 43-48, 53-56.

At the same time, DCF annually conducts Medicaid quality control reviews, and generates written reports from this that are sent to federal CMS. In particular, as indicated above, Defense exhibit 169A, included a review of continuous eligibility for newborns. In 2011, DCF began reviewing its performance on

presumptive eligibility. 10/27/11 JF 62-63, 72.

C. Provision/Utilization/Timeliness of Primary Care (e.g., EPSDT)

The FMP covers comprehensive CHCUPs for eligible children from birth through age 20, per the agency-approved periodicity schedule. This includes appropriate immunizations, and laboratory testing, including blood lead screening. DX 263 at 2-1, 2-2, 2-13.

The FMP also covers an array of physician services provided by PCPs for kids. Plaintiffs have not presented any proof that the coverage provided by the FMP for PC is inconsistent with any requirement of 42 U.S.C. §1396a. Rather, they claim isolated instances of difficulty obtaining PC, most often attributed to switching or a lapse in eligibility (See VI.B for their proof problems on this). Plaintiffs presented witnesses to testify that, on occasion, CMS providers close their practices to CMS patients. Plaintiffs also present anecdotes from a couple of physicians about problems with PC; however, they do not present reliable evidence of widespread or systematic problems in obtaining PC for Medicaid children sufficient to support a determination of class-wide liability. DX 266 and PX 781.

Regarding immunizations, Florida participates in the federally funded VFC Program, which provides vaccines at no charge to providers, who provide them free to certain eligible children, i.e. under 18 years old and enrolled in Medicaid, uninsured or American Indians or Alaskan Natives. All vaccinations

recommended by the AAP are covered by the VFC program. Several of Plaintiffs' provider witnesses participate in the program, such as Drs. Cosgrove, Isaac and Schechtman. DX 225; TT 2609, 2634, 3922, 4477-78; 11/7/11 CA 16.

The FMP provides PC services to most Medicaid children either through MCOs, such as HMOs and provider service networks (PSNs), its MediPass program (a PCMS program), or on a fee-for-service basis. The most recent data available in the record shows that 459,092 children are assigned to the MediPass program, 226,268 are in Medicaid fee for service (FFS), and the remainder, 964,625, are assigned to an HMO, PSN or a minority physician network (MPN). The children on fee-for-service include those in the process of being assigned to a managed care plan ("MCP") (because recipients have 30 days after enrollment to choose a managed care plan), as well as any children in an institution (such as the state wide inpatient psychiatric program), those enrolled in Medicaid in the medically needy program (as was the case for K.K. for a period of time), or if they are dually eligible for Medicaid and Medicare. DX 262a; Fla. Stat. §409.9122(2) (2011).

An MPN is a network of PCPs experienced with managing Medicaid or Medicare recipients, and predominantly owned by minorities. It functions like a MediPass provider. A PSN is much like a HMO, except that licensure is not required. A PSN must comply with the same requirements as an HMO, including

the requirement that it establish an adequate provider network (including adequate numbers of PCPs for the population it is approved to serve). A PSN may be reimbursed either on an FFS basis (with a $2 per member per month (PMPM) case management fee), or on a capitated basis (meaning the PSN is paid a PMPM amount for serving Medicaid enrollees assigned to their care, and assume the risk for providing all contractually required medically necessary services to the enrollees). 10/18/11 MW 8-9; 10/19/11 MW 95-98; DX 262a.

MediPass providers (including MPNs) are responsible for providing PCMS for assigned Medicaid children. Fla. Stat. §409.901(23) (2011). They receive a $2 PMPM payment to coordinate patient care, including specialty referrals. MediPass providers must also provide CHCUPs, as well as other PC. MediPass providers are credentialed periodically by AHCA. TPF and Drs. Schechtman and Cosgrove are MediPass providers. As such, they are responsible for helping patients access needed care. DX 321; 47, 60-66; 10/18/11 MW 8; D.E. 692 pg 33-35, ¶ 106; TT 4114, 4141; DX 71; DX 71c; DX 20; DX 21c; 1/26/12 TS 62-63, 1/31/12 LC2 160.

HMOs and PSNs also provide PC services to members. They must offer enrollees a choice of PCPs; but, if an enrollee does not choose one, the health plan must assign one. Even after being assigned to a PCP, the enrollee may change to another participating PCP at any time. HMOs and PSNs must provide a list of

available PCPs to the Medicaid enrollee. A plan also has to provide the enrollee with written information about the importance of scheduling and keeping PC appointments. DX 474 at 26648; DX 309C at 27-28; 10/18/11 MW 27-30.

The PCPs who participate in the MediPass program, HMOs and PSNs are responsible for providing enrollees with a medical home. A medical home is also the purpose of the Florida Medicaid CHCUP Program. TT 518-19; 1/18/12 CS 52; 12/7/11 CS 11-12; DX 263 at 1-1.

CSHCN may also receive PC services as part of the CMS Provider Network. CMS is a principle provider for CSHCN, who represent about 3% of all Medicaid enrolled children. Each enrolled child has a nurse care coordinator, who is available to help schedule medical appointments, including specialty appointments, and access care and community services. CMS provides each child with a PC medical home. DX 320; D.E. 692, pg. 11, ¶ 18, 22l; PX 320 at 2.

A "medical home" means that there is a single entity or group of providers who are responsible for the individual's care coordination. The provider and care coordinator work together to identify necessary services, and then follow up to make sure that the care is delivered, appropriate and of high quality. 12/7/11 CS 11-12.

AHCA has set contractual standards for HMOs, PSNs and MediPass providers relating to timeliness of care: urgent care within a day, routine sick care

within a week, and well care scheduled within one month. Absent waiver, HMOs and PSNs must ensure PC is available within 30 minutes average travel time of the enrollees' residence. DX 321, pp. 20225-6; DX 474, pg. 26703.

The approved FMSP reflects that the FMP is organized into 11 area offices, which consist of groupings of counties based on data showing natural trade areas for economic and medical services. The plan further provides that, "Each geographical area…has at least a 50% participation rate by its obstetricians, obstetrician-gynecologists, family practitioners, and pediatric practitioners." PX 712, Attachment 4.19-B, Page 7a.

Plaintiffs' exhibit 221 shows that as of November 2000 the FMP had pediatrician access which was higher than the highest estimate of need (which was 212.03, and the FMP had 328.57 full time equivalent physicians). Access to pediatricians exceeded the highest estimate of need in all 11 area offices. For the two year period covered by the 2009 Florida Physician Workforce Annual Report, about 75% of the pediatricians responding to the survey indicated they were accepting new Medicaid patients. PX 221, pg. Fl-Med 1081, 1126; DX 501, pg. 68.

There are no pediatricians in 10 of Florida's 67 counties. Four counties in Northwest Florida have 2 or fewer physicians of all types. Sixteen Florida counties have been designated as full PC health practitioner shortage areas by

HRSA. Four other counties have been designated as partial PC health practitioner shortage areas, including Escambia County. DX 289, pp. 19166-89-19166-90; DX 290c; DX 437.

Dr. Rex Northup, is an FPS member, part time CMS Medical Director for the Northwest Region, and a full-time pediatric intensivist in Pensacola. Although he admitted that there is a shortage of pediatricians in Florida's Northwest Region that affects kids regardless of payment source, he testified in generalities that it was more difficult for Medicaid children to obtain PC than privately ensured children. He stated that the further one travels from Pensacola, the more difficult it becomes to locate PC for Medicaid children; however, he also testified that it is generally easier to obtain PC in Panama City, Florida and Ft. Walton Beach, Florida. TT 1649-50, 1673-74, 1678, 1703.

Dr. Northup's part-time CMS duties, include oversight for a ten county area including Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Jackson, Bay, Calhoun and Gulf Counties. Large portions of the Region are rural. Calhoun, Washington and Holmes Counties have no pediatricians. Gulf County has only one, and Northup acknowledges that other counties in his region have extremely low numbers. For children in those areas, their choices are to see family practice physicians, or to travel for general pediatrician care. However, in Calhoun County, for example, there are 2 family medicine physicians to serve its 14,625

residents, meaning that the family physicians have an average patient load of 7,300 patients per physician. Washington County is itself designated as a PC shortage area, as are portions of Escambia County. PX437; PX 320, pg. 10; *compare* DX 290C, pg. 19281, and D.E. 1127-26, pg. 8; TT 1650, 1696, 1703.

Dr. Northup also testified that "at times," CMS children had "considerable travel distances, considerable time delays, that type of thing," but acknowledged that the majority of the time they were seen by a PCP within 30 days of enrollment. TT 1723.

Dr. Northup testified that he received complaints about "problems getting appointments" with primary and specialty providers combined for CMS children in his region at a rate of about 4 children per week, or about 208 complaints a year total (52 multiplied by 4). His region has 4,200 CMS children. Assuming that each of the complaints related to a unique child, (maybe not a valid assumption) that still would mean that only 5% of his region's CMS children had problems accessing any physician care, and there were no complaints relating to 95%. TT 1720, 1722.

CMS children in Pensacola receive care at the Sacred Heart Florida State University Clinic or from private pediatricians. Children from Santa Rosa County may also receive their care from the Sacred Heart clinic. In 2010, Northup testified that "some" children previously served by Staywell, a Medicaid HMO

which withdrew from Escambia County, Florida, could not be seen at the Sacred Heart Clinic, because it had reached its cap (the 1,500 patient MediPass limit described above); however, Sacred Heart was "taking the majority of the kids" and working to try to get the remaining kids in the clinic. TT 1723-26, 4834.

To ensure that children across the northern most portion of Northup's region have access to PC, CMS has enrolled pediatricians nearby in Alabama. Additionally, there are two FQHCs to provide care to Medicaid children, in DeFuniak Springs, Florida and Crestview, Florida. CHDs are available to provide PC to children, although some of the CHDs may not see very young children. There are also RHCs that provide services to CMS clients in Northwest Florida. TT 1733-34, 1736-38, 1744-45.

Notwithstanding Dr. Northup's testimony that privately insured children had better access to PC, he couldn't think of any pediatricians or family practice providers who refused to see Medicaid children. Rather, he was only aware of a "significant number who limit their numbers of patients significantly." TT 1650-51.

Dr. Northup cannot reliably testify about the access to PC enjoyed by all or even a majority of the Medicaid children in the Northwest Region. His experience as a hospital-based critical care physician does not provide him with an adequate foundation on which to testify about access for anything other than the relatively

small subset of general Medicaid children he may see at Sacred Heart. When Northup testified in the Fall of 2010, there were approximately 54,636 children enrolled in the AHCA Area 1 office alone. AHCA Area 1 is smaller than the area covered by the CMS Northwest Region office of which Northup is the medical director. AHCA Area 1 consists only of Escambia, Santa Rosa, Okaloosa and Walton Counties. The remaining six counties that are part of the CMS Northwest Region are in Area 2 of AHCA, so the actual number of Medicaid children in the Northwest Region is much larger. The 4,500 CMS children served by Northup's region amount to only a small percentage of all Medicaid children in the ten county area covered by the Northwest Region of CMS. Plaintiffs have presented no scientifically reliable proof of the availability of Medicaid PC services in Northup's region, whether for CMS or general Medicaid, and no reliable proof that the problems with PC with which Northup is familiar are widespread or system-wide even in his Region. DX 262; *compare* DX 215 *with* PX 320 at 10.

Dr. Mary Seay, another part-time CMS Medical Director for the Big Bend Region (Leon, Gadsden, Wakulla, Franklin, Jefferson, Taylor, Madison, and Liberty Counties), who also holds a couple of other part-time jobs, testified that occasionally her region has had problems locating PC. She stated the further one gets outside of Leon, the more difficult it is to provide PC close to home,

particularly in areas located more than an hour's drive from a metropolitan area. 11/14/08 MS 85-86.

Of the counties in the Big Bend Region, all but two (Leon and Taylor) have been designated as PC health practitioner shortage areas by HRSA. As of 2009, Gadsden, Jefferson, Madison and Liberty had no pediatricians. Wakulla and Franklin each had one, and the Franklin pediatrician participates in CMS. Taylor has two pediatricians. 11/14/08 MS 88; DX 437; DX 289 at 19166-89-90.

Data from 2007-2008, shows that outside of Leon, Gadsden (located to the west of Leon County, Florida) faired the best of the above-named counties as it relates to family medicine physicians, having 19. Liberty had one, while Jefferson had two. Franklin and Wakulla had four each, while Madison and Taylor had six. Moreover, several counties have large general population to physician ratios, with Liberty having 8,365:1, Jefferson having 7,380:1, and Wakulla having 6,155:1. DX 290c; D.E. 1127-26.

Dr. Seay testified that although Franklin is the furthest away from Leon (a two hour drive), some parents from Franklin prefer to come to Tallahassee for their PC. As noted above, there are few providers of PC in Franklin. 11/14/08 MS 86-88.

Dr. Seay also testified she recalled that her area had reported difficulties recruiting PC providers in outlying areas, and that, in her Region, "some" private

PC practices were closed to new CMS patients. Seay's testimony does not establish the extent to which CMS children experience difficulty in obtaining PC, or that there exists a widespread problem in availability of PC services for CMS children in the Big Bend Region. Further, her testimony does not establish that the availability of PC services for CMS children in the Big Bend Region differs from the availability of PC for the privately insured. She acknowledged that "[w]e've been very fortunate in this area, specifically the Leon County area, that we have had cooperative primary care physicians." 11/14/08 MS 86, 113.

Dr. Chiu is a part-time CMS Medical Director for the North Central Region (consisting of 23 counties, including Duval, Nassau, Baker, Clay, Columbia, Union, Bradford, Hamilton, Suwannee, Lafayette, Dixie, Levy, Gilchrist, Alachua, Levy, Citrus, Hernando, Sumter, Marion, Lake, Volusia, Putnam, Flagler and St. Johns Counties), chairman of pediatrics for UF's Department of Pediatrics in Jacksonville, and a FPS member. He testified that his region has enough general pediatricians to meet their PC needs. PX 320 at 10; 11/25/08 TC 10, 11, 66.

Dr. Bucciarelli is a part time assistant medical director in the CMS North Central region (Gainesville/Ocala), chair of the Department of Pediatrics at UF, and a member of FPS. He testified that there is a CMS Clinic for PC in Ocala to address the fact that pediatricians there don't participate in CMS. He said some

parents will drive from Ocala to Gainesville for PC, but he did not know why they did so. 11/05/08 RB 86-88.

Dr. Curran is employed by USF as a professor of pediatrics, associate V.P. for faculty and academic affairs, and a senior executive associate dean for the College of Medicine. He is also a member of the AAP, and a part time CMS Medical Director for the Tampa Bay area (Hillsborough, Pasco, Pinellas, Polk, Highlands, and Hardee counties). While he identified low reimbursement as a reason why PC physicians stated they would not participate in CMS, he testified that in his region they work hard to enroll children with PC within their network. They do use FQHCs as medical homes, but he did not have any quantifiable data about the extent to which PC providers were available (and willing to accept new patients) as CMS providers. He had no knowledge of any unreasonable travel distances for PC. 10/7/08 JC3 4-6, 10, 27-29.

Dr. Ritrosky is a part time assistant CMS Medical Director and a full time pediatrician. His area of the state includes Lee, Hendry, and Glades counties. Hendry and Glades have been designated by HRSA as full PC health practitioner shortage areas. Glades has no pediatricians. Hendry has 3. He stated that some physicians just won't take CMS patients. However, he also testified that nursing care coordinators would go out and "beat the bushes," and if they weren't able to find a PC provider, they would refer the patient to a FQHC which has multiple

offices in his area, and which serves as their medical home. 11/10/08 JR 7, 19, 25-26; DX 437; DX 289 at 19166-89.

Dr. Ritrosky testified that there were practices that were intermittently open to new CMS patients. If a private practice was not open, and as another alternative, the CMS nurse coordinator would contact him, and he would frequently take the patients, or get someone in his group to do so. At one point, Ritrosky was asked "so do children in the area go without general primary care," and he answered "yes, unless you count the emergency room as a source of primary care." However, the question was ambiguous, in that it did not indicate which "children" went without general PC (i.e. uninsured children, other children, children on Medicaid, CMS clients). No factual determination can be made from that question and answer pairing (or indeed the questions following it) that Ritrosky was stating that CMS children (or Medicaid children) could only obtain PC in the ER. Although he was repeatedly asked if there were CMS MediPass clients who did not have a PC provider, he did not identify any, but rather testified about what is done to provide a PC provider. He acknowledged that a child enrolled in CMS has to have a PC provider. 11/10/08 JR 24-27, 67.

Dr. Ritrosky testified that MediPass children in his area who are not in CMS have difficulty locating PC, but this testimony should not be given any weight,

because no foundation was identified that would provide a basis for him to have personal knowledge of this. *See* 11/10/08 JR 19.

Dr. Dolores Tamer, a former part time CMS Medical Director and pediatric cardiologist with UM, testified that there was a shortage of PC doctors willing and able to treat CMS Medicaid kids in the Keys; but her jurisdiction did not include the Keys, and she acknowledged that they were "a very special environment." Further, she had no knowledge of the workloads of pediatricians in the Keys, or whether they had capacity to serve additional patients. As a consequence, her testimony should be given little weight. It was Dr. Tamer's experience that her own Medicaid patients (whether CMS or not) had PC physicians. TT 4544-45, 4558-60.

Vicki Posner, a deceased employee of DOH, testified that there might be difficulty locating PC in more rural areas of the state. She mentioned Ocala and Panama City (an area that Dr. Northup said was "easier" to get PC). She also mentioned Ft. Myers as an area where there were prior issues, although she did not have any evidence that the problem persisted. 10/28/08 VP 92-93.

Plaintiffs also presented testimony from a few other provider witnesses for anecdotes about PC issues. Dr. Isaac, a FPS member and a private pediatrician, testified anecdotally about a program at Sarasota Memorial Hospital, where pediatricians are paid a stipend of $2,000 to encourage them to provide care for the

infants delivered of mothers who participate in a prenatal program at the CHD.[42] No evidence was presented by Plaintiffs that any other hospital in the state of Florida had difficulties securing pediatrician services for Medicaid newborns. TT 3888-91; Record.

In 2008, Dr. Paulino Milla-Orellana, a pediatrician and a FPS member, expressed concern about possible consequences to Medicaid patients when he closed his practice in Gainesville, Florida. However, no evidence was presented to show that his concerns (that children would be forced to seek PC from emergency rooms) actually came to pass. Although some patients chose to follow him to his Lake City Office, there is no evidence that they had to. Further, more than 75% of the physicians in Alachua County (where Gainesville is located) who responded to a 2009 Workforce Survey from the DOH, reported that they were accepting new Medicaid patients. Plaintiffs failed to produce evidence that there are widespread generalized problems with access to care in Alachua County or other portions of Area 3, where Gainesville is located. 11/23/08 PO 58-59; DX 501, pg. 65; Record; PX 215.

Although Dr. Milla-Orellana testified that his patients came from a broad geographic area (including from neighboring counties), there is no record evidence

[42] Dr. Isaac also testified to problems with activation of newborns by Medicaid, as part of this process. This issue is addressed above in Part V.B. TT 3892-93. This is an issue for which there is no representative Plaintiff, however.

that any of them had to travel to his office to seek care that was not located closer to home. 11/23/08 PO 58; Record.

Although blood lead screening is a component of age-appropriate CHCUPs, the record is largely devoid of evidence of a difficulty meeting this requirement (except for CMS-416 report inferences, discussed below). Dr. Julia St. Petery testified that, in Leon County, where S.M. lives, there are multiple places where Medicaid children can get their blood lead testing. Her office typically refers to the TPCA lab, but there are also labs in Gadsden County, where this testing can be obtained. Although she testified that it is a problem that children can't get their routine blood lead testing the same day as their doctor's appointment if they use Medicaid transportation services (routine services must be scheduled with advance notice), no evidence was presented to show the extent to which Dr. St. Petery's concern actually impacted on the willingness of enrollees get their blood lead testing. 11/11/08 JS 140-42; 6/2/11BK 66, 74-75.

Plaintiffs rely heavily on the CMS 416 report to show deficiencies in PC or EPSDT services. This annual report is required to be submitted to federal CMS by the FMP. 42 U.S.C. §1396a(a)(43)(D). It must include information about the number of children provided CHCUPs; referred for corrective treatment; and receiving dental services (and other dental services information); as well as results in achieving federal CMS' set participation goals. *Id.*

Florida uses two sources of information to create the CMS 416 report: adjudicated (paid or denied) claims data for services that are fee-for-service reimbursed, and annual unaudited HMO 416 reports submitted by the capitated health plans by January 15 of each year (an audited report must also be filed by October 1). The CMS-416 report is due on April 1 and covers the federal fiscal year ending the prior September 30. PX 25; PX 474 at Def. 26750; TT 1149-51.

Several factors cause the CMS 416 report to underreport the actual services, including CHCUPs, provided during a federal fiscal year. The CMS 416 captures services based on the date the service is provided . Claims with dates of service within the reporting parameters but adjudicated or paid in time to be captured in the CMS 416 report will not be included. These services are also not reported the following year.[43] TT 1151-52; 6/1/11 BK 15-16.

"Claims lag" is the term used to describe the period of time which elapses between the time that a Medicaid service is provided and the time the claim is adjudicated or paid. Claims lag may be due to delays by the physician in submitting a claim for payment, or the time it takes FMP's fiscal agent to adjudicate the claim after receipt. Providers have up to one year to submit claims. 42 C.F.R. § 447.45(d)(1). On average, the fiscal agent adjudicates/pays electronic

[43] Plaintiffs claim that the solution to this problem is to submit an amended CMS 416 report each year. However, the finite FMMIS resources are subject to competing priorities, which make this impractical. 1/10/12 CS 91; 1/17/12 CS 130-33.

claims within 7 days, paper claims within about 20-22 days. But, services might not be reflected in the CMS 416 report if providers delay submitting claims. TT 1149-51; 10/11/11 AS 54-55.

Dr. Darling, Plaintiffs' expert, acknowledged the possibility that claims lag would impact the completeness of the CMS 416 report, but didn't analyze the extent of any impact because, he was not asked to do so. Darling also believes that claims lag becomes less of an issue as more physicians use electronic billing, but conducted no analysis of the frequency with which Florida Medicaid physicians submit electronic claims.[44] Claims lag is not a "huge issue", but is one of several issues which in the aggregate causes underreporting of services on the CMS 416 report. TT 1012-14; 10/3/11 BK 102-03.

Dr. Flint conceded that physicians do not bill promptly 100% of the time, but believes it implausible that claims lag significantly impacts the results of the CMS 416 reporting. He believes that physicians bill "promptly" over 90 or 95% of the time, but has done no analysis to determine how quickly physician claims are submitted. Therefore, his opinions are entitled to less weight (other than for the general proposition that physicians do not always bill promptly). 1/30/12 SF 58-59.

[44] Across all provider types, AHCA processes roughly 97% of its claims electronically and 3% by paper. 10/11/11 AS 9. No evidence was presented at trial regarding the percentage of physicians who still use paper claims.

The CMS 416 report will only capture correctly coded services. Since 2003, CHCUPs have been identified for purposes of Florida's CMS 416 report using the following CPT codes: 99381-99385 (new patient preventative office codes by age), 99391-99394 (established patient preventive office codes by age), 99431 (newborn care – history and examination), 99432 (normal newborn care), 99435 (newborn code) and a single RPICC (Regional Perinatal Intensive Care Center) Code, 99499. 12/12/11 CS 3-4, 18; 8/28/08 AB 86-87, 89-90; PX 25.

The use of all of these codes to report CHCUP services on the CMS 416 report, began in 2003, to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub.L. No. 104–191, 110 Stat. 1936 (1996). Before the change in 2003, AHCA used a single code, W9881, for all CHCUPs. 8/28/08 AB 87-88, 90-91.

Federal CMS also permits states to identify CHCUPs for the CMS 416 report, using the following CPT codes, so long as they are used with certain codes that identify the care as preventive services: 99201-99205 (new patient office visit codes) and 99211-99215 (establish patient office visit codes). AHCA policy did not permit the CPT codes 99201-99205 and 99211-99215 to be billed using a preventive services code, and as a result, these codes were not included in Florida's CMS 416 reporting. PX 25; 10/21/08 AB 117-18.

If a screening service is not billed using a CPT code which AHCA uses to identify CHCUPs for the CMS 416, it won't be included in the CMS 416. Some providers have billed screening services using CPT codes 99201-5 and 99211-5, rather than the approved CHCUP codes. Dr. Darling performed an analysis using AHCA claims data, which showed that there were some claims in the data that were billed using these codes, along with a preventive care code. The amount was small, but he could not quantify it, because it wasn't in his report. TT 1015-19.

Dr. Darling also acknowledges that inadvertent coding errors may be made which would impact the CMS 416 report accuracy; but he likewise believes that coding errors may occur which would cause services to be included in a CMS 416 report which shouldn't be included. However, he did not research the incidence of coding errors by health professionals in claims submission, and, therefore, has no way of knowing whether the incidence of errors varies by code type. TT 1019-20.

Providers billing using CHCUP CPT codes must document all required components of the CHCUP in the medical record. AHCA conducts periodic random medical records reviews of MediPass providers (and HMO and PSN providers) looking at, among other things, compliance with the child health check up requirements. DX 263 at 2-2; 11/20/11 MW 79-80; 10/24/11 MW 62-64; 11/8/11 MW 97-98; 10/18/11 MW 122-23.

Some physicians may choose to bill using a code that requires less documentation; others may have inadvertent coding errors in their claims' submission. The billing process has several phases between the physician's determination of an appropriate code for a service and when the claim for the service is submitted. At every phase of this process, there is opportunity for error (defined as using the wrong CPT code for a particular service). The highest incidence of errors occurs with the evaluation and management services, including all of the CHCUP codes captured on the CMS 416 report. 1/30/12 SF 53-54; 12/8/11 CS 13-16; 12/7/11 CS 78-82; PX 572.

Dr. Flint acknowledges that physicians will not correctly code their services 100% of the time; however, again, without any research or analysis to support his statement, he opines that miscoding will not cause any material changes in the CMS 416 report. Flint misses the point, however. In isolation, coding decisions may not in his words "materially alter" the bottom line result on the CMS 416, but coding errors are but one factor which causes the CMS 416 report to understate the services provided to FM children. 1/30/12 SF 50-51.

Problems with incomplete HMO encounter data in turn cause problems with the completeness of the data in the CMS 416. HMOs which "subcapitate" PC services, or pay a monthly PMPM payment to PCPs to provide care to enrollees, experience difficulties in obtaining complete and accurate encounter information

about the CHCUPs provided by those PCPs. Reports by the Government Accountability Office (GAO), including one from 2011, have acknowledged the problem, and its impact on the CMS 416 report. While as of 2011, individuals interviewed for the GAO report acknowledged improvements in collection of encounter data, problems still existed. TT 1156-57; 1/9/12 CS 131-33; 1/26/12 SF 149-51; 1/30/12 SF 37-38, 47-48; PX 450, pg. 17.

Screening and participation ratios in the CMS 416 report are adversely impacted by the combination of the above-referenced factors, because the numbers of screenings identified using the best data available to AHCA forms the "numerator" used to determine these ratios. Additionally, the numerator will not include screening services for which the Medicaid program does not pay, such as screens received outside the period of Medicaid eligibility or services provided as charity care. To the extent that the numerator is smaller, because it doesn't include every screening service provided to FM children (for the reasons described above), the screening and participation ratios will be lower. As discussed below, however, the problem is aggravated because the denominators used to calculate these ratios include children who have not had the opportunity to seek a service. TT 839, 843, 848-49, 859-60; 10/13/11 PW 85.

The CMS 416 reports in evidence include in the total number of eligibles (Line 1), all children who have been eligible for Medicaid for any portion of the

year, however small. Without question, the CMS 416 report includes eligibles who have had no opportunity to seek services, because, for example, the report includes children determined eligible on September 30. Recently, federal CMS addressed this problem by requiring that the participation and screening ratios report only on the percentage of those eligibles continuously eligible for 90 days or more who have received a CHCUP (giving them some opportunity to recognize the need for and seek services). However, this change in policy doesn't apply to the CMS 416s in evidence. 6/1/11 BK 8, 12; PX 4-8.

There is one other problem with the calculations used to create the denominators for the participation and screening ratios in the CMS 416 reports, relating to the average period of eligibility. Florida has selected the option available to it in federal regulations to make Medicaid effective on the first day of the month in which eligibility is determined. Line 3A of the CMS 416 report counts the total months of eligibility for all children who are included in Line 1 (total eligibles) of the report. The calculation of eligible months will include even those months where a child became eligible at any point in the month. No rounding is done of months, to account for the fact that eligibility determinations may be done in the second half of a month. The total months of eligibility is used to determine the average period of eligibility (Line 3b of the CMS 416 report), which is used in turn to determine expected number of screenings, and the total

eligibles that should receive at least one screening service during the reporting period. The result of over-reporting the actual total months of eligibility is that the denominators used to determine both the screening and participation ratios are larger, making the resultant ratio smaller. Darling's own analysis shows that there is an inflationary impact in calculating periods of eligibility based on months, rather than actual days of eligibility. 42 CFR § 435.914; TT 1144; PX 25, instructions for lines 3-10; PX 475, Table 1 at 8.

Plaintiffs wish to utilize the CMS 416 report to show how many children don't get screening services, but the CMS 416 reports are simply not reliable indicators of utilization of services. Darling has acknowledged that there are problems with the CMS 416, although he focuses in his expert analyses principally on methodological errors by federal CMS, and creates alternate versions of the CMS 416 report, in an effort to show that the report overstates screening services. PX 461.[45]

[45] Using CMS 416 data, Dr. Darling attempts to create an alternate version of the report using, among other things, benchmarks which exceed what federal CMS requires of Florida or any other state. See PX 461, pp. 30-36, where Dr. Darling determines "expected number of screens/eligible" which exceed what is required under Florida's periodicity schedule. Compare, DX 263, pg. 2-4. Plaintiffs have not demonstrated that these benchmarks are reliable or appropriate measures of the adequacy of Florida's EPSDT program. Also, Plaintiffs have presented no proof regarding how privately insured children would measure up using these benchmarks.

Notwithstanding these problems with the CMS 416 report, federal CMS has stated that Florida is among the most successful states in its Region in providing EPSDT services generally to its population. Also, the health screening ratios reported in the CMS 416 reports show consistent improvement in meeting CMS' **goals** for Florida. Between FFY 2003 and FFY2007, the FMP's participation ratio has increased from 55 to 68%, and the screening ratio has increased from 67% to 81%. The HMO 416 reporting shows a similar pattern of consistent improvement. PX 441, pg. 2; PX 11-16; PX 4-8

Plaintiffs have introduced two exhibits where AHCA recognized an error in the CMS 416 report for FFY 2004, in that it counted unborn children as eligibles in the under one year of age category, which made it look as if AHCA was less successful in its health screenings than it really was. However, that issue was corrected in 2005. Plaintiffs own exhibits also show the way that AHCA scrutinizes the annual HMO 416 reports from HMOs, looking for errors or problems. PX 38, PX 41, PX 26, PX 46; TT 848-849, 925.

Ms. Sreckovich's analysis showed that for the most recent year available, State Fiscal Year 2007, on average, Florida Medicaid children under the age of 21 received 3 physician office visits per year, with children under 1 receiving on average 14.4 visits per year, and the oldest children, the 19 to 20 year olds, receiving 1.4 visits per year on average. Darling offered no criticisms specific to

this analysis, but in response to similar analyses, he criticized the use of averages (because he believes they obscure important details), and the use of the HMO 416 reports (prepared on a federal year basis) in Sreckovich's analysis, which used the state fiscal year as the period of measurement. DX 428; PX 475; 1/23/12 TD 42-43.

Ms. Sreckovich used the state fiscal year because this period afforded an opportunity to utilize the most complete data. Further, Plaintiffs have not demonstrated that Darling's methodology of converting FFY data to a SFY provides any greater degree of reliability or precision than Ms. Sreckovich's methodology (which involved utilizing the FFY data, without attempting to convert it to an SFY). Attempting to convert the data to a federal fiscal year format requires that an assumption be made that utilization of services does not vary at different points in the FFY period. Darling conducted no examination of utilization patterns using claims data to test this assumption. 1/23/12 TD 104; 12/12/11 CS 10-11, 65-67; PX 475.

Averages are one acceptable measure to compare access. Dr. Flint acknowledged that the use of means can be an appropriate comparison point in looking at utilization data; however, Dr. Flint believed that using mean data in this case is "less preferred," because he would have measured the median or central tendency. He acknowledged that this is a "relatively minor point," and also that he

himself had done no analysis of utilization of services by FM children. Nonetheless, Darling believes that averages obscure the extent to which children receive no services. 1/30/12 SF 66-68; 1/23/12 TD 36-37; PX 475.

Identifying, from any data source, a specific number of children who may not have obtained a screening service in a given year is not a reliable indicator of access or compliance with the provisions of Section 1396a(a). First, the salient number is children who requested and could not obtain a CHCUP service, under Section 1396a(a)(43)(B), and Plaintiffs have not provided any quantitative analysis of this issue. Additionally, Plaintiffs have provided no benchmarks in the commercially insured population against which Florida's health screening statistics may be measured. We do not know if commercially insured children fare better, or indeed worse, as it relates to use of PC services, and CHCUPs, when measured against the FMP's periodicity schedule. Record.

In his rebuttal report, Darling performed an analysis measuring the average screens received for Florida Medicaid children in state fiscal years 2006 and 2007, based on claims analysis and the HMO 416 data. The results were "an unexpected upward shift between SFY 2006 and SFY 2007." At trial, Darling theorized that the results he obtained using actual claims data combined with the HMO 416 reports were higher because he might have double-counted some of the HMO services, and failed to identify all encounter data. However, Dr. Darling's

testimony rests on a misunderstanding of the evidence presented by Sreckovich. At pages 28 and 29 of his report, Dr. Darling describes the process he used to identify encounter data, by looking at "pay to" providers with a type of 70, reflecting an "HMO/PHP/PMHP Service." Confining his analysis to **EPSDT service records only**, he identified 2,429 **EPSDT service records** for 2006 and 60,187 **such records** for SFY 2007 that appeared to be encounter records. At trial, Darling stated that he believed that Sreckovich was able to identify encounter data that he was unable to identify, because she identified 4,504 reports of encounter in the 2006 data and 215,280 reports of encounter in the 2007 data. However**, Darling missed the fact that Ms. Sreckovich's counts of encounter data were not confined to EPSDT service records, but rather also included "other office visits."** Dr. Darling recalled this difference when he wrote his Rebuttal Report (pg. 24), but not when he testified at trial. The fact that Ms. Sreckovich identified a greater amount of combined encounter data for EPSDT services and other office visits, does not explain the increase that Dr. Darling observed in average services. DX 475, pg. 30-31; PX 475, pg. 28-20; DX 426; 1/23/12 TD 29; *see* DX 426; 1/23/12 TD 123, 175-79; PX 461, 475.

Moreover, although Darling criticizes Defendants for failing to achieve benchmarks he has created (and which are inconsistent with Florida's periodicity schedule), his analysis does not show any children who sought but were unable to

obtain services, and does not show how the FMP compares to the privately insured population in Florida. 1/23/12 TD 123; PX 461, 475.

A review of FMP HMO and PSN performance measure reporting does not change things – because, like the CMS 416 reports, performance measure reporting doesn't measure the extent to which children seek but cannot get services. Rather, it simply reports how the plans perform on certain measures. Nonetheless, in the first year of reporting (calendar year 2006), the statewide weighted averages for the performance measures exceeded the National HEDIS means for all but a single performance measure, the Well-Child Visits First 15 months of life, where Florida's weighted average was 3.5% (meaning that 96.5% of children received one or more CHCUPs in their first 15 months of life).[46] PX 296.

For calendar year 2007, the measures were reported separately in non-reform and reform areas, for comparison. As a result, it is impossible to know how the state would have fared in reporting, if the scores were combined. Nonetheless, again, the scores for well child visits in the 3rd, 4th and 5th years of life exceeded the National HEDIS mean. More than 95% of the children received one or more CHCUPs in the first 15 months of life. The scores for adolescent well care were very close to the National HEDIS mean. While the FMP is certainly striving to do better (and has a number of strategies in place to help the plans improve their

[46] The rate is weighted by the eligible population size for the particular measure. PX 297, pg. 2-2.

scores), the scores do not support the conclusion that there are widespread problems with children being able to obtain CHCUPs or other primary care that they are seeking. DX 334, 361; e.g. 10/19/11 MW 30, 120, 124-25, 127-28; 10/20/11 MW 20-21, 28-29.

Data analysis shows that for state fiscal year (SFY) 2007, 21,256 physician practices provided services to FM children and were paid more than $464 million for these services. This is the most recent year for which claims data was available. During the prior year, 20,893 physician practices providing services to FM children were paid more than $480 million for these services. These numbers don't include physicians who provided health care to children in FQHCs and CHDs, and the numbers don't capture all of the physicians who provide care through HMOs, because there is incomplete encounter data for HMOs in SFY 2007. DX 607, pg. 51-52; 12/12/12 CS 92-93.

In 2007, an analysis of the Top 50 physician providers, in terms of dollar amount of claims showed that 4 of those providers were pediatric practices, but again, the numbers of the Top 50 physician providers do not include physicians who provided health care to children in FQHCs and CHDs, and the numbers don't capture all of the physicians who provide care through HMOs, because there is incomplete encounter data for HMOs in SFY 2007. DX 607, pg. 51-52; 12/12/12 CS 92-93.

Plaintiffs presented the testimony of 23 of physician provider witnesses to testify live or by deposition. This represents less than 1% of the number of fee-for-service primary care providers who cared for Florida's Medicaid children in 2007. This is not a statistically significant number of providers on which to make generalizable findings as it relate to PC provided to FM children. 12/14/11 CS 22-23; TT Vol. 1-2, 4-5, 9-10, 11, 15-16, 18, 20, 22, 25-26; 1/19/12 NS; 1/24/12 BB; 1/26/12 TS; 1/31/12 LC2; Deposition designations of Bucciarelli, Curran, Knappenberger, Ritrosky, Seay, Cohen, Donaldson, Didea, Milla-Orellana, Phillips, J. St. Petery and Weber.

D. Provision/Utilization/Timeliness of Specialty Care

Children who are in MediPass and other fee-for-service Medicaid programs may receive specialist care from participating fee-for-service Medicaid providers. However, children enrolled in MediPass require a referral from their PCP for specialty care. 10/19/11 MW 69-71; 10/24/11 MW 51.

As noted above, Florida's Medicaid State Plan establishes generally that its eleven Medicaid areas establish trade areas for medical services. Therefore, for the fee-for-service aspects of Medicaid, services should generally be available within the trade area (or within the boundaries of the Medicaid area). PX 712, Attachment 4.19-B at 7a.

Children who are in Medicaid MCOs, whether HMO or PSN, may receive

care from the plan's network specialists, but, if the plan lacks a necessary provider then it must pay for the service out of network. AHCA's contract with MCPs requires them to have in-network specialist care available within 60 miles or 60 minutes average travel time of the beneficiary's home. There is evidence that MCPs have increased specialist access, as measured by the greater number of specialists who are now in the Medicaid Reform plan networks. DX 309C at 155-56; DX 344, PX 683.

Comparing Medicaid specialist coverage to private insurance specialist coverage is problematic. Unlike private insurance, Medicaid has no deductibles and no lifetime limit on the amount that it will pay for a child's specialist care, which is a definite advantage for children who need a lot of specialist care - named plaintiffs have received tens and hundreds of thousands of dollars of care, and one received over $1 million of care.

As to difficulty accessing specialists, it should be recognized that a few days between when a parent seeks an appointment and when the child sees the specialist is not proof of an access problem or an unreasonable wait - named plaintiffs do not show that any of their doctors involved in their specialist care formed a medical judgment that they did not receive timely appointments. TT 2821; s*ee above* section V.B.

1. Title 19 Children

Plaintiffs rely on Dr. Agwunobi's remarks to an audience of doctors in November 2007 at a "Specialty Access Summit", and a chart entitled "Acute Shortages" that was prepared in advance of that. Neither are specific to children, as opposed to adults. Agwunobi's remarks do not reference input from parents of children, or their doctors. Kidder testified that children and adults are different in terms of specialist access, and that, in her experience, specialist access has been an issue for adults, not children. PX 205; TT 2672-73.

As to PX 205, the local Medicaid offices that provided the information that was used by someone else to prepare the chart did not assemble or report that information in a systematic or uniform matter. Likewise, they did not include input from parents or doctors. Since this case is focused solely on children's access, it is not fair to infer from the remarks or the chart that Medicaid children are unable to access specialist care. 11/14/11 RG2 95-100; TT 2032-35, 2154-55; 10/6/11 LC 120-23; 11/29/11 DF 110-12.

There is AHCA email in evidence that prove occasions on which a parent requested help from a Medicaid office to locate a specialist for a child. The email proves the diligence of the local office staff in pursuing this. At the same time, the record is silent on the result of the local office staff's efforts, with no medical records in evidence, as there are for named plaintiffs, which makes it impossible to

know whether the child is eligible under Title 19, and what, if any, programmatic issues contributed. The record is silent on the outcome of these, whether the child was seen by a specialist, and when. The record is silent whether the child was made to wait longer than a child with private insurance. PX 170; PX 184; Record.

Steps have been taken to promote children's access to specialists. As noted above, AHCA implemented a 24% fee increase for services provided to children by certain specialist types. Years before AHCA implemented the increases, AHCA prepared a document concerning specialist access, PX 211, which was based on information from 1998-1999 and, even at the time it was prepared, had questionable reliability on account of methodological flaws. Nevertheless, this is a prospective relief case, and it is not reasonable to determine whether prospective relief is appropriate based on information over a decade old. TT 381, 5037-41; PX 128A at AHCA 98141411; TT 5037-41.

Another way Florida has sought to promote specialist access is with case management programs to assist recipients access the care. MediPass is the primary care case management program for beneficiaries who are fee-for-service, and the recipient is assigned a primary care doctor, who coordinates care and makes specialist referrals.

AHCA's local offices further assist fee-for-service providers and recipients locate specialists. Each office maintains lists of specialists whom they believe are

accepting patients, either through a review of fee-for-service claims data and/or direct contact with specialists' offices. Neither the Chief of the Bureau of Medicaid Services, Ms. Kidder, nor managers of local offices are aware of any child who has been unable to successfully locate specialist care after office assistance. Additionally, local office staff has contacted specialists on behalf of specific recipients to facilitate access. 11/7/11 RG2 82; 11/28/11 RG2 29, 31; 5/31/11 RC 30; 11/29/11 DF 68-72; 10/6/11 LC 107; TT 2752-53, 2136-68.

Ms. Nieves is Field Office Manager for Area 8, which includes Immokalee County. In that county, there is a FQHC that provides specialist access. Collier County, also in Area 8, has pediatric orthopedic and ENT services available. Two additional provider service networks (PSNs) have improved specialist access for Area 8 children. Other counties in that area do not have specialists available to Medicaid children, and thus, in some cases, children who live in Charlotte County will have to travel to Lee or Sarasota County. There is no evidence that any Medicaid child in Area 8 has not received timely care in the medical judgment of that child's referring physician or the specialist who saw the child. Ms. Nieves testified that "[m]y understanding is that when children need care, we've been able to find it for them." TT 2127-28, 2218-89, 2121-33, 2671-72.

The local offices are in contact with each other on at least a weekly basis. If a local office has not had success locating a specialist type needed to care for a

recipient, AHCA's policy is that the local offices contact others to see if the recipient can access care in an adjacent area. For example, Ms. Nieves testified that her local office refers children to dermatologists outside Area 8, but transportation is available. Nevertheless, there is no evidence that a local office, when requested, ever has failed to locate specialist care for a recipient under age 21, or that a referral to a specialist in a different area was unsuccessful. TT 2139, 2141-42, 2153; 11/7/11 RG2 63-64, 73-75; 4/5/11 RC 35-37.

Plaintiffs elicited trial testimony from 7 pediatricians and 4 specialists about specialty care issues. All of the pediatricians are FPS officers or board members, with the exception of Dr. Northup[47] and Dr. Chiaro. Moreover, they lacked the first hand knowledge foundation to testify about overall access that Medicaid children have to specialists in their communities, and, to a greater extent other parts of the State. Instead, they gave impressions based on their own patients in regards to particular types of specialist care they have sought. TT 705, 2588, 3900, 257-66, 2563-74, 2779-94, 2837-46, 3871-75; 1/26/12 TS 59-60; 1/19/12 NS 164-65.

There is evidence that children have sufficient access to specialists to meet their needs. In the DOH physician workforce study from 2008, pediatric specialists were asked to identify if they were accepting new Medicaid patients, and close to

[47] As noted above in Part VI.C, Dr. Northup is an FPS member. His partner and close friend, Dr. Robert Patterson, is a regional representative for FPS. TT 1674-75.

90% responded that they were. DOH contracts to have independent university-based research entities survey parents about their CMS experience, including the program's specialty care. The parents positively rated their experience with their childrens' specialists. AHCA has independent university-based research entities survey parents of children in Medicaid Reform, and parents' responses to survey questions relating to specialist care are generally positive. DX 501/PX742 at 68; TT 1444-46, 1546-68; DX 477, DX 390, DX 391, D.E. 1126 (motion to admit survey exhibits).

Challenges to specialist care occasionally arise, which is not proof of system wide problems with access. After all, the program covers approximately 1.7 million children at any given time. In these instances, AHCA witnesses explained that it has established procedures that local office staffs follow, sometimes with involvement by others in Tallahassee, to resolve those access issues brought to their attention. Mr. Snipes, a former Medicaid Director, characterized these as "isolated situations where we have to work for access." Ms. Kidder was permitted to offer a lay opinion that "when children need care, we've been able to find it." 6/2/11 BK 17; TT 1251; TT 2672 DX 249 at 016184, 016186.

Certain doctors called by plaintiffs have testified they have difficulty locating a particular specialist. Testimony was that the patients received the care, but traveled to another county, and/or that the specialist supposedly made the

Medicaid patients wait longer than privately-insured patients. However, there are no records to support these anecdotes. Also, there is no testimony from any specialist whom the doctors contacted in those situations. Likewise, no specialist who testified has stated that he or she did not accept a child because the child had Medicaid. In short, no reliable evidence exists to know what factors led to a specialist's refusal to accept the patient, or a specialist's decision on the amount of time that the patient waited for an office appointment. Equally important, there is no evidence that the local Medicaid office was unsuccessful when asked to assist, or that AHCA was informed of the doctor's reported difficulty to find a specialist. TT 2813-20, 2612-13, 3908-13, 3644-45, 4318-19, 3669-70, 3237, 43 01-02, 4497.

Dr. Silva, a board member of FPS, testified that she has not called a local Medicaid office for help finding a specialist in 10 years, nor has she obtained the specialist lists that she knows the office maintains. Nonetheless, Silva acknowledges that there are fewer specialists in Brandon where she practices, than there are about 11 miles away in Tampa, which has St. Joseph's Children's Hospital, and also in St. Petersburg, which has All Children's Hospital. Schechtman did not know the extent that his in-house referral staff has reached out to the local AHCA office in the instances he reports. The record is not sufficient to reach a conclusion about the causes of the difficulty in the anecdotal examples the

doctors provided when they testified, or the effectiveness of the measures that the programs have in place to facilitate specialist access. 1/19/12 NS 164-65, 172, 185, 191-96; TT 2779, 2780-82, 2784-87, 2789-92, 2813-15, 2817-20, 3908-13; 1/26/12 TS 68-72.

Dr. Cosgrove reported occasions when she has referred patients enrolled in a HMO (Wellcare) to see specialists in Orlando, and one case of an eight year old seeing a rheumatologist in Gainesville. She does not know of any rheumatologist in Brevard County who accept children, regardless of insurance. There is no evidence that any of her Medicaid patients have not received timely care from the Orlando specialists, or the other specialists that Wellcare has found for Cosgrove when she called that Medicaid HMO. Other times, she did not call Wellcare for assistance, and did not call the local Medicaid office for assistance where she now reports an inability to find a specialist in Brevard County to see a Medicaid patient. TT 2565-69; 1/31/12 LC2 149, 168, 150-52, 164-65.

Dr. Northup agreed that specialist access issues are not constant, and can emerge and resolve "month to month." Dr. Chiaro testified to the same effect, as did Ms. Nieves, who leads the AHCA Area 8 office on the west coast. Dr. Schechtman similarly characterized specialist access as "a changing, you know, scene." When deposed in 2008, Dr. Isaac (a pediatrician and former FPS president) stated that he could not find an orthopedic surgeon or dermatologist in

the area that would treat his Medicaid patients. However, he testified at trial that there were now 3 orthopedic surgeons and a dermatologist that would treat his Medicaid patients. Meanwhile, the programs take proactive measures, which include transportation services, so children continue to have specialist access even as AHCA works to resolve the particular issue in that locality. 2/9/11 JC 41-44, 136-37; TT 2143, 4487-88, 3909-13, 2139-41; 11/7/11 RG2 101-05.

While Dr. Northup observed that his Medicaid patients wait longer for specialist office appointments than his "private pay" patients, he was not asked whether any of those patients failed to receive timely specialist care. In fact, there is no testimony that any Medicaid child in the Panhandle has received untimely care in the medical judgment of that child's referring physician or the specialist who saw the child. TT 1598-99, 1629-49.

Wait time and travel distance to specialist appointments is not unique to the Medicaid population. In the Panhandle, for instance, the number of specialists has not kept up with the increase in the general Panhandle population, which is often medically underserved. Indeed, there are no specialists in 6 of the 10 counties that comprise Dr. Northup's Northwest Region of Florida CMS, and other counties have a limited number. For instance, Panama City has 1 pediatric gastroenterologist, one pediatric orthopedic doctor, 1 pediatric cardiologist, and 1 pediatric surgeon. Panama City is one of only two urban areas in the Northwest

Region, the other is Pensacola. Certain specialist types are non-existent or underrepresented in parts of Florida, and thus children need to travel to where the specialists are located, regardless of insurance. Dr. Chiaro recalled that more than half – and perhaps three-quarters – of complaints about difficulty to access specialists that he received were attributed to: "there simply was no one in the community who was providing those services." Pediatric specialists are in short supply and typically around larger metropolitan areas and the medical centers in the State. Thus, a child in Ocala requiring a cardiac surgeon, an orthopedic surgeon, a neurosurgeon, or a neurologist will have to leave Ocala to obtain care regardless of insurance. Likewise, email in evidence refers to pediatric cardiac surgery being unavailable locally in Area 2 of Florida Medicaid. By the same token, Dr. St. Petery, a pediatric cardiologist in Area 2, explained that he sends his patients for cardiac surgery to Shand's Children's Hospital in Alachua County, regardless of insurance. The email in evidence, PX 182A, does not indicate that access to pediatric cardiac surgery is only a challenge for Medicaid children. TT 257-58, 1706-07, 1710-12; 2/9/11 JC 35, 176-77, 45-46; 2/10/11 JC 66-67; 11/15/08 RB 84-85; 11/25/08 TC 85, 100; PX 182A.

There was testimony regarding the need to expand access to pediatric specialists for all children. Indeed, Dr. Chiaro explained that Orlando pediatricians, recognizing the need, organized and obtained funding, and the

involvement of PGA legend Arnold Palmer, to bring a children's hospital to that area, Arnold Palmer Children's Hospital. 2/9/11 JC 173-74; TT 4249, 4275.

Plaintiffs have not presented statistical proof to demonstrate that there are widespread access problems with Medicaid children. For example, Dr. Cosgrove testified about experiences that she had in obtaining specialty care in her practice, and she has about 400 Medicaid patients, out of 2,000 total patients. She and Dr. Knappenberger both practice in Brevard County, which is part of AHCA's Medicaid Area 7. Knappenberger is a medical director for the CMS office in Brevard County. In the Medicaid Area 7, which includes Brevard County, where both Cosgrove and Knappenberger practice, as of the Fall of 2010, there were 204,500 children enrolled in Medicaid. If one assumes that Knappenberger's private practice had the maximum number of Medicaid patients possible by policy then together, these physicians' experiences can represent less than 1% of the Medicaid children in Area 7. If CMS patients comprise 3% of the Medicaid population in Area 7, that means that in all of Area 7 (not just Brevard County), there are about 6,135 children on CMS. If every one of those children as well as every single Medicaid child in the practice of Cosgrove and Knappenberger (assuming he had 1,500 Medicaid children in his practice) had difficulties accessing specialty care, then their experiences would still only amount to less than 4% of all of the Medicaid enrolled children in Area 7 – meaning that there is no

evidence regarding the experiences of 96% of the children in Area 7 as it relates to specialty care. TT 2636-37, 2552; DX 215; 11/20/08 WK2 11-13; DX 262; DX 321 at Defendants S020230; DE 692 pg. 11 ¶18.

For AHCA Medicaid Area 6 (which consists of Hillsborough, Manatee, Polk, Highlands and Hardee Counties), Plaintiffs presented one live witnesse about specialty care, Dr. Nancy Silva. We have no estimates of the number of Medicaid patients in Silva's practice, but if we assume that every Medicaid child in Silva's practice had problems accessing specialty care (an unlikely scenario), then her experience would account for problems with a small percentage of children in Area 6. DX 215, PX 320; TT 2767-2831; DE 692 pg. 11 ¶18.

2. Title 19 Children with Special Health Care Needs

Medically complex children may receive specialist care from the DOH's CMS program. DE 692 pg 10-1 ¶ 15, 16, 18.

CMS's former head, Dr. Chiaro, who was a CMS Medical Director in Orlando, never recalls a staff member reporting that a child did not receive care within the medically necessary period of time. FPS President, Dr. Cosgrove, agreed that CMS patients generally receive care from specialists, and offered no contrary example. 2/9/11 JC 182; TT 2563, 2598-99.

Dr. Chiaro explained that the key role of the medical director in each CMS region is to look in their region at access to care issues and address them. Chiaro

became head of Florida CMS in 2005. A constant subject in Dr. Chiaro's visits with local CMS offices was provider recruitment. For example, Jaime Lambrecht, M.D., the regional medical director in Ft. Lauderdale helps to recruit and retain providers. In addition to recruitment, the CMS offices provide support to their specialists. 2/9/11 JC 3-4, 48-49, 157-58; 4/4/11 PD 5, 12, 147-48.

Additionally, CMS has eight regions around the State, each of which holds weekly and monthly specialist clinics that are staffed by board certified specialists, who follow the medically complex children at regular clinic appointments and in the office setting. 1/8/10 DS 28-29; 4/4/11 PD 6, 9, 15; TT 2339; DE 692 pg 11 ¶ 19-23; PX 320.

When asked to compare the specialist access of Medicaid children to that of privately-insured, Dr. Northup answered "relatively equal." Dr. Northup was asked if a CMS child who needed specialty care was unable to access it. He answered, "I don't know that I'm aware of any that that has been the case." He also testified that the frequency with which he received appointment complaints was 4 or 5 a week, for a population of 4,200 CMS children (as noted above in Part VI.D). Thus, in a population of children more likely to be higher users of specialty care, only 5% of them report any problem accessing physician care in that region. TT 1663, 1745.

While Dr. Northup testified that on a relatively infrequent basis, perhaps 8-

10 times, he had to pay a rate different than the Medicaid rate for dermatology care in his area, he also testified that some counties in his region did not have any dermatologists. In fact, based on 2008-2009 survey data, six of the ten counties in Dr. Northup's region had none, meaning that anyone there needing dermatology would have to travel. TT 1617, 1619-20; DX 289 at 19166-5.

Plaintiffs have not presented statistical proof to demonstrate that there are widespread access problems in CMS. Dr. Northup is a good example. Although he testified about various access issues regarding specialty care, he also testified that he received complaints about "problems getting appointments" with primary and specialty providers combined for CMS children in his region at a rate of about 4 children per week, or about 208 complaints a year total (52 multiplied by 4). His region has 4,200 CMS children. Assuming that each of the complaints related to a unique child, (maybe not a valid assumption) that still would mean that only 5% of his region's CMS children had problems accessing any physician care, and there were no complaints relating to 95% of the children. We do not know the number of general Medicaid patients he treats each year, but it is unlikely to be a large number apart from the CMS population. Nonetheless, if he treated 1,000 Medicaid children outside of CMS during a year and had problems securing specialty care with everyone (which is unlikely), then comparing his experience with general Medicaid kids to the total number of Medicaid children in Area 1 (which is the

AHCA area office in which his county is located), he would have experienced problems with less than 2% of the Medicaid children in his area (1,000/54,636). Northup's experiences (limited to his practice as a hospital based pediatric intensivist) cannot be generalized to all Medicaid children in the area; any more than he would be competent to testify about all of the care available to all privately insured children in either Escambia County, or in the ten county area covered by the CMS Northwest Region. TT 1720, 1722; DX 262.

The evidence shows that occasional specialist access issues faced by CMS emerge for reasons that are unrelated to Florida's policies and practices, or for reasons that are unknown. These issues can be resolved by program staff within a month's time. Northup recounted successful efforts to increase access to pediatric orthopedic care in Panama City after the unexpected death of the specialist who had served there. Since then, Northup testified it is available in Panama City for CMS children, and identified two orthopedists. He identified an ENT group in Panama City that treats Medicaid children and Florida CMS patients without limitation on the number they will see. More generally, he reported that accessing follow-up specialist care after hospital admissions "has not been terribly problematic" for these children. Dr. Northup testified that, in the past, when he deemed it necessary to obtain specialist care for a CMS child in his region, he has authorized the use of "Purchase Client Services" or PCS funds for that purpose.

The concern about availability of pediatric orthopedic services in Panama City arose when the pediatric orthopedist unexpectedly died, and there is no evidence that any child went without timely orthopedic care during the time that this unexpected situation was being managed. PX 195; TT 1713, 1745-46, 4839-43, 4860-65, 4888-90.

Regarding neurology, Northup testified that there had been wait for care, for CMS children, but they hired a new neurologist for their clinic, and hoped to reduce the "back log." Based on the 2008-2009 workforce survey data, there are no neurologists in Holmes, Jackson, Calhoun, Gulf and Washington Counties, meaning that anyone needing neurology care there will have to travel. Santa Rosa and Walton Counties each have one. There is only one pediatric neurosurgeon in the entire Panhandle area. TT 1643-44, 1704-5; DX 289 pp 19166-48 to 50.

CMS holds pediatric neurology clinics in Panama City, which means that a CMS child in Gulf County can travel less distance to see the neurologist than a "private pay" child in Gulf County, who is not in Florida CMS and must travel to Escambia County. Northup explained that there is only one pediatric neurology group to treat children in the Northwest Region, regardless of insurance. Email in evidence refers to neurology access issues for children and adults in Area 1 of Florida Medicaid, which is located within the larger Northwest Region of Florida CMS. There is no indication in the email that the issues are specific to children in

these programs, or the result of these other challenges that all children in the Panhandle face with regard to specialist care. TT 1755-56; PX 181; DX 201.

Apart from their anecdotal examples, plaintiffs rely on a "survey" of Florida CMS program staff, including Medical Directors, from 2003. That survey identifies challenges to recruiting more specialists to the program. It also identifies certain specialist types for which Florida CMS program staff report appointment wait times of over a month. Dr. Chiaro, a pediatrician and head of Florida CMS, explained that the wait times are not necessarily concerning to him, provided they were routine follow-up visits. Other reasons the survey did not necessarily concern Chiaro are that it does not define "no" access or "limited" access, and that it does not identify that any Florida CMS child has difficulty to access specialist care. Instead, PX 319 reports the stated reasons doctors gave for not participating in Florida CMS, or not participating more than they have. In this regard, the primary concern Chiaro heard expressed in the case of providers who closed their practices to new Florida CMS patients was: "these kids were complex and that they wanted to limit the amount of complex children that they saw." Northup also understands from conversations with specialists whom he has sought to recruit for Florida CMS that some of them do not want to participate in this particular program because of the children's medical complexity. PX 319. 2/9/11 JC 25-27, 38; 2/10/11 JC 66-67, 61-62; TT 1685.

Meanwhile, Chiaro explained that travel distance and wait times for a specialist office appointment can be consistent with those patients having access to care. In fact, the number of Florida CMS network providers has increased since 2005. The appointment wait times listed on PX 319 did not necessarily concern him, because the document does not provide all of the relevant information that he would need to form a medical judgment on timeliness of care. 2/9/11 JC 26-27; 2/10/11 JC 68-69, 135-36.

At the same time, PX 319 was not prepared by an independent research entity using an accepted survey tool, and did not incorporate input from parents of the children. It also does not make any medical judgment whether the identified challenges result in inadequate access to specialist care. On the other hand, DOH has contracted to have a university-based independent research entity survey parents annually about their children's experience with Florida CMS, including their impressions about specialist care. These annual surveys use an accepted survey tool and, while parents report areas for improvement, their reported overall level of satisfaction has been high. PX 319, DX 329, 390, 391.

E. Provision/Utilization/Timeliness of Dental Care

Florida's approved Medicaid State plan requires "[a] direct dental referral for every child, 3 years of age and older, or earlier as medically indicated." Thereafter, "examinations by a dental professional are recommended every six

months or more frequently as prescribed by a dentist or other authorized provider." The periodicity schedule for these examinations meets the requirements of section 1905(r) of the Medicaid Act. Orthodontic services require prior authorization to be obtained for medical necessity. PX 712 p. FL-MED 8709; DX 264 p. 2-3, 2-15.

These dental services are provided by different provider types. If provided by private dental practices, services are reimbursed on a FFS basis. For this provider type, claims data for the most recent full state fiscal year available (July 1, 2006 - June 30, 2007) showed 757 practices (a number with multiple dentists) and paid claims exceeding $66,400,000. DX 607 ¶ 88 p. 52-53; 12/12/11 CS 107.

CHDs and FQHCs provide a significant volume of FFS dental, but their dentists are not compensated based on the Medicaid dental fee schedule. State Fiscal Year 2007-2008 reporting shows that close to one-third (32.6%) of recipients under age 21 received dental services at a CHD, and 12% received dental at a FQHC. PX 739; DX 353; TT 2681-82; 10/3/11 BK 173-74; 12/12/11 CS 107, 109; 10/13/11 PW 73.

Depending where they live, children may also be eligible to receive dental services through Medicaid MCOs, such as HMOs or prepaid dental health plans (PDHPs). These dentists are paid by the plans and separately negotiate payment terms. Medicaid HMOs that provide dental for Medicaid recipients under age 21 have their own dental provider networks. 10/18/11 MW 123-24; 10/24/11 MW 70-

73; TT 2682; DX 354A (ADI contract); DX 355 (MCNA contract).

In a 2008 monitoring report, federal CMS commented favorably on AHCA's PDHPs and HMOs, particularly their flexibility to pay higher reimbursement. AHCA is implementing a statewide PDPH program. There will be two PDHPs in the statewide program: Dentaquest (formerly, Atlantic Dental, Inc., one of the PDHPs in Miami-Dade County), and MCNA (the other PDHP in Miami-Dade County). Enrollment in these PDHPs began in January 2012, in Area 9 (Palm Beach, Martin, St. Lucie, Okeechobee and Indian River counties). AHCA projects completed statewide enrollment by June 2012. PX 441 p. 9-10; 11/15/11 WA 96; 10/25/11 MW 57-69.

CHDs are important providers of dental in the FMP. Dental services are provided by 55 of the 67 CHDs in Florida. FMP children obtaining dental from CHDs increased from about 48,000 in 2003 to about 76,000 in 2007. This suggests that parents are informed of the availability of dental care at CHDs. For example, J.W. received dental services from the Escambia CHD before his next friend, E.W., began taking J.W. to the Sacred Heart dental clinic, co-sponsored by the CHD. 10/5/11 MS2 91-92, 94-96, 116-38; TT 2680; 11/8/11 MW 142-44; TT 1600; 10/12/11 PW 154-58, 163-66; TT 3914; DX 550; DX 551; DX 552; DX 553; DX 554; PX 739. Plaintiffs did not provide evidence that individuals seeking services as CHDs were unable to receive services there.

Improvements in Medicaid children's dental services include expansion of these services in the CHDs. This is an increase in the number counties providing, and an expansion of services within the counties. For example, the Sacred Heart Dental Clinic in Escambia County has doubled the number of available dental chairs, and increased its dentist and dental hygiene staff. Several CHDs offer mobile dental clinics. 10/5/11 MS2 91-92, 94-96, 116-38; TT 4864-73.

FQHCs are important for dental care in rural counties and areas of the state where there are underserved populations. FMP children seeking dental services from FQHCs increased from approximately 17,000 in 2003 to approximately 27,000 in 2007. TT 2680, 3914; 10/12/11 PW 154-58, 163-66; PX 739; TT 5348.

Dr. Primosch is the executive director of FAPD, and until 2003 was Chair of Pediatric Dentistry at UF's dental school. This school offers a pediatric clinic in Alachua County, which is a referral center for patients with special health care needs. The complexity of care it offers is "significantly higher than would be in the average private practice." Primosch agreed that this may explain why patients come from all over the State to the clinic. In addition, a pediatric dental clinic has opened in Collier County, which is staffed by pediatric dentistry residents from UF. Fran Nieves testified about improvements in dental access with this new clinic. Nova Southeastern University in Broward County has a dental school, which provides services to Medicaid children. TT 3722-23, 3725, 3735, 3756,

3760-61, 3768, 2127-28; 5/31/10 RC 54.

FMP children also may receive free dental from volunteer programs in Florida. According to DOH's Public Health Dental Program, there are 41 "Project Dentists Care" volunteer clinics and 18 other such programs in Florida providing free dental to children. This is acceptable, because "[u]nless otherwise provided by federal law, Medicaid is considered to be the payor of last resort." *Caremark, Inc. v. Goetz*, 480 F.3d 779, 783 (6th Cir. 2007). However, AHCA cannot track the volume of free dental provided to FMP children (and who receives them), because it receives no claims or encounter data for this. DX 598 p. 3; 1/23/12 NC 9; TT 1149.

FMP children receive dental screenings as a component of the well-child visits with their pediatricians, who are instructed to refer to a dentist starting at age 3, or earlier if the screening reveals a need. If the pediatrician cannot locate a dentist, he is supposed to notify the area Medicaid office of the need. Since April 2008, Florida Medicaid reimburses pediatric practices for application of fluoride varnishes on these children, which is another way the program provides dental to these children**.** 5/31/11 BK 117-19; 6/1/11 BK 17; DX 263 at 2-2, 2-10.

As with specialty care, the AHCA area offices are available to help Medicaid children locate dentists. Thousands of parents contact their area office for dental referrals yearly, and dentists are their most frequent referral request. The

volume of these requests reflects that parents are aware of this assistance. The area offices also maintain lists of dental providers on their websites. AHCA field office managers testified that there were sufficient dentists to meet the demand for the dental referrals for children that they receive. They were not aware of Medicaid children for whom they could not find a dentist or dental specialist. 11/15/11 WA 106-07, 120-21; 11/16/11 WA 13-16, 19, 22-29, 98-99; PX 202; 11/7/11 RG2 63-64, 68, 94-97; 11/28/11 RG2 9-10, 54, 64-65; 4/5/11 RC 69-70, 86-87, 89-92, 171-72; 10/6/11 LC 90-92, 103, 106-10, 146-49; 11/29/11 DF 103-104; DX 605; TT 2121-22, 2126-28, 2135-36.

Similarly, a review of the dental services received by the class reflects that there are not system-wide issues. An analysis of claims data for State Fiscal Years 2005-2006 and 2006-2007, which did not include any MCP encounter data, showed that Medicaid children ages 6 to 14 (excluding Miami-Dade County children, almost all of whom are in PDHPs) averaged 0.95 to 0.90 dental visits in SFY 2006 and 0.95 to 0.83 visits in SFY 2007. However actual dental services are underreported because the denominator for the averages included children outside Miami-Dade County who are enrolled in MCPs that provide dental services, but the numerator does not include these children's services. Even so, comparing these averages to a report by the U.S. Agency for Healthcare Research and Quality shows these children received services at a rate comparable to the general

population. That report found that nationally, after excluding orthodontic visits children 2-17 yrs on average saw a dentist 0.9 times a year. Here, the right comparator is the average visits which exclude orthodontic visits, because of the very restricted coverage for orthodontic care provided to FMP children. DX 430 (Table 5A); 12/12/11 CS 71-74, 76-83; 1/17/12 CS 66-68.

Independent university-based research entities' evaluation of parents' experience and satisfaction with the FMP and CMS programs also show no systemic access issues for dental. The Institute for Child Health Policy (ICHP) at UF reported for SFY 2007-2008 that 57.6% of FMP children in the MediPass program and 46.8% of children in a Medicaid MCP were reported by their parents as having used dental services in the past year. Parents reported a higher percentage of children in CMS, 65.3%, used dental services in the past year. These statistics are the result of surveys, using the Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey instrument, and they are in the range of national statistics for children's dental use. For example, based on surveys, the GAO has reported percentages of children 2-18 yrs receiving dental care that range from 42% to 64% for "privately insured," and 30% to 45% for Medicaid. PX 452 at Crall 1732-34 (GAO Report); 1/17/12 CS 31-32; D.E. 1088-3 (Schenkman); DX 477 p. 60-61; DX 532; D.E. 1126 (motion to admit survey exhibits).

ICHP reported that parents of children in CMS rate their children's dental

care in excess of 8 points on a 10-point scale in all eight program Regions, with an overall average rating of 8.5 points. ICHP also reported that between 56% and 69% of these children saw a dentist in the last year. D.E. 1088-3 (Schenkman); DX 390 (Figure 17); DX 391 (Figure 15, p. 17); D.E. 1126.[48]

AHCA and DOH high-level administrators have regular contact with their local offices. Those called at trial did not identify any Medicaid children for whom their program could not find a dentist or dental specialist. For CMS children, Dr. Chiaro testified that the program has used funds besides Medicaid reimbursement on occasion to secure oral surgery services for certain medically complex children. AHCA's Ms. Brown-Woofter could not recall being advised that a dental MCP failed to make dental available to a recipient. 2/9/11 JC 63-64; 2/10/11 JC 42-43, 77-79; TT 2756-57; 6/2/11 BK 21-24, 79-86, 115-16, 124-25, 156-58; 7/1/11 BK 37-39, 41-42, 46, 54-56; 10/3/11 BK 18-20; 11/14/11 MW 57-59, 61.

Ms. Cerasoli testified that the number of Medicaid-enrolled dentists statewide had increased from 2008 to 2010. The Medicaid dental program is also beginning to use teledentistry to increase Medicaid children's access to dental care, particularly in rural parts of the State. 6/1/11 BK 17, 57; 5/31/11 BK 109-11; 6/2/11 BK 156-60; TT 3976-78, 3981-82, 3987-88.

In 2001, federal CMS sent a letter to State Medicaid Directors regarding

[48] The national study referenced by ICHP was not Florida specific, and included all children with special health care needs, not just those enrolled in Medicaid.

dental services. The letter addressed factors that federal CMS would consider in determining compliance with both Section 1396a(a)(30)(A) and Section 1396a(a)(43)(A). The letter provided that "significant shortfalls in beneficiary receipt of dental services, together with evidence that Medicaid reimbursement rates that fall below the 50th percentile of providers' fees in the marketplace, create a presumption of noncompliance with both these statutory requirements." States with a "proportion of Medicaid enrolled children who made a dental visit in the preceding year" that was 30% or less were to submit to federal CMS a "Plan of Action" for improving children's access to oral health care services," which AHCA did. PX 447 at CRALL 00750-51.

Notwithstanding the 2001 letter and the 2008 dental monitoring visit, federal CMS has not found Florida to be out of compliance with any provision of Section 1396a(a). Nevertheless, the Court should not invade federal CMS's role and determine compliance issues relative to dental fees and services, when federal CMS monitors these issues and has yet to take any such action. PX 447; PX 441; TT 2724-28; 5/31/11 BK 107-15.

The most recent Florida CMS 416 report in evidence was for SFY 2006-2007. It reported that 21% of all Medicaid children for any part of the year received a billed dental service. Dr. Crall, acknowledged the "general concerns" with the CMS 416 reports as a true measure for utilization of dental services,

although he posits that it is "the best yardstick we have right now." Dr. Darling similarly acknowledged that he is familiar with the GAO's reporting released in 2011, which rejected CMS 416 reporting as "not sufficient for overseeing the provision of dental and other required EPSDT services in state Medicaid programs." 1/26/12 JC2 150-55; PX 8 (CMS 416 report); 1/23/12 TD 157-58.

The same problems with the CMS 416 report as described in Part IV.C are pertinent here, as it relates to the reliability of the CMS 416s as a source to estimate actual provision of dental services. In fact, notwithstanding the low percentage of dental services reported on the CMS 416 report, as a result of its 2008 monitoring, federal CMS did not find Florida to be out of compliance with federal law. Instead, as part of the monitoring process, federal CMS sought separate reporting of the numbers of providers and recipients served. PX 172; PX 141.

It would be unfair to use CMS 416 utilization percentages to judge the FMP's dental performance, when federal CMS has not seen fit to make such a judgment, and given the admitted general concerns in doing so. In addition to the issues related in Part IV.C. above, measuring Florida's success at providing dental using as a denominator all children eligible during any part of a federal fiscal year, when dental referrals are required at age 3, does not measure Florida's success at getting dental services to children ages 3 and over. TT 5310-11, 5317-18; 6/1/11

BK 17; PX 8 (CMS 416 report).

Additionally, measuring dental access using all eligibles (as is the case with the CMS 416), rather than including only children who have been eligible for some minimum time such that they have an opportunity to seek dental services provides lower measures of utilization than other methodologies which ensure that a child is enrolled for sufficient time to recognize his need for and seek dental services. In fact, when analyzing dental utilization by Medicaid children in Iowa, Crall and his co-authors used survey data for Medicaid children who were on Medicaid for 11 months, which resulted in him reporting a higher utilization percentage in Iowa than if he had used Iowa's CMS 416 reports, because "each additional month that a child is enrolled in Medicaid, the greater the likelihood it is that they will use services, because there's a process to obtaining dental care." TT 5211, 5218-19.

There are also well known problems with obtaining accurate information from MCPs about the physician and dental services they provide. Crall was not concerned with this problem, because he perceived that managed care arrangements "are very small part of the dental Medicaid program." In fact, these plans are the principal model for delivering dental services to children in Miami-Dade, Broward, and Duval counties, which are three of Florida's most populous counties. Only since SFY 2010-2011 has the CMS 416 report captured claims data for fluoride varnish applications by pediatricians' offices. 1/26/12 JC2 156-58;

4/5/11 RC 58, 69-70, 171-72; 11/7/11 RG2 77-78; 6/1/11 BK 17-20; 10/3/11 BK 67-68.

From the CMS 416 report, it is impossible to determine whether anyone who did not obtain at least one dental service actually sought the service, or had difficulty in obtaining it. Medicaid patients are more likely to assign a lower priority to preventative dental, and may not seek it until they are in pain. They may more frequently fail to show up for appointments. DX 607 p. 66; DX 612, pg. 50; 12/7/12 CS 55- 58, 61-67; 12/12/11 CS 46-47, 84-86; 12/13/11 CS 57-68; 12/14/11 CS 51-52; 1/17/12 CS 31-32, 71.

Along the same lines, FAPD's executive director, Dr. Primosch, shared his impressions at trial: (i) "that many families choose not to seek dental care," (ii) "there is a segment of the population, whether they can afford it or not, or even if it's free care paid for by the Medicaid program are still not going to access dental care," (iii) "I imagine there are a number of parents of Medicaid kids who simply don't seek out dental care, even though they have this entitlement," and (iv) "Someone would have to show me that Medicaid recipients are not aware that Medicaid covers dental services for children." While Primosch was Chair of Pediatric Dentistry, the dental school attempted to improve on what was then "under ten percent of the pediatric dental clinic program's patients who were hospitalized for their dental care [who] returned for follow-up visits." In his words,

the results of these attempts were "dismal." Ms. Kidder pointed out that CMS 416 reports do not allow one to assess the drivers of the reported dental utilization rates, and "whether that's because they can't get in or because they didn't seek care, that I can't say." Darling did not analyze, and has no opinions to measure, the extent to which parents whose children are included in the CMS 416 reports were actually seeking any kind of dental services. TT 3778-79, 3780-81, 3783-84, 2756-57; 1/23/12 TD 123.

For similar reasons, comparing CMS 416 reported percentages among different states is not a reliable indicator that one is outperforming another. To be sure, there are other states whose CMS 416 reports showed an increased dental utilization percentage, as compared to a dental utilization percentage on an earlier CMS 416 report. Nevertheless, there were a number of variables in play in those states over that period of time. The research needed to determine the impact of these multiple variables on increases in utilization and what, if any, role increasing dental fees had in regards to utilization has not been performed by the experts in this case or anyone else. TT 5310-11; 1/26/12 JC2 116-17; 1/31/12 JC2 78-92, 101-02; 12/7/11 CS 84-85.

Crall has co-authored studies that warn against drawing comparisons among states based on their CMS 416 reports, and warn against comparing CMS 416 reports before and after the year 1999, when the methodology for the CMS 416

reports underwent significant changes. Because of confusion in reporting prior to the 1999 changes, it is impossible to determine whether increases or changes in utilization are the result of improved reporting, or something else. 1/31/12 JC2 78-92, 101-102; DX 573.

Unlike survey data, the CMS 416 reports do not allow any comparison of dental utilization between FMP children and the general population, least of all in any particular geographic area. Survey data suggests that, nationally, in the range of one-half of "privately insured" children do not receive dental care. Florida is recognized by the federal government as having a shortage of dentists to serve the general population in all or part of 61 of its 67 counties, particularly rural counties, which, of course, poses access problems for the general population that are not limited to Medicaid children. Primosch blamed this dentist shortage on insufficient dental school funding. Indeed, the steps that AHCA and DOH have taken to expand dental services in rural counties and underserved areas, for example, expanding CHDs and FQHCs' dental offerings in those areas, may suggest that Medicaid children in those communities have as good or better access to dental than the general population. PX 452 p. 11-13 (GAO report); TT 639-51, 5349-59; DX 351; 10/5/11 MS2 91-92, 94-96, 116-138; TT 2680; 11/8/11 MW 142-44; TT 1600; 10/12/11 PW 154-58, 163-66; TT 3914, 3742-43; DX 550; DX 551; DX 552; DX 553; DX 554; PX 739.

In addition to the factors noted above, the CMS 416 report does not consider the differences in when each state mandates initial dental referrals. Federal regulations require dental referrals starting at age 3, but states may require dental referrals earlier, or obtain a waiver to provide them as late as five years of age. Some states may have larger numbers of very young children under 3 than others (25% of Florida's Medicaid children are under the age of 3). Some states may have a larger proportion of their eligibles enrolled for the majority of a year in all age groups. Because the CMS 416 reports do not account for these differences from state to state, the reports are of questionable relevance in comparing dental effort from state to state. PX 4, PX 5, PX 6, PX 7, PX 8; 42 C.F.R. § 441.56(b)(1)(vi).

In sum, the unknowns associated with CMS 416 reports underscore the general concerns with using CMS 416 reports to assess available access to dental services. It makes sense, therefore, that FMP administrators consult measures of utilization besides CMS 416 reporting, including HEDIS measures, which they count as more accurate than CMS 416 reports in terms of utilization of services. Florida Medicaid considers CMS 416 reports when evaluating the program, but as "just one piece of a much bigger puzzle." 6/1/11 BK 42-51, 53-57, 64-72, 90-95, 110; DX 477B; PX 452 p. 11-13 (GAO report); 11/17/10 JC2 639-51; D.E. 1088-3 (Schenkman); DX 477 p. 60-61; DX 532; DX 390 (Figure 17); DX 391 (Figure

15, p. 17); D.E. 1126 (motion to admit survey exhibits).

Email in evidence, such as when AHCA's Ms. Gray wrote during the transition to PDHPs in Miami-Dade County that the local Medicaid office was finding it "nearly impossible" to find dentists for Medicaid children exempted from those plans, does not prove that AHCA personnel could not find dentist services for Medicaid enrolled children on a timely basis. Ms. Gray explained that it required work for her office, but that it found the care even during the transition, and offered transportation assistance to facilitate access to endodontists and other dental providers in adjacent Broward County. PX 199; 11/7/11 RG2 63-64; 11/28/11 RG2 9-11, 64-65. Further, these emails alone do not establish that a statistically significant number of Medicaid children cannot secure needed dental care, when they seek it.

Unattributed comments made to Florida CMS Medical Directors about difficulty in finding dentists or related specialists to care for children in that program does not reveal whether or not the parents of these medically-complex children found timely dental care. Of course, the named plaintiffs in Florida CMS (N.G. and T.G. and N.A.) who might otherwise represent absent class members on these issues report no problems accessing dental care on a timely basis. 11/25/08 TC 88:15-89:1, 92:3-9 (not for the truth), 9, 93, 180; 10/7/08 JC3 39-44; 11/20/08 WK2 32, 51-53, 98-99; 11/10/08 JR 49; *see above* section V.B. (N.G., T.G., and

N.A.). Likewise, these anecdotes do not reliably establish widespread problems in obtaining dental care. We do not know how many children out of the tens of thousands of children served by CMS experience actual problems. CMS Surveys, as noted above, do not bear out any claims that this is a systemic issue.

Dr. Northup's testimony typifies the problems with Plaintiffs' proof. He testified that he has to pay more than the Medicaid rate to get general dental care for CMS clients in his region about 30-40 times a year (he said the number could be "a little bit greater" in the most recent year for which he had full data – but he provided no further specifics). Specialized dental care has to be paid for at a rate higher than Medicaid "100% of the time." He described specialized dental care as more extensive dental restoration work, orthodontic work, or oral surgery; however, we have no reliable way to determine the frequency with which CMS children in his region need specialized dental care. Dr. Northup testified that a "number of our children" need orthodontics and oral surgery – but we don't know what a "number" means. From Dr. Northup's testimony (and he provides more detail than the other CMS directors who testified), it is not possible to determine the percentage of time that it is necessary to pay higher than the Medicaid rate to get children dental care overall (although we can determine that it is necessary to pay higher than the Medicaid rate for services about 1% of the time – 40/4,2000, the number of CMS children), the percentage of children who have to travel for

dental care, or the percentage of children who wait for dental care. Additionally, there is no reliable data provided about the extent to which privately insured children wait for nonurgent dental care. TT 1599, 1606, 1609; see also depositions of Knappenberger, Ritrosky, Seay, Chiu and Bucciarelli.

Two pediatricians, Dr. Silva and Dr. Cosgrove, recalled one and two occasions in which they made calls to find dental care for a Medicaid patient and were unsuccessful. Neither of them sought help to locate a dentist from the local Medicaid office, or made AHCA aware of these one and two occasions. Silva testified that she now refers parents of her Medicaid patients to the local Medicaid office to identify dentists for them, rather than notifying the AHCA Area Office as she should, per policy, that the child needs a dentist. Dr. St. Petery testified that he hadn't called a dentist for children assigned to his wife's panel in five years, but did not indicate he had ever sought help from the Area Office locating a dentist. DX 263, pg. 2-10; TT 261-67, 2573-76, 2795, 2820, 2846; 1/31/12 LC2 148-49, 166; 1/26/12 TS 65-66, 75-79; DX 321 p. 14-15.

Dr. Claussen practices pediatric dentistry in Panama City, and draws his patients from that county and the surrounding five counties. He is aware of three endodontists in that area, only one of whom he understands is practicing full time. He has not succeeded in referring his patients with Medicaid to this endodontist. He has never had to refer his patients with private insurance to an endodontist to

have a basis for comparison. He has succeeded in having the one periodontist that he knows of in Panama City see his patients with Medicaid, although she is not a participating provider and does not bill Medicaid for her services. Although in 2008 Dr. Claussen testified in his deposition that he knew of no orthodontist in his area accepting Medicaid, an orthodontist is now in Panama City who accepts Medicaid children. Dr. Claussen testified that he is the only pediatric dentist he knows of in the six county area surrounding Panama City, and that 50% of his practice is Medicaid patients. That being so, Medicaid children in that six county area have 50-50 equal access to the one pediatric dentist in that area. Dr. Claussen, however, acknowledged that his understanding of the extent to which there are problems with the quality of dental care available to Medicaid recipients as compared to the general population is "purely anecdotal, it's not through data-gathering." 3/14/08 PC Vol. II: 134-136, 139-142, 177; TT 3967.

F. Provider Enrollment

1. Non-Rate Variables that Influence Provider Participation

There was abundant evidence at trial of several reasons, other than reimbursement rates, that would cause medical providers to choose not to treat Medicaid children. Dr. Northup referred to these as a "constellation of unpleasantries." TT 1680-81.

Evidence suggested that it is more difficult for a provider to communicate to

a Medicaid child's parent the importance of having the child treated for a medical issue, and about the importance of routine pediatric care. Medicaid families are generally more reluctant to come to a provider for routine well care. One mother told Dr. Chiaro that, although the medical care was free, she didn't get paid when she took time off from her employment to bring her child in for medical care, so each trip to the doctor resulted in a loss of money. Medicaid families seem to have a greater reluctance to vaccinate, and Dr. Chiaro believes that they are more receptive to negative rumors that concern vaccinations. 2/9/11 JC 107-08, 110.

Since Medicaid families are generally unwilling to avail themselves of preventative care, they are generally seriously or acutely ill when they visit the physician. Dr. Cosgrove referred to it as a "chronicity of illnesses." TT 2560; 2/9/11 JC 108.

Medicaid patients often have transportation problems. There was evidence that many Medicaid patients do not appear for their medical appointments, which are referred by providers as a "no-show." Testimony stressed that this no-show rate was greater than the non-Medicaid population. Although Dr. Chiaro stated that CMS clinics were able to overbook clinics by 20 or 25 percent to account for the no-shows, he noted that private medical practices generally don't do this, but, instead provide patients with a particular reserved appointment spot. 2/9/11 JC 108-9; TT 1680-82, 2560, 2811, 3660, 3906-07, 4410; 10/5/11 MS2 100, 105.

There was evidence that while Medicaid families are in the providers' office, they are more disruptive than non-Medicaid patients. Dr. Chiaro testified that there were occasions when he treated CMS patients that he had to ask his nurse to "restore order," but never had to do that when he was in private practice. Mr. Sentman testified that several county health departments in Florida have security and are considered to be semi-secured facilities. He stated that he has had to call for law enforcement assistance because of the conduct of Medicaid clients. 10/5/11 MS2 101; TT 1682; 2/9/11 JC 110.

Medicaid children are thought to be more difficult to treat, and more complex. The medical complexity of CMS children, who have special health care needs, is a concern for providers who don't feel that they have the necessary training, or have maintained their expertise to treat particular conditions. Dr. Chiaro noted that the CMS child's complexity, not the reimbursement rate, was the explanation of some providers placing a cap on the number of CMS children they would see. 2/9/11 JC 106-07, 130, 135-36; TT 1684-86.

During the appointment, Medicaid families frequently present difficulties understanding directions and the importance of home health care, taking medications, and complying with medication schedules. Medicaid children require more office time for a variety of reasons, including their need for more complex treatment, and their communication difficulties. Dr. Silva testified that

some non-Medicaid patients have stopped using her as their physician because of the amount of time she has had to take in the office with Medicaid patients. 2/9/11 JC 108, 110; TT 1683-84, 2811-12, 2560; 10/5/11 MS2 100; 1/19/12 NS 175-76.

After appointments, Medicaid children are not as compliant in obtaining prescription medication, taking all of their prescription medication, and taking their medication on time. Medicaid children are thought to be more difficult to treat, and more complex. Dr. Chiaro found that when Medicaid children did not follow his direction for after-appointment care, it created frustrations for him as a treating physician, and these frustrations, as well as others, were shared with him by other providers. In particular, Dr. Chiaro noted that the CMS case management often provided parenting for the child in arranging for after-appointment medical tests and specialist appointments, and did all of the things that he would think a parent would ordinarily know to do. The potential of non-compliance was a particular concern for physicians asked to treat CMS children. 2/9/11 JC 111-14, 131-33.

Many Medicaid children require referrals to several specialists. One pediatric subspecialist testified that Medicaid children have a greater need for referrals to other specialists. 2/9/11 JC 111-12; TT 3668.

Physicians have stated that they believe Medicaid children are a higher litigation risk. TT 3798; 2/9/11 JC 114-15; PX 319 at 2.

There was similar evidence from dentists about “non-rate” reasons why

dentists choose not to treat Medicaid children when they are compared to non-Medicaid children. There was testimony of transportation problems, a much higher no-show rate, poor personal hygiene, a much higher cavity rate, crowding of the waiting area with extended family, a tendency to be uncooperative, and a failure to return for follow-up visits. Dr. Primosch testified that many Medicaid families simply choose not to seek dental care. There was testimony about CMS children, that dentists and oral surgeons were concerned about their medical complexity, their need to sedate many of them, and the time the child would take in their office. 2/10/11 JC 40-42; TT 3778-80, 3798, 3806, 4866-67; 3/14/08 PC 254-55.

Dr. Carr, who is a pediatric dentist, testified that the rate of litigation among Medicaid patients is higher. TT 3798.

Although there was evidence that providers have mentioned the reimbursement rate as a reason to decline to participate in Medicaid, Dr. Chiaro testified that he did not recall anyone mentioning the reimbursement rate to him as a factor, and that in getting recruitment information from the local offices he was never told that reimbursement rate was the sole reason why a doctor did not want to provide for CMS. Instead, he testified that when he tried to recruit physicians to treat CMS children, and they declined, the reasons they gave included that Medicaid children did not keep appointments, did not arrive on time for

appointments, did not follow directions and do what they were supposed to do, were difficult to treat, were complex, and they did not have time for the Medicaid children. They were also concerned about what non-Medicaid families would think of their having Medicaid children in their office. Dr. Northup reiterated that the problems that existed in treating the Medicaid population, which included transportation issues, not coming to appointments, not understanding or following through on directions, are concerns that providers have that are independent of the reimbursement rate. As to dental services in particular, Dr. Northup stated that in talking to dentists about their refusal to provide services to CMS children, his impression was that their reasons were "multifaceted," and that a large part of their reasoning probably had to do with the difficulty of providing the services. Dr. Claussen gave similar testimony when he stated that there are reasons other than reimbursement rate that dentist use when they decide not to treat Medicaid patients. 3/14/08 PC 254-255; 11/14/08 MS 84-85; 2/9/11 JC 114-15, 162-63; 2/10/11 JC 60-62, 106; TT 1716-17; 4867.

2. Provider Shortages: The 2009 Florida Physician Workforce Annual Report (the "Report") indicated that while Florida had 203 physicians per 100,000 population, the national figures showed 250 physicians per 100,000 population. According to the Report, there were shortages of physicians in the majority of Florida counties, Florida falls "far short of the national average," and needs an

additional 8,523 physicians in order to reach the national average. DX 501 at 9, 24.

This shortage affects specialty areas. The Report noted that Florida lacks a substantial number of physicians in Family Medicine, Internal Medicine, Pediatrics, OB/GYN, General Surgery, Psychiatry, Emergency Medicine, and Neurology. DX 501 at 8-9.

Yet, there is an overall shortage of pediatric specialists in the state for all children. Dr. Chiaro specifically mentioned the pediatric specialties of psychiatry, pulmonology, infectious disease, neurology, and orthopedics as problem areas. He stated that the shortage of pediatric specialists is caused by the fact that they are not being trained, and are not re-locating to Florida, in sufficient numbers. 2/9/11 JC 38-39, 101-03, 121-22, 139-40.

3. Physicians Generally Practice In Urban Areas: The absence or shortage of providers is particularly acute in rural areas of the state. During trial, for example, there was testimony that there were rural areas around Ft. Pierce, within the CMS Ft. Lauderdale Region; there were ten rural and underserved counties in Florida's panhandle; and that Ocala was rural. 10/28/08 VP 108-09; 4/4/11 PD 33-34; 2/9/11 JC 123; TT, 1655-56, 1718-19.

Florida physicians have also concentrated their practices in urban areas. The Report notes that 97% of all physicians practice in an urban area. Dr. Chiaro

explained that specialists want to practice near larger metropolitan areas or around universities in order to have access to the latest high-tech equipment. Moreover, he explained that pediatric specialists often do not want to be the first such specialist to locate in a particular area, because of the fear that they will not have any assistance; and that adult specialists who previously treated children will then become unwilling to treat children because of the fear that they will be held to the pediatric specialists' standard of care. 2/9/11 JC 101-2, 125-30; DX 501 at 8

Defendants introduced physician workforce survey data from 2007 and 2008, which shows actual numbers of physicians practicing in each county, and contains specialty category called "pediatric subspecialists." A review of this data will demonstrate that some Florida counties do not have any pediatricians practicing in them, many counties have no pediatric subspecialists, and many counties have very few pediatric subspecialists. Hence, even if this court considered the hearsay testimony from Plaintiffs provider witnesses as to access difficulties for Medicaid children in a particular geographic area, it must be considered in the light of the data from Defendants' exhibit 290C as to the availability of pediatric specialists for all children in that area. 11/15/11 JR2 27-8, 50; DX 290C at 2-7.

As Paula Dorhout testified, unfortunately CMS does not have any control of when providers move into counties, or where they decide to locate their practices.

Of particular interest and pertinence to this case is the statement in the Report that the Healthcare Practitioner Ad Hoc Committee (the "Committee") made recommendations that "focus on the overall goal of improving access to care in the state by developing primary and specialty care coverage across Florida", and that the Committee felt it necessary to specifically recommend supporting physicians who would be interested in practicing in rural and underserved areas . Finally, the report included strategies for promoting the physician workforce in Florida, with a stated goal of improving "the overall geographic distribution and specialty mix of active, practicing Florida physicians to support the healthcare needs of all people in Florida." 4/4/11 PD 33; DX 501 at 9, 92.

G. Managed Care

Florida operates two federally approved waivers through which it is authorized to provide care to certain Medicaid coverage groups through MCOs, such as HMOs and PSNs: the non-reform managed care waiver, operated pursuant to Section 1915b (42 U.S.C. §1396n(b)) , and the Medicaid reform and demonstration waiver operated pursuant to Section 1115 (42 U.S.C. §1315). 10/20/11 MW 96-100; 11/9/11 MW 84.

MCOs contract with AHCA to provide services to Medicaid enrollees. The MCO contracts establish policy regarding the standards and requirements to which the MCO must adhere. TT 1206; 10/18/11 MW 22-23; DX 309C.

According to Dyke Snipes, former deputy secretary for Florida Medicaid, about half of the children enrolled in Florida Medicaid are enrolled in a Medicaid managed care plan. TT 351, 1206.

MCOs are paid a capitated PMPM to provide all contractually covered care to their beneficiaries. Capitation rates are set annually for HMOs and PSNs using a combination of historical fee-for-service claims data, financial data from the HMO, and inpatient and behavioral health encounter data. Regarding the claims data, AHCA uses two full years of historic claims data and applies trend adjustments. The trend adjustments include inflation adjustments and adjustments required as a result of changes in the General Appropriations Act. 10/12/11 PW 102-107, 110.

PDHP capitation rates are set annually using historical fee-for-service claims data. Basically, two full fiscal years of claims data are used for this purpose, and then inflation factors are applied, as well as adjustments needed as a result of changes in the General Appropriations Act each year. For example, changes to the dental reimbursement rate in 2011 were included in the trend factors applied to the historic claims data. 10/12/11 PW 102, 108-110. Also, contractually, the PDHPs are obligated to pass the rate increase along to their providers. 10/25/11 MW 48-49.

The capitation rates for prepaid mental health plans (PMHPs) are set using

behavioral encounter data, which have been determined to be complete for this purpose. 10/12/11 PW 103-104.

Before MCO capitation rates may be implemented, they must be determined to be actuarially sound, and must be approved by federal CMS. In a single circumstance in 2008-2009 (where the Legislature adopted a decrease in MCO rates), AHCA's **proposed** capitation rates were such that the actuaries could not certify that they were actuarially sound. In that instance, the rates were further modified, and not implemented prior to both a determination by the actuaries that they were actuarially sound and they were approved by federal CMS. Beyond that single circumstance, AHCA's MCO rates have been determined to be actuarially sound. Federal CMS has never declined to approve MCO rates for the FMP. 112, 117, 129-131.

An MCO must ensure that its provider networks are adequate. Plans are required to report to AHCA at least once a month the providers in its network. The MCO must include whether a provider has any limitations or restrictions accepting patients and information on the provider's active patient load in order for AHCA to determine whether the provider network is adequate. An MCO must also make its provider directories available on-line and update them at least monthly. Health plans are required to credential every provider in the network. DX 309C at 147-148, 209-213; 10/19/11 MW 6-21.

Provider network adequacy and limits on beneficiary enrollments are determined on a county specific basis. When AHCA determines that a provider network is inadequate, they may take corrective action including freezing the plan's enrollments. 10/19/11 MW 82-84; 11/10/11 MW 74.

AHCA checks network adequacy when an HMO or PSN first applies, requests expanded enrollment, if there any complaints related to available services, or if information comes to AHCA's attention from any source suggesting a problem with a plan's network.. 10/19/11 MW 84-86.

Time standards (including travel time) for PC care are described above in Part V.C. AHCA requires the plans to submit a report on wait times for PCPs in its network. AHCA analyzes data sources such as claims aging reports, appeals and grievances to help determine whether services are provided in a timely fashion. Overall children enrolled in Medicaid HMOs don't have difficulty accessing PC within these time standards established in the Medicaid contract. 10/19/11, 23-27, 29-31, 38-51; DX 309C at 131-132.

An HMO or a PSN must provide a new enrollee with an initial screening evaluation that includes a physical exam, an assessment of behavioral health, a nutritional assessment, an immunization check, a dental screening, and a blood lead screening, if age appropriate. An HMO or a PSA is required to adhere to the periodicity schedule that AHCA has adopted. DX 309C at 53-54; 10/18/11 MW

95:9-98:22, 111:6-112:2.

As mentioned in Part VI.C, an HMO or PSN must submit an annual HMO-416 report which provides information about CHCUPs, dental services and blood lead screenings provided to enrollees. DX 10-16. AHCA has placed plans on corrective action for low levels of blood lead screenings and they are required to show improvement. The same is true if plans do not meet both state specific participation requirements and the federal CMS participation and screening ratio goals. AHCA may also levy financial sanctions if an HMO or a PSAN does not meet the required screening rate. 10/18/11 MW 95-, 111-112, 115-117; DX 309C at 53-54.

AHCA requires that HMOs and PSNs have at least one specialist per county, if a specialist is available. AHCA requires that a plan's network contain a specialty care provider within 60 minutes or 60 miles. HMOs and PSNs must also have the following pediatric subspecialty types in their network: cardiology, endocrinology, nephrology, neurology, and orthopedics. If a specialist is not available in a county, the plan may apply for an exemption. Plans are required to provide transportation if beneficiary must travel outside the county for care. Overall, children on Medicaid managed care plans do not have difficulty accessing specialty care. 10/19/11 MW 69-77; DX 309C at 136-37; DX 474 at 90-91.

AHCA does provider network accuracy surveys to confirm that the

information each plan reports to it about its network (whether non-reform or reform) is accurate. 4/5/11 RC 51-55.

Plaintiffs' Exhibit 205 does not relate to the specialty care access available in Medicaid managed care plans. 11/9/11 MW 31-34.

AHCA requires HMOs and PSNs to provide care management services. Care management services include the coordination of referrals and transportation for specialty care as well as follow-up services for children who the plan identified through blood screenings as having abnormal levels of lead. 10/18/11 MW 134-136; DX 309C at 155.

AHCA requires that HMOs and PSNs provide behavioral healthcare services, including inpatient hospital services, outpatient hospital services, psychiatric physician services, community mental health services, mental health targeted case management, and mental health intensive targeted case management. 10/19/11, MW 3-6; DX 309C at 98-99, 109, 116, 122. AHCA requires that HMOs and PSNs have at least one certified child psychiatrist available within 30 minutes average travel time in urban areas and 60 minutes average travel time in rural areas, unless there are no psychiatrists available with the travel time (in which event the plan must seek a waiver). DX 309C at 134; 10/19/11 MW 52-53.

HMOs and PSNs must submit their behavioral health networks to AHCA for approval before they are operational and on a regular basis. A plan also must

report its expenditures on behavioral health services, and is required to spend at least 80 percent of the behavioral health capitation paid to them on direct care and services for behavioral health. Plans have been sanctioned for not meeting this benchmark. 10/19/11 MW 55-56; 10/20/11 MW 92-94; DX 309C at 127-28.

Children enrolled in a Medicaid HMO or PSN do not have difficulty accessing behavioral health services. 10/19/11 MW 65:11-69:14.

AHCA does extensive monitoring of each HMO and PSN. AHCA conducts an on-site review of each HMO or PSN, to review the plan's operations, policies and procedures and analyze documentation such as medical records to determine whether the plan is in compliance with the requirements of the contract. During the site review, AHCA also samples provider credentialing files and provider network contracts to verify provider network information. AHCA uses a standardized software program that incorporates all the requirements of the managed care contract, which helps to ensure that each review is complete and standardized. 10/18/11 MW 122-123; 10/19/11 MW 77-86.

AHCA requires that HMOs and PSNs have a peer review process, which includes an analysis of its providers including their methods and patterns, morbidity/mortality rates, grievances and appeals filed against the provider, and the appropriateness of care rendered by the providers. The peer review process allows for corrective action and develops policy recommendations to maintain or

enhance the quality of care provided to enrollees. 10/19/11 MW 104-106; DX 309C at 146-47.

AHCA requires that each HMO or PSN have a Quality Improvement Program in place. A quality improvement program is a program that objectively and systematically monitors and evaluates the quality of care and services rendered. The quality improvement program must consider how to promote healthier enrollee outcomes, including submitting ideas for performance improvement projects (PIPs). 10/19/11 MW 109-119; DX 309C at 140-43.

An HMO or PSN must submit numerous performance measures, including HEDIS measures, to AHCA on an annual basis. Required performance measures include well-child visits in the first 15 months of life, Child Health Check-up in the fourth, fifth, sixth years of life, adolescent Well Care visits, childhood immunization status, lead screening, follow-up care for children prescribed ADHD medication, and preventative and total dental visits for children. Performance measures results for each plan are available on AHCA's website. Plans must have an independent audit on the data and methodology used in its performance measure reporting. Furthermore, AHCA's Bureau of Quality Management and an External Quality Review Organization ("EQRO") meets with each plan regarding its performance measure results. 10/19/11 MW 121, 10/20/11 MW 4-8, 23, 35; DX 309C at 144-45, 217.

AHCA has contracted with the Health Services Advisory Group ("HSAG") to be its EQRO for managed care plans. In this role, HSAG advises AHCA on the adequacy of each managed care plan's Quality Improvement Program. HSAG also analyzes each managed care plan's performance measure results as well as the audited reports submitted with those results. Furthermore, HSAG has oversight of each plan's PIPs and the statewide collaborative PIPs. A statewide collaborative PIP is a project that all managed care plans in Florida are collaborating on.[49] HSAG created a standardized approach to monitor plans by developing a tool and methodology that enables AHCA to readily assess a plan and trend a plans performance against other plans. Federal CMS approved HSAG's methodology. TT 1207; 10/19/11 MW 119-30, 148-52; 10/20/11 MW 71- 72; 11/14/11 MW 13-14; DX 309C at 10; DX 474.

AHCA may sanction a plan if its performance measures do not meet the required benchmarks established in the managed care contract. Available sanctions include corrective action plans, monetary sanctions, a freeze of plan enrollment, and a termination of the contract. For instance, AHCA recently levied financial sanctions against Universal Health Plan for failure to meet certain performance measures. 10/20/11 MW 48-60; DX 474 at 162.

[49] One such statewide collaborative PIP aims to improve the utilization of well child checkup for children under 15 months. Another statewide PIP aims to encourage enrolled member to use primary care for their routine treatment rather than the emergency room. 10/19/11 MW 119-130, 148-152; 10/20/11 MW 71-72.

AHCA also requires all MCOs (including HMOs, PSNs, PDHPs and PMHPs) to submit its patient encounter data. It has been a priority of AHCA's over the last few years to improve the submission of encounter data by the plans and to be able to validate that data. 10/20/11 MW 136-138.

All MCOs must annually survey their members using CAHPS surveys, which are a standardized survey that helps evaluate enrollee and provider satisfaction. The results of the survey must be submitted to AHCA. AHCA may then require the managed care plan to provide a corrective action plan to address the results of the CAHPS survey.[50] 10/20/11 MW 75-78.

HMOs and PSNs are required to have procedures in place to identify underutilization and overutilization of services by enrollees. 10/20/11 MW 78-79.

AHCA received federal approval from CMS via a 1115 Research and Demonstration Waiver to operate Medicaid Reform, which began in Broward and Duval counties in July 2006 and expanded into Baker, Clay and Nassau counties in July 2007. Under Medicaid Reform, health care services are provided by Medicaid HMOs and PSNs. 10/20/11 MW 96-100.

None of the individual named Plaintiffs resides in one of the five counties utilizing Medicaid Reform.

[50] AHCA also contracts with the University of Florida to complete CAHPS survey for all Medicaid enrollees, including enrollees in managed care plans. 10/20/11 MBW 75-78.

Medicaid Reform has brought in more providers to treat Medicaid patients, who weren't previously doing so in the areas where Medicaid Reform operates. 4/5/11 RC 90.

As noted in Part VI.C Reform plans submit separate performance measure reporting.

AHCA submits annual and quarterly reports to federal CMS that address the operations, enrollment, choice counseling, plan performance, and appeals and grievances of the non-reform managed care plans. These reports are available on AHCA's website. 10/20/11 MW 96-100; 10/24/11 MW 18-21, 37; DX 331. Moreover, as required by the federal waiver from CMS, AHCA has contracted with the University of Florida to do an evaluation of Medicaid Reform. AHCA. 10/24/11 MW 18-21, 37; 4/5/2011 RC 55-56.

Under Medicaid Reform, managed care plans may provide "enhanced benefits" for those beneficiaries that engage in healthy behavior by receiving preventative health care. Beneficiaries may use these enhanced benefits to purchase certain items not covered by Medicaid, such as diapers and over-the-counter medications. 10/20/11 MBW 107-108.

Just as is the case with non-reform plans, requires Reform plans maintain an adequate network for their members. 4/5/2011 RC 51-55.

A Medicaid managed care plan in the "non-reform" counties may choose to

provide dental care. In the reform areas, a managed care plan must provide dental care. A managed care plan that provides dental care must report dental services and screenings in the Child Health Check-up reports. These plans must satisfy various reporting measures, one of which is reporting the percentage of enrollees that had an annual dental visit. 10/18/11 MBW 112-113, 124; DX 309C at 54.

In 2004, AHCA began its prepaid dental health plan pilot in Miami. There are presently two PDHPs in Miami-Dade County for children to chose form, Dentaquest (formerly Atlantic Dental, Inc.) and MCNA. 10/24/11 MBW 70-77.

The requirements for PDHPs are similar to what is required for HMOs and PSNs, albeit limited to dental services. PDHPs must have an approved provider network in every area where they are approved to provide services. This includes a PC dentist of one for every 1,500 enrollees. Urgent dental care must be provided within one day, sick dental care within two weeks, and routine dental care within one month. Primary dental care must be available within 30 minutes average travel time and specialty care must be available within 60 minutes average travel time. 10/24/11 MBW 81-85, 96.

Furthermore, a PDHP is required to have a quality improvement program that will monitor and evaluate the quality and appropriateness of the care and services delivered to its enrollees. The PDHP is required to submit encounter data, participate in PIPs, submit performance measures, conduct dental record reviews

of its enrolled members, and perform surveys of its members and providers. PDHPs must also provide a service utilization summary report, an enrolled and dental user report, a grievance report, and a provider network report four times a year, a child preventive dental services report twice a year, and a dental health checkup report, a child dental checkup report, a 60 percent treatment ratio report, an incentive payment distribution report, and audited financial statements once a year. 10/24/11 MW 115-121; 10/25/11 MW 25-27, 32-39.

AHCA has worked with Dentaquest and MCNA to improve their encounter data reporting and on their PIPs to target improvements with the utilization and provision of preventative services for children. 10/25/11 MW 73.

AHCA has required Dentaquest to take corrective action, including requiring that Dentaquest renegotiate its contracts with many of its providers from capitated fee arrangements to FFS arrangements. This was intended to help with encounter data reporting, because FFS providers must submit a bill to be paid (providing the plan documentation of the service). AHCA also required Dentaquest to conduct outreach activities in dental providers' offices and to conduct an analysis of potential reasons for payment delays. 10/25/11 MW 24; 11/10/11 MW 21-22.

As noted above, in Part VI.E., AHCA is in the process of expanding the PDHP statewide, and it should be fully implemented by June 2012. 10/25/11 MW 67.

PMHPs have similar requirements as do the other MCOs described herein, including network adequacy, timeliness of care and other requirements. See DX 296. The monitoring of PMHPs by AHCA is similar to the monitoring conducted of other MCOs, including the use of correction action where necessary to address deficiencies. Test. of BK, 6/1/11. *See e.g.*, DX 300-301.

H. Outreach

AHCA's outreach materials include correspondence, wallet-sized reminder cards, Public Service Announcements, pamphlets, brochures, newsletters and posters. 8/28/08 AB 91; DX 200, DX 202, DX 205-208, DX 210; DX 491.

AHCA sends a letter to the parent of every Medicaid child (including children enrolled in MCOs) when the child is enrolled in Medicaid and annually and periodically, notifying them of the CHCUP program. The letters advise parents that their child is due for a free CHCUP, what is included in it and its importance, and who to call (their area office) if they need help making appointments or obtaining transportation. The letter advises parents that, at age 3 or earlier, CHCUPs include visits to a dentist every six months. Although not an issue for the named Plaintiffs, the letters are available in Spanish, and beneficiaries can also call the Area Office (AO) at a number provided to get help. These letters have been sent to the named Plaintiffs. One plaintiff's mother, R.G., even testified

that she received annual reminders by mail all the time. 5/31/11 BK 124-129; DX 205, DX 205a; TT 2402; DX 52; DX 138.

The Eleven AOs are available to tell enrollees about Medicaid Services, including CHCUP services . They are also available to link beneficiaries with providers, for medically necessary services, and to help beneficiaries access services, particularly in the FFS or MediPass system. 6/2/11 BK 114-15; 4/5/11 RC 31-32, 48-49; 11/15/11 WA 97; 11/29/11 DF 51.

AOs participate in various activities, including back to school activities, health fairs, homeless coalition meetings, and other events to inform children and parents about Medicaid. At the events, written outreach materials prepared by AHCA about CHCUPs and other services are distributed, and staff is available to answer questions. DX 202, DX 203, DX 204,DX 209; DX 210, 5/31/11 BK 109-10, 131-36; TT 2246-7; 4/5/11 RC 65, 68; 11/7/11 RG2 83-84; DX 204; DX 209; DX210.

On its internet site, AHCA provides information about the CHCUP program as well as other written materials and brochures about Medicaid, because more and more people have internet access at work or at home. TT 4696-97; 5/31/11 BK 110-111; 10/31/11 BK 10-11; DX 491.

AHCA provides materials at or near a 4th grade reading level; however, it must strike a balance between making the material as easy to understand as

possible and providing correct information. AHCA can usually bring the materials to a 7th grade level. Multi-syllable words pose a problem. For example, AHCA will replace "Immunization" with the word "shots," but no substitute for "Medicaid" exists, and even the word "dental" poses problems. 5/31/11 BK 127-128.

Federal CMS conducted a dental monitoring visit of the FMP in 2008. No adverse action was taken as a result of the visit, but federal CMS recommended that AHCA send a separate annual letter encouraging use of dental services to parents of Florida Medicaid children. AHCA did not agree with the recommendation (and federal CMS did not pursue the matter). Instead, AHCA agreed to include information about dental services in its quarterly Medicaid bulletin. AHCA also placed its dental provider directories, by local Medicaid office, on the Internet, and has simplified its annual informing letters regarding all CHCUP services, including dental services. PX 441 at 6-7; PX 441; DX 205a; DX 605; 11/20/2011 DF 73.

In 2008, federal CMS also recommended that a separate letter be sent to parents of beneficiaries who had not received periodic dental services. Although AHCA agreed to send such a letter, it was necessary to wait until the fiscal agent transition process (to a new fiscal agent and a new Medicaid Management Information System computer) was completed so the new fiscal agent could work

with AHCA to identify the correct subset of beneficiaries. The transition process was not completed until the Summer of 2010. Thereafter, AHCA staff worked with the new fiscal agent to have the letter sent out in automated fashion (similar to what is done with other letters). Because that process was taking too long, AHCA staff worked out a manual solution for sending out the letter, which was sent in two batches, in July 2011 and September 2011. TT 2652-55; 5/31/11 BK 128-30; 6/1/11 BK 2-6; 10/3/11 BK 15-16, 89-97; TT 3970-72, 3980; PX 441 at 7.

MediPass providers must also provide outreach, by contacting the parent of new MediPass patients under age 21 within three months of their enrollment date to perform a health risk-assessment, which includes questions regarding the CHCUP history. Using the health-risk assessments and other sources of information, MediPass providers are to identify children who have not had their CHCUPs according to the periodicity schedule. MediPass providers are to attempt to contact up to two times any patient who is more than two months behind on his periodicity screening schedule to urge the patient or guardian to make a CHCUP appointment. PX 321at 20221.

Similarly, HMOs and PSNs are also required to contact new enrollee at least twice, within 90 days of enrollment, to offer to schedule an initial appointment with the child's PCP (which should occur within 180 days of enrollment). The plans are to use health risk assessments and/or released medical records to identify

enrollees who are behind on their CHCUP screenings, and they are to contact twice if necessary any enrollee more than two months behind in their periodicity schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PCP for a CHCUP. HMOs and PSNs that provide dental services must also provide outreach about those services as well. 10/18/11 MW 73-76; DX 309c at 020018; PX 474 at 26649, 26653-4.

Likewise, the PDHPs and the prepaid mental health contracts have specific new member outreach requirements. In addition to new member outreach, the PDHPs must contact members at least twice if they are more than six months behind in getting their dental check-ups. DX 355at Def. 22325-6, 22347-8; DX 296 at 19568-70.

AHCA provides transportation to all Medicaid covered services for beneficiaries who do not have transportation. This includes out of county transportation. The Commission for the Transportation Disadvantaged is the statewide vendor for nonemergency transportation services and is responsible for providing to all beneficiaries eligible for transportation a member handbook which describes the services, how to get them, rights and responsibilities, and how to file a complaint, grievance, or appeal. 6/2/11 BK 62, 67, 74-75.

CHDs participate in outreach regarding child immunizations. 10/5/11 MS2 138-39; 11/7/11 CA 34-37.

42 CFR § 441.56(a) describes the duty of the "agency" to provide information about the EPSDT Program. Florida's single Medicaid State Agency is AHCA, which is responsible for administering Medicaid, including the EPSDT/CHCUP program.

DCF has no statutory responsibility for providing outreach regarding the EPSDT Program, in Florida; however, DCF provides AHCA with names, addresses, phone numbers, emails, and demographic information of any individual DCF has determined to be eligible for Medicaid, to allow AHCA to perform outreach to children who are eligible for services. No evidence was presented that DCF is not complying with its responsibilities. TT 4761.

While AHCA has supported additional funding in the past for outreach in the KidCare program, PX 100, AHCA, DCF and their partner agencies already conduct various types of outreach, using community partners, to provide Medicaid information to the uninsured.

Presently, all state agencies who deal with children are involved in outreach, including DCF, AHCA, DOH, the Department of Juvenile Justice, the Department of Education, the Agency for Workforce Innovation, and the Agency for Persons with Disabilities. These agencies provide Medicaid and "KidCare" outreach together and form partnerships at the local level with places, like schools and CHDs, where they can reach uninsured children. TT 2646; 10/12/11 PW 168-70.

The Florida KidCare program provides health benefits for children. Fla. Stat. § 409.812 (2011). Healthy children who enroll in SCHIP (State Children's Health Insurance Program, 42 U.S.C. §§1397aa *et seq.*), receive health insurance through the FHKC (FHKC), a public corporation. Both the KidCare Program and FHKC provide outreach to the uninsured.

FHKC provides statewide outreach to the uninsured, working with community partners. FHKC also sponsors a state-wide advertising campaign in middle and high schools, where students create PSAs for health insurance that target kids their own age. This campaign is designed to target adolescents because they are one of the highest groups of uninsured kids. 11/19/08 GV 133-134; TT 2689; DX 179;DX 181; DX 185-185.

AHCA also has a $200,000 a year contract with the University of South Florida (USF), so USF's outreach experts can train and develop self-sustaining outreach efforts using coalitions at the local level. USF also informs businesses, particularly ones that don't offer health insurance, about the options available through the KidCare Program, so they can tell their employees. TT 2688.

Both KidCare and FHKC use their websites to provide outreach to the uninsured. The KidCare Program also has information on its website about Medicaid for children, and a two-page application which may be used to apply for

Medicaid or other KidCare insurance. The FHKC website also has information about how to apply for KidCare insurance. DX 179; DX 180; DX 185; DX 186.

The above-described work by AHCA Medicaid AOs, in attending health fairs, back to school events, and other community events, also helps the community learn about Medicaid. Area Office staff also have other initiatives that help get the word out about Medicaid. DX 210; 11/29/11 DF 109-13; 11/7/11 RG2 83-86, 90-91, 93.

Individuals who wish to apply for Medicaid may now apply online 24-7, go to a DCF service center or store front, or go to a community partner. DCF has 3,000 community partners spread throughout each Florida county, including churches, hospitals, doctors, food banks, homeless shelters, and senior centers. The community partners' goal is to provide information and assistance in applying for Medicaid in areas where potential DCF customers might already go for regular activities. TT 4686-88; 10/27/11 JF 36-37; 10/4/11 SP 20-21.

DCF implemented the online application process for financial assistance, including Medicaid, on a statewide basis around 2006. DCF uses the internet-based application because studies show that 65-70% of potential Medicaid recipients have internet access at work or home. TT 4696-97.

Those who do not have internet can still go to a community partner or service center to apply online, or they can obtain and complete a paper application.

Paper applications may be obtained from some community partners, DCF service centers or store fronts, or by calling and requesting a copy. TT 4697.

County Health Departments ("CHDs") participate in outreach by partnering with DCF and keeping DCF computer terminals in their buildings. Many of the CHDs pay or partially pay an eligibility person to be on site and enroll patients in Medicaid. 10/5/11 MS2 138.

Although Plaintiffs have presented evidence of the numbers of uninsured kids in Florida who may be eligible for Medicaid, they have failed to prove that the reason there are uninsured children in Florida is because of inadequate outreach or because it is too hard to apply for Medicaid. PX 682 at FL MED 07806.

The fact remains that some parents are not motivated to apply for benefits – whether they apply using the two-page KidCare application or the longer DCF application (which allows them to apply for a broader array of benefits and benefits for the family). Florida can educate someone about the benefits, but it cannot force enrollment. 2/10/11 JC 13-15.

Conclusions of Law

A. Plaintiffs have failed to reliably prove class wide deficiencies.

There are significant concerns regarding the admissibility and reliability of Plaintiffs' proof to show pervasive and system-wide violations. Plaintiffs have not presented systematic statistical evidence to quantify the extent of the problems

they claim exist. In some instances they try to quantify problems, but those efforts fall short of allowing the Court to determine the extent to which claimed violations exist across the Florida Medicaid program to any significant degree.

The CMS 416 reports do not provide the type of reliable statistical proof needed to establish a need for class-wide relief for three reasons: (1) they do not measure the number of children who seek but cannot get a reported service; (2) they do not accurately and completely report on service utilization for the reasons set forth above; and (3) no benchmarks have been provided against which the statistics may be compared.

B. Official capacity liability claims

Count I: The Court finds that Sections 1396a(a)(8) and (10) do not create enforceable rights. Even if they did, Plaintiffs have failed to identify the existence of a policy or custom which is closely connected to an injury to them sufficient to support a claim under these statutes. As to DCF, only S.M. and N.A. have any standing to sue DCF regarding delays in services, under Section 1396a(a)(8) and they are only injured as a consequence of alleged switching. They have not proven issues with continuous eligibility or newborn activation. No other Plaintiffs have alleged (let alone proven) that DCF has in any way caused them harm. Regarding "switching," there is no evidence that DCF has adopted a policy that affirmatively directs its employees to violate federal law. Neither is there evidence that DCF is

deliberately indifferent to widespread practices that result in violations of federal law (or problems that lead to switching). Plaintiffs have not presented evidence of a custom that is so wide-spread and pervasive that it has the effect of a policy, or that DCF is deliberately indifferent to any such custom. The law does not require perfection or the absence of any mistakes. The record shows the many efforts made by DCF to minimize problems in the eligibility determination process, to ensure that correct eligibility determinations are made, and to minimize the possibility that its partner, AHCA, may misconstrue communications between computer systems regarding eligibility as breaks in eligibility. There is simply not an adequate basis on which to predicate liability.

Since no named Plaintiff has demonstrated he or she has been harmed as a result of either continuous eligibility issues or newborn activation issues, there can be no liability for DCF as to the class. Further, the organizational Plaintiffs have not presented adequate proof sufficient to support their third party standing to sue DCF on these claims. Alternatively, even the proof of the organizational Plaintiffs is not sufficiently reliable to support a finding of liability for any group of children who have experienced delays in activation of their Medicaid or as regards continuous eligibility.

Regarding Defendants Farmer and Dudek and the claims under Sections 1396a(a)(8) and (10), Plaintiffs failed to show that a custom or policy of

Defendants caused delays in care to J.W., L.C. (as regards mental health services), N.G., J.S. or T.G. Additionally, Plaintiffs have identified no problems with coverage of required services for any of the named Plaintiffs.

Plaintiffs have not identified a policy or custom that causes harm to Plaintiffs. Plaintiffs have not proven that the reasons that these individuals experienced waits in care had to do with reimbursement rates. In fact, regarding J.W.'s CT Scan, there was no evidence of any rate-related issues and the same is true with L.C. In both instances, they sought services through MCOs (an HMO and a PMHP), and allege a delay in care. Notwithstanding the fact that they didn't prove those delays were the result of inadequate rates (as opposed to delays in the prior authorization process, for J.W., and waits for scarce child psychiatry care, in the case of L.C.), the rate-setting processes for MCOs are different than in the fee-for-service setting, and must be approved by federal CMS before implementation (deference must be accorded to CMS' approval of AHCA's rates, and, if Plaintiffs had demonstrated that MCO rates caused harm, their recourse was in a federal APA proceeding). As regards N.G., the record does not show that low rates were the cause of any wait for care, but rather that DOH was not aware that N.G. believed there was an urgent need for ENT care. Regarding T.G., again rates were not the issue; rather, there is no evidence that R.G. sought the orthopedic care during the gap period. From Dr. Baynham's perspective, he remained T.G.'s

provider. Regarding J.S., assuming that a wait of one day is an "undue delay," there is no evidence that AHCA knew that J.S. had difficulty locating care, and in fact, AHCA provides assistance to beneficiaries in locating services – a fact of which beneficiaries are well aware as evidenced by the calls that the Area Offices handle. Further, as to J.S., N.G. and L.C., there is no evidence of any unreasonable delay.

Evidence at trial demonstrated that are several reasons for a provider to be unavailable or unwilling to treat a Medicaid child. However, even if there were proof that it was the rates that caused the harm to Plaintiffs, Plaintiffs have failed to reliably prove that there are widespread and pervasive issues with children obtaining timely care. One need only look at the broad array of care that the named Plaintiffs obtained without difficulty, to determine that the issues about which they complain are anecdotal and isolated.

Assuming for argument that Plaintiffs could demonstrate a policy or custom, and causation, Sections 1396a(a)(8) and (10) prior to 2010, did not create enforceable rights to actual provision of services, but rather to prompt payment for covered services. There is no evidence that Defendants failed to make prompt payments for covered services, to the extent that Plaintiffs claim delays that occurred before 2010.

For all of these reasons, Plaintiffs have failed to prove their claims under

Count 1.

2. Count 2

The Court finds that the statutory text is insufficient to create an enforceable right under Section 1396a(a)(30)(A). The broad and general language of the statute (along with the fact that the statute is not phrased in terms of a benefitted class) dictates the conclusion that it was not Congress' intent to create enforceable rights. See *Blessing*, *Gonzaga* and *Independent Living*. At the same time, Plaintiffs have failed to meet their burden of proof under Section 1396a(a)(30)(A). Specifically, they have failed to reliably prove the following:

1. The relevant geographic area or market which must be considered for any specific medical or dental service;

2. The availability of any medical or dental service in any particular area of the state for the privately insured;

3. That the availability of particular medical or dental services for the Medicaid population in a particular area differed from the availability of a particular medical or dental services for the privately insured persons in the area.

Plaintiffs have failed to reliably prove any of these factors for the named Plaintiff claims, let alone prove that relief is needed on a system wide basis because the problems are pervasive and widespread.

Additionally, even if Plaintiffs had presented proof on the foregoing issues,

federal CMS conducted a monitoring of the FMP's dental services in 2008, and did not find the state to be out of compliance with federal law as relates to reimbursement rates. Deference should be accorded this determination by CMS, which is far better suited to determine whether reimbursement rates meet the competing objectives set forth in Section 1396a(a)(30)(A).

Therefore Plaintiffs have failed to prove their claims under Count 2.

3. Count 3

Assuming that a right exists of outreach to the uninsured, no named Plaintiff has testified that there was any point in time when they did not apply for Medicaid because they did not know about it. The organizational Plaintiffs have not identified patients who do not know about Medicaid, and would apply if they only knew.

In contrast, Defendant Dudek and Wilkins have proven that they have substantial and effective outreach to the uninsured about the Medicaid program, using a variety of methods. This includes participation in a variety of community activities where they can inform potential recipients about Medicaid, use of public service announcements which also orally convey information about Medicaid, and use of written materials available through community partners and on the worldwide web. Plaintiffs have failed to demonstrate that Defendants do not have an effective program of outreach to the uninsured, and have not shown that the

numbers of children who are uninsured (but would be eligible for Medicaid if they applied) are the result of a lack of effective outreach.

Regarding outreach about the EPSDT or CHCUP program, the Plaintiffs have likewise failed to show that Defendants are in violation of Section 1396a(a)(43)(A). Defendants presented abundant evidence about the outreach conducted regarding the EPSDT program, including letters that were sent to the parents of actual named Plaintiffs. The outreach conveys the type of information that 42 C.F.R. §441.56(a) requires. Plaintiffs did not plead claims for violation of Section 1396a(a)(43)(B) or (C). Even if they had, there is no evidence of a Plaintiff who has been injured by a failure to adhere to these separate subparts of Section 1396a(a)(43). Specifically, there is no evidence that a Plaintiff was denied the care that state Medicaid plans are to make available to Medicaid recipients under these subparts.

For all of these reasons, Plaintiffs have failed to prove their claims under Count 4.

VII. Proposed Declaratory Relief (if any)

In light of the foregoing, Plaintiffs do not demonstrate a basis for declaratory relief.

VIII. Conclusion

In light of the foregoing, judgment should be entered in favor of Defendants

on all claims, and Plaintiffs' claims should be dismissed with prejudice.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been served by Notice of Electronic Filing on **Stuart H. Singer, Esq., Carl E. Goldfarb, Esq., Damien J. Marshall, Esq.**, and **Sashi Bach Boruchow, Esq.,** Boies, Schiller & Flexner LLP, 401 East Las Olas Blvd., Suite 1200, Fort Lauderdale, FL 33301, and by United States Mail on **Thomas K. Gilhool, Esq.** and **James Eiseman, Jr., Esq.**, Public Interest Law Center of Philadelphia, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103; and **Louis W. Bullock, Esq.**, Bullock, Bullock, & Blakemore, 110 W. 7th Street, Tulsa, Oklahoma 74112, on March 22, 2012.

/s/ Stephanie A. Daniel ____
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