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

CASE NO. 05-23037-CIV-JORDAN/McALILEY

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

Plaintiffs,

vs.

LIZ DUDEK, et. Al.,

Defendants.

_____/

PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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"The Agency determines physician fees using the Medicare Resource Based Relative Value System. . . . [It] calculates a conversion factor to maintain budget neutrality, unless the legislature provides additional funding for the physician budget."

Memo. from B. Kidder to D. Snipes
January 2, 2008
Pl. Trial Exh. 128A

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Q: [T]he reason that Medicaid fees are 40 percent [less than] Medicare fees is not based on a judgment that that's appropriate in terms of operating the program, it's a function of how much money the Florida legislature has put into that program, right?

A: That is correct.

Dyke Snipes
Former Medicaid Director
December 9, 2009
Trial Tr. at 360

"I don't think any of us disagree[s] that there needs to be an increase to the dental fees. And the arguments that we put forward for that to the legislature are . . . as compelling as we could make them."

Beth Kidder
Medicaid Services Bureau Chief
May 20, 2010
Trial Tr. at 2757

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"[W]e're acknowledging that for a federally required service, at least for the children's portion of dental care, that the state is not even meeting federal requirements for the provision of that care."

Robert Sharpe
Former Medicaid Director
November 16, 2010
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INTRODUCTION

This Court has previously held that the Medicaid Act confers upon Florida's children judicially enforceable civil rights. *See* D.E. 40, 672. After more than ten weeks of trial – and at the close of Plaintiffs' case-in-chief – it is now clear that those rights are being violated with each passing day. As then-Secretary Andrew Agwunobi publicly stated, the Florida Medicaid program is suffering from "a serious access to health care problem that must be addressed." *Infra* at 10. Plaintiffs ask this Court to enter a preliminary injunction that would address two particularly egregious aspects of that program during the remainder of this litigation.[1]

First, with respect to physicians' services, the Agency for Health Care Administration ("AHCA") sets Medicaid reimbursement rates without even considering – much less attempting to comply with – the Medicaid Act's mandates. AHCA employs a conversion factor by which the reimbursement rates are set at a fraction of Medicare rates, with the fraction depending solely on the level of appropriations from the Florida Legislature. *Infra* at 6–9. As a former Medicaid Director explained, the Medicaid reimbursement rates for physicians' services are "basically tied to the budget," not to the requirements of federal law. *Infra* at 8. In fact, AHCA's own Rule 30(b)(6) designee was not even aware of the applicable legal requirements until she was deposed in connection with this litigation. *Infra* at 9. From the State's internal memoranda and the testimony of its most senior officials, it is now undisputed that budget neutrality – not compliance with the Medicaid Act – is the dispositive factor the State considers when setting Medicaid reimbursement rates for physicians' services. *Infra* at 6–9. Courts across the country

[1] Plaintiffs will request that more sweeping injunctive and declaratory relief be entered as a final judgment at the conclusion of trial. Such relief will be similar to that entered in connection with similar litigation in other states, such as Oklahoma. *See* Exh. 22 (Final Judgment and Permanent Injunction in *OKAAP v. Fogarty*). The requested relief will include not only mandatory injunctive relief concerning reimbursement levels for Medicaid providers, but also will address improper eligibility terminations, switching, lack of outreach, and problems with the Medicaid application process.

have determined that states violate the Medicaid Act when they set reimbursement rates in such a fashion. *Infra* at 21–23. This Court can and should conclude that the State is violating the Medicaid Act with respect to physicians' services for children when AHCA uses a budget-neutral conversion factor as the dispositive consideration in setting reimbursement rates.

Although the State's failure to consider the Medicaid Act's legal mandates in its rate-setting process is itself sufficient to establish a violation of federal law – and establishes that Plaintiffs are substantially likely to succeed on the merits of their claims as to the injunctive relief they are now seeking – additional evidence of the State's non-compliance with the Medicaid Act is readily available. The Court need not consider that additional evidence to grant Plaintiffs the relief they seek with respect to children's medical care because AHCA's rate-setting process alone shows that such relief is necessary. That evidence, however, does provide further support for such relief. Data that the State submits to the federal government show that hundreds of thousands of children do not receive *any* of the Early Periodic Screening, Diagnosis, and Treatment ("EPSDT") services to which they are entitled, *infra* at 11, and the State's own top officials have acknowledged that children on Medicaid in Florida lack access to medical services, *infra* at 10–13. In 2007, then-AHCA Secretary Agwunobi described the "unacceptable delays" that children face when seeking medical care and the "terrible shortage of access" to physicians. *Infra* at 10. He also wrote a letter to Florida's doctors, admitting that Medicaid beneficiaries were "struggling to access the care they desperately need." *Infra* at 10. During trial, a former Medicaid Director flat out admitted that he "personally didn't believe" that the State was complying with the Medicaid Act. *Infra* at 11.

Second, interim relief is required to address children's access to Medicaid dental services. During trial, the State's top officials "acknowledge[ed] that for a federally required

service, at least for the children's portion of dental care, that the State is not even meeting federal requirements for the provision of that care," *infra* at 15, and that nobody "disagree[s] that there needs to be an increase to the dental fees," *infra* at 18. Year after year, AHCA has submitted legislative budget requests ("LBRs") to the Florida Legislature warning that access to dental services is "critically low" and that "[a] fee increase for dental services is needed if services are to be available." *Infra* at 19. Year after year, however, the LBRs have been met with inaction from the Florida Legislature, thus necessitating this lawsuit. *Infra* at 19–20. In the last 24 years, while dentists' operating costs have skyrocketed, Florida's reimbursement rates for dental services have increased just once – by 13% in 1998. *Infra* at 16. Today, Florida ranks no better than 48th in the nation in its Medicaid fees for dental services, and it ranks dead last in the nation in children's utilization of Medicaid dental services. *Infra* at 15. Worse still, Florida is falling further and further behind. As the number of dentists actively participating in the Florida Medicaid program continues to fall, children's enrollment in the Medicaid program continues to rise. *Infra* at 17.

To address these two issues, Plaintiffs ask this Court to issue a preliminary injunction that would **(1)** enjoin AHCA from relying on a budget neutral conversion factor when setting Medicaid reimbursement rates for physicians' services and require AHCA to set those reimbursement rates in accordance with the mandates of 42 U.S.C. §§ 1396a(a)(8), (a)(10), and (a)(30)(A),[2] and **(2)** require AHCA to set the Medicaid reimbursement rates for children's dental

[2] Alternatively, this Court would be well within its discretion to affirmatively require AHCA to raise the Medicaid reimbursement rates for children's physicians' services to 100% of Medicare rates, a level that expert analysis shows is minimally adequate to provide access to care, *see* Exh. 25 (Pl. Trial Exh. 495, Flint Report at 2); that other states have been required to adopt as the result of similar litigation, *see* Exh. 22 (Final Judgment and Permanent Injunction in *OKAAP v. Fogarty*); and that is supported by recently enacted federal legislation, *see* 42 U.S.C. § 1396a(a)(13)(C) (requiring temporary increase in Medicaid rates to Medicare rates).

services at no less than the 50th percentile of dentists' usual and customary charges, the minimum rate that expert analysis shows is required to make those services available. AHCA has spent years pleading with the Florida Legislature to undertake improvements to the children's Medicaid program, and it cannot now be heard to argue that measures such as these are unwarranted.

These steps are entirely appropriate at this juncture, as all four prerequisites for issuance of a preliminary injunction are satisfied. First, Plaintiffs are substantially likely to succeed on the merits of their claims. Six years of litigation – including ten weeks of trial over the course of fourteen months – have established not only that children have judicially enforceable civil rights under the Medicaid Act, but also that those rights are being violated in Florida. *Infra* at 21–29. Second, children suffer irreparable harm when their civil rights to health care services are violated. *Infra* at 29–32. As one court has explained, a lack of "medical coverage for the children of the working poor who are otherwise unable to pay for needed medical attention is an irreparable harm of the highest order." *Infra* at 30. Third, a preliminary injunction will benefit all interested parties. *Infra* at 32–34. Not only will it ensure that Medicaid services are made available to children during the pendency of this lawsuit, it also will require the State to take the Medicaid Act's requirements into account as it considers changes to and funding for the Medicaid program in the upcoming legislative session. Finally, a preliminary injunction will advance the public interest by making health care services available to Florida's most vulnerable residents and by requiring the State to make cost-effective and federally-subsidized investments in children's health care. *Infra* at 34.

The justification for limited injunctive relief is particularly compelling at this juncture of the litigation. The evidence overwhelmingly establishes that the State is violating the Medicaid

Act and that Florida's Medicaid-eligible children lack access to health care services as a result. Nonetheless, final injunctive relief appears to be many months – if not well over a year – away. Defendants have estimated that their case will take 264 hours (or 44 to 52.8 days) of trial time, *see* D.E. 917, a period that does not include time for Plaintiffs' rebuttal witnesses and which likely would run well into 2012 at the current pace of the proceedings. Florida's children should not have to wait any longer to see their civil rights vindicated, particularly where the State's own officials have been admitting for years that something must be done to bring the Florida Medicaid program into compliance with federal law.

BACKGROUND

I. FLORIDA MEDICAID'S REIMBURSEMENT RATES FOR PHYSICIANS ARE BASED ON A CONVERSION FACTOR THAT ACHIEVES BUDGET NEUTRALITY WHILE IGNORING THE REQUIREMENTS OF FEDERAL LAW.

AHCA is responsible for setting the reimbursement rates paid to physicians who provide Medicaid services. *See* FLA. STAT. § 409.902. In discharging that responsibility, AHCA does not consider whether the reimbursement rates are sufficient to ensure that children on Medicaid have access to health care services equal to that of other children in the general population. *See* Exh. 1 (Trial Tr. at 360 (Snipes)); Exh. 2 (Trial Tr. at 2492–93 (Kidder)). Nor does AHCA consider whether the rates are sufficient to ensure that EPSDT services are made available with reasonable promptness. *Id.* In fact, in this litigation, the State repeatedly has disavowed any legal responsibility for ensuring that health care services are made available to children on Medicaid, arguing that its only duty is to cut checks with reasonable promptness when such services are rendered. *See, e.g.*, D.E. 548–2 (Def. Mot. for Summ. J. at 5). Instead of setting reimbursement rates with reference to the Medicaid Act's mandates, AHCA "establish[es] the

fees in accordance with the funding that [it] get[s] from the Florida legislature when they pass the budget." Exh. 1 (Trial Tr. at 363 (Snipes)).

AHCA sets Medicaid rates for physicians' services as a fraction of Medicare rates, which are determined by the federal government, and which are generally viewed as being barely sufficient to purchase services in the health care market. *See* Exh. 23 (Pl. Trial Exh. 128A, 1/3/08 Memorandum from B. Kidder to D. Snipes); Exh. 24 (Pl. Trial Exh. 685, HB 329 AHCA Bill Analysis); Exh. 25 (Pl. Trial Exh. 495, Flint Report at 13–14). The "Medicare fee schedule is derived and updated through a complex process done in collaboration with . . . medical provider groups as well as health policy researchers." Exh. 25 (Pl. Trial Exh. 495, Flint Report at 13). That process results in the Resource Based Relative Value System ("RBRVS"), by which all health care services are assigned a code and a total relative value based on physician work, practice expense, and malpractice expense. *See* Exh. 23 (Pl. Trial Exh. 128A); Exh. 24 (Pl. Trial Exh. 685). The federal government adjusts the Medicare rates for each procedure code to account for geographical practice cost variations. *See* Exh. 25 (Pl. Trial Exh. 495, Flint Report at 13). Even though the resulting Medicare rates "historically have been below private market rates" and are "unsatisfactory to much of the provider community," they are intended to "provide current, fair relative reimbursement rates through [a] quasi-public utility model driven by production cost theory and tempered by real world data and clinician review." *Id.* at 13–14.

AHCA determines Florida Medicaid rates by applying a conversion factor to the Medicare rates so that total expected outlays for children's Medicaid services fit within the program's appropriations from the Florida Legislature. *See* Exh. 23 (Pl. Trial Exh. 128A); Exh. 24 (Pl. Trial Exh. 685). In other words, to achieve budget-neutrality, AHCA uses a conversion

factor to convert Medicare's minimally adequate reimbursement rates into lower rates for use in the Florida Medicaid program. As an internal State memorandum explains:

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

Exh. 23 (Pl. Trial Exh. 128A); Exh. 24 (Pl. Trial Exh. 685); *see also* Exh. 1 (Trial Tr. at 354 (Snipes, testifying that AHCA "places relative value and relative weights on certain practitioner procedures [and] utilizes those relative values and weights each year in calculating the practitioner fee.")); Exh. 2 (Trial Tr. at 2490 (Kidder)). In 2008, the conversion factor was 34.0682 for Medicare, compared with just 19.6332 for Medicaid. *See* Exh. 23 (Pl. Trial Exh. 128A); Exh. 1 (Trial Tr. at 357 (Snipes)). Generally speaking, this means that Medicaid rates for children's primary care services are about 40% less than Medicare rates for comparable services, both in the fee-for-service and the managed care contexts. *See* Exh. 23 (Pl. Trial Exh. 128A); Exh. 25 (Pl. Trial Exh. 495, Flint Report at 13–14 (comparing Florida Medicaid rates for primary care and specialty care services to Medicare rates); *id.* at 6 (explaining that "most HMOs that contract with the states pay physicians at the state's Medicaid fee-for-service level at most")).[3]

The bottom line is, literally, the bottom line: Florida Medicaid's reimbursement rates for physicians are "basically tied to the budget," not to the requirements of federal law. Exh. 1 (Trial Tr. at 363 (Snipes)). A former Medicaid Director who stepped down shortly before he

[3] The AHCA memorandum explaining its rate setting process incorrectly states that a one-time 24% increase for Florida Medicaid's pediatric reimbursement rates for certain specialists' codes put those rates at 81% of Medicare rates. *See* Exh. 23 (Pl. Trial Exh. 128A at 6). That figure is based on a mathematical error, and it overstates the value of the reimbursement rates for specialists relative to Medicare rates. *See* Exh. 1 (Trial Tr. at 1234–35 (Snipes)).

testified repeatedly admitted during trial that AHCA considers the budget, but not the Medicaid Act, when it sets reimbursement rates:

- "Really, what contributes to the level that Medicaid is of Medicare is the amount of funding that's put in the program by the Florida legislature." *Id.* at 360.
- "[T]he agency is limited to establishing the fees in accordance with the funding that we get from the Florida legislature when they pass the budget." *Id.* at 361–62.
- "Q: [T]he reason that Medicaid fees are 40 percent [less than] Medicare fees is not based on a judgment that that's appropriate in terms of operating the program, it's a function of how much money the Florida legislature has put into that program, right? A: That is correct." *Id.* at 360.
- "[T]he fees are . . . based on what's built into the budget[.]" *Id.* at 362
- "The Court: [D]o you take any other factors [other than the budget] into account in setting rates for a given year, in the aggregate? A: I believe the answer to that is probably no. If we were to do anything other than that, that would increase or decrease spending in the aggregate, then we would be out of compliance with what drives the budget." *Id.* at 364–65.

In fact, it was not until she was deposed in connection with this litigation that AHCA's own Rule 30(b)(6) designee – the person AHCA identified as being knowledgeable about whether reimbursement rates are sufficient to enlist enough physicians to provide care for children on Medicaid – learned that the Medicaid Act's legal mandates even existed. *See* Exh. 3 (Trial Tr. at 2727 (Kidder)); Exh. 4 (Kidder Depo. Tr. at 167, 284–85); Exh. 26 (Rule 30(b)(6) Depo. Notice).

As explained below, the State violates the Medicaid Act when it structures its Medicaid program without even considering the statute's mandates. *Infra* at 21–23. The Court need not go any further in finding that Plaintiffs are substantially likely to succeed on the merits of their

claims with respect to physicians' services. However, the record is now replete with additional evidence that children do, in fact, lack access to the health care services to which they are entitled.

In 2007, then-AHCA Secretary Andrew Agwunobi gave a public speech in which he stated that "the surveys indicate and our experience confirms that we have a serious access to health care problem that must be addressed." Exh. 27 (Pl. Trial Exh. 126, DVD of Agwunobi Speech); Exh. 28 (Pl. Trial Exh. 125, Outline of Agwunobi Speech). He noted that he had personally travelled to all of the State's area offices "and found that the biggest problem our agency faces is access to specialty care for Medicaid recipients." *Id.* He discussed a "critical need" for certain specialists and a "terrible shortage of access" to others. *Id.* Though the State's counsel repeatedly has tried to argue that access problems affect adults only, that position is inconsistent with what Secretary Agwunobi said:

> What this means is that a child goes to the ER with a broken arm and then cannot find an orthopedic surgeon to follow up with. Or an adult or child has an abscessed tooth and cannot get care. Usually through many hours of work and essentially pleading on bended knee we eventually find care for that patient. However there are unacceptable delays (which translate into poor quality scores and sometimes the patients have to travel for many miles even across the state for care).

Id.; *see also* Exh. 29 (Pl. Trial Exh. 211, 11/2/07 Access to Specialty Health Care Summit). Secretary Agwunobi expressed similar views in a letter to doctors in which he observed that "the increasing lack of access to specialty medical care for Medicaid beneficiaries" is "the most critical issue facing the [Medicaid] program" and that "[a] significant segment of Florida's citizens are struggling to access the care they desperately need, and we must act to help them do so." Exh. 30 (Pl. Trial Exh. 210, 10/1/07 Letter from A. Agwunobi). Other State officials have made similar statements throughout the course of this trial. For instance, the Department of

Health's Rule 30(b)(6) designee admitted that it is "fairly widely recognized in the state of Florida" that "[p]rivate insurance children have access to services that Medicaid children do not have." Exh. 5 (Posner Depo. Designation at 84:8–84:11). In addition, a former Medicaid Director testified that children did not have adequate access to specialists through Medicaid, and that he "personally didn't believe" that the State was complying with federal law. Exh. 6 (11/16/10 Rough Tr. at 16, 52–53 (Sharpe)).

Because the State does not consider the Medicaid Act's mandates when it sets physicians' fees, it has not bothered to study whether those fees are sufficient to comply with the law. *See, e.g.*, Exh. 1 (Trial Tr. at 366 (Snipes)); *see also* Exh. 2 (5/19/10 Trial Tr. at 2649 (Kidder, testifying that AHCA has not conducted any studies since that referenced in a 2003 LBR stating that AHCA had "found critical shortages of Medicaid participating physicians in the state.")). Though AHCA has not conducted any such analysis, experts in this litigation have. For example, Dr. Samuel Flint – an Assistant Professor of Public Affairs at Indiana University Northwest who has published extensively on health economics – studied the health care market in Florida and concluded that "the Florida Medicaid program is not a competitive purchaser for pediatric care at this time" and that Florida's Medicaid rates would have to be doubled to bring the Florida Medicaid program into compliance with federal law. *See* Exh. 25 (Pl. Trial Exh. 495, Flint Report at 2, 20). Meanwhile, Dr. Thomas Darling – an Associate Professor at the University of Baltimore with specialized experience in quantitative analysis of large information files – analyzed Medicaid service utilization data and concluded that hundreds of thousands of children in Florida are not receiving the Medicaid services to which they are entitled under federal law and that, each year, more than 380,000 children receive no EPSDT services at all.

See Exh. 31 (Pl. Trial. Exh. 461, Darling Report at 22); *see also* Exh. 32 (Pl. Trial Exh. 8, April 2008 CMS-416 Report).

Dr. Flint's and Dr. Darling's analyses are confirmed by the State's own internal documents. For example, a former Medicaid Director wrote an email stating that access problems had become a "crisis" that "may get worse as fees remain static." Exh. 33 (Pl. Trial. Exh. 195, 2/22/07 Email from T. Arnold to S. Richard)). Similarly, another former Medicaid Director described Medicaid as "a bad system" in which "providers are paid less and less each year, access is limited, outcomes are not measured, racial disparities in health access continue, and participants are stigmatized." Exh. 34 (Pl. Trial Exh. 277A, 1/9/05 Email from A. Levine to M. Vonborstel). An internal AHCA survey identified "acute shortage[s]" of Medicaid services from a wide-range of specialty areas – including ear, nose, and throat doctors; neurologists; dermatologists; urologists; and allergists – in every region of the state. *See* Exh. 35 (Pl. Trial Exh. 205, List of Most Common Specialty Shortages). Another internal AHCA survey concluded that the Children's Medical Services ("CMS") program was experiencing difficulty recruiting new providers and retaining existing providers and that "[l]ow reimbursement is the number one reason cited by both groups as a barrier to CMS participation." Exh. 36 (Pl. Trial Exh. 319, 2004 Provider Access Survey). As part of a summit on Medicaid beneficiaries' access to specialty care, AHCA created a presentation featuring a series of bar graphs which illustrated the gap between the number of licensed physicians in the State and those participating in Medicaid. *See* Exh. 29 (Pl. Trial Exh. 211, Access to Specialty Care Summit Presentation).

Parents and physicians alike have testified about the consequences of Florida Medicaid's inadequate reimbursement rates for physicians' services. S.C. was forced to pay out-of-pocket for mental health services for her adopted son because the only Medicaid provider in the area had

unreasonably long wait times and a caseload that was too large for one provider. *See* Exh. 7 (Trial Tr. at 1338, 1341–46 (S.C.)). T.G.'s spinal surgery was delayed by more than one year after T.G.'s orthopedic surgeon discontinued his involvement in the CMS program because of reimbursement issues. *See* Exh. 8 (Trial Tr. at 2321, 2323, 2326–27 (R.G.)). J.W. had to wait more than a month to get an imaging study to confirm that a tumor had spread from his leg to his neck, during which time the tumor invaded his spinal canal. *See* Exh. 9 (E.W. Trial Depo. Tr. at 22, 32). N.G. had to wait several days to see an ENT specialist even though he was in severe pain. *See* Exh. 8 (Trial Tr. at 2302-2304 (R.G.)). K.S. had to call a personal injury lawyer to get an orthopedist to set her daughter's broken ankle. *See* Exh. 10 (Trial Tr. at 1966-1968 (K.S.)). A pediatric cardiologist and a pediatric neurologist in Tallahassee both explained that they rarely have trouble locating referrals for privately insured children but that it is often difficult or impossible to find referrals for children on Medicaid. *See* Exh. 11 (8/9/10 Rough Tr. at 29 (Ayala)); Exh. 12 (Trial Tr. at 258 (St. Petery)). A pediatrician in Cocoa Beach had to limit her Medicaid practice because "it was hard to make ends meet with the number of patients that we had coming in that were Medicaid patients." Exh. 13 (Trial Tr. at 2555–2556 (Cosgrove)); *see also* Exh. 14 (Trial Tr. at 2772 (Silva, testifying that her practice limited its Medicaid caseload to "cut down on our losses")); Exh. 11 (8/9/10 Rough Tr. at 24 (Ayala, testifying that his practice would go out of business if everyone paid the Medicaid rates)). An orthopedic surgeon in Winter Park explained that his practice decreased its Medicaid patient caseload because "the reimbursement for Medicaid is lower than our cost to care for patients[.]" Exh. 15 (10/18/10 Rough Tr. at 12 (Fenichel)); *see also* Exh. 16 (8/4/10 Rough Tr. at 51–52 (Postma, testifying that his practice loses money on each Medicaid encounter)). Because Medicaid reimbursement rates for physicians are so low, the State is "very dependent" on a handful of providers "who, through

the goodness of their heart or for other reasons, will choose to see Medicaid patients." Exh. 12 (Trial Tr. at 247 (St. Petery)).

AHCA repeatedly has urged the Florida Legislature to increase appropriations for physicians' Medicaid services so that it could increase reimbursement rates while maintaining budget neutrality. With respect to preventative services, AHCA has stated:

> Increasing the Child Health Check-Up reimbursement will increase access to services, which will increase the early identification of medical conditions before they become serious and disabling; thereby decreasing future costly treatment services. An increase will also more accurately reflect the cost of providing and documenting this comprehensive and preventative service and will encourage provider participation and retention in the Child Health Check-Up Program. Since 1995, provider fee increases have only been a few dollars due to the Resource Based Relative Value System. In 1995, there was a fee increase from $30 to $64.82 and the participation rates increased from 32 percent to 64 percent.

Exh. 37 (Pl. Trial Exh. 703, 2006–07 CHCUP LBR). With respect to specialists' services, AHCA, following an appropriation from the Legislature, increased the rates for some medical specialists' codes by 24% in 2004, Exh. 23 (Pl. Trial Exh. 128A), not nearly enough to bring the program into compliance with federal law, *see* Exh. 25 (Pl. Trial Exh. 495, Flint Report at 2, 14, 20 (finding that Medicaid reimbursement rates are 56% of Medicare rates for certain primary care services and are 68.7% of Medicare rates for certain specialists' services). AHCA has warned the Florida Legislature that reimbursement rates need to be increased because "[t]he Medicaid area offices have identified physician specialty provider shortages and critical access to care problems," and that "providers [had] cited low reimbursement as a major reason for non-participation or limited participation in the Medicaid program." Exh. 38 (Pl. Trial Exh. 89, 2008–09 Specialty LBR). Despite these pleas, the Florida Legislature has refused to increase the budget, and physicians' reimbursement rates have remained woefully inadequate as a result. *See*

Exh. 6 (11/16/10 Rough Tr. at 51 (Sharpe, testifying that efforts to increase reimbursement rates were a "failure" during his tenure)).

II. FLORIDA'S MEDICAID-ELIGIBLE CHILDREN DO NOT HAVE ACCESS TO DENTAL SERVICES.

Only about one-in-five children on Medicaid in Florida receives *any* dental services, much less the multiple dental services to which children are entitled under federal law. *See* Exh. 32 (Pl. Trial Exh. 8, April 2008 CMS-416 Report). These figures rank Florida dead last in the nation. *See* Exh. 39 (Pl. Trial Exh. 440, CMS National Dental Summary at 52). A recent Medicaid Director conceded at trial that "that's not acceptable." Exh. 1 (Trial Tr. at 373 (Snipes)). Not only is it unacceptable, it is unlawful, and the State's own top-ranking officials have admitted as much: A former Medicaid Director testified that AHCA had "acknowledge[ed] that for a federally required service, at least for the children's portion of dental care, that the state is not even meeting federal requirements for the provision of that care." Exh. 6 (11/16/10 Rough Tr. at 46 (Sharpe)). In fact, AHCA repeatedly has submitted to the Florida Legislature LBRs stating, in unequivocal terms, that "[l]ow Medicaid fees for dental services contribute to poor beneficiary access to dental care." Exh. 40 (Pl. Trial Exh. 82, 2006–07 Dental LBR); Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR).

Florida Medicaid's dental reimbursement rates are "exceedingly low" and pale in comparison to all applicable benchmarks. Exh. 6 (11/16/10 Rough Tr. at 18 (Sharpe)). They "are substantially less than usual and customary dental fees." Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR); *see also* Exh. 42 (Pl. Trial Exh. 85, 2009–10 Dental LBR); Exh. 43 (Pl. Trial Exh. 418, Crall Report at 4). They do not even cover dentists' costs for most procedures. *See* Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR); Exh. 17 (8/10/10 Rough Tr. at 16–17 (Primosch)); Exh. 6 (11/16/10 Rough Tr. at 16 (Sharpe)). And they are much lower than the fees

paid in other states. *See* Exh. 43 (Pl. Trial Exh. 418, Crall Report at 4–5); *see also* Exh. 44 (2004 ADA Report (cited in Crall Report and ranking Florida 48th in diagnostic and treatment fees and 49th in preventative fees)); Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR (comparing Florida rates to those in other states); Exh. 6 (11/16/10 Rough Tr. at 15 (Sharpe)). As Dr. James Crall, the Chair of Pediatric Dentistry at the University of California at Los Angeles, summarized, "Florida Medicaid program rates fall far short of levels that would be considered adequate to engage sufficient numbers of dentists in the Florida Medicaid program[.]" Exh. 43 (Pl. Trial Exh. 418, Crall Report at 6); *see also id.* at 12 (the 50th percentile of prevailing fees is the minimum market-based rate); Exh. 46 (Pl. Exh. 439, Crall Rebuttal Report at 5–6 (same)). Florida Medicaid rates for dental services are not only low, they are falling further behind the pace of medical inflation. *See* Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR (stating that, in the past 24 years, dentists' costs have increased 65% while dental reimbursement rates were increased only once – by 13% in 1998)); *see also* Exh. 18 (8/11/10 Rough Tr. at 99–100 (Cerasoli)).

Inadequate Medicaid reimbursement rates result in an inadequate network of Medicaid dental providers. AHCA has reported to the Florida Legislature that only 26% of licensed dentists in Florida are enrolled as Medicaid providers, that only 15% file one or more claims per year, and that fewer than 9% treat 100 or more beneficiaries per year. *See* Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR)); *see also* Exh. 18 (8/11/10 Rough Tr. at 88–89 (Cerasoli)); Exh. 45 (Pl. Trial Exh. 154, DOH Provider Participation Data). Throughout the State, beneficiary-to-dentist ratios exceed 1,000 to 1, "ratios far above [those] generally considered as being consistent with adequate availability of services[.]" Exh. 46 (Pl. Exh. 439, Crall Rebuttal Report at 7).

Tellingly, Florida Medicaid has been unable to enlist dentists even "in counties with relatively favorable dentist-to-population ratios and the bulk of Florida's EPSDT beneficiaries." *Id.*

The number of dentists participating in the Florida Medicaid program is decreasing while the number of children enrolled in the program is on the rise. As the LBRs acknowledge, "[d]uring the past five years, the number of Medicaid dental providers has declined 15 percent." Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR); *see also* Exh. 1 (Trial Tr. at 373–74 (Snipes)). Dr. Crall reports that "[t]hese declines, while troubling, are not surprising given Florida's failure to make needed increases in reimbursement rates for dental services over the past 20+ years." Exh. 43 (Pl. Trial Exh. 418, Crall Report at 9). Meanwhile, children's enrollment in the Florida Medicaid program rose by about 78% from 1998 to 2008, thus widening the gap between the amount of services needed and the amount of services available. *See* Exh. 47 (Pl. Trial Exh. 682, 2009 KidCare Coordinating Council Recommendation at 12); *see also* Exh. 2 (Trial Tr. at 2485 (Kidder)); Exh. 48 (Def. Trial Exh. 249, Florida Medicaid Program Overview at 14 (not yet offered for admission)).

As dentists' participation in the Medicaid program has decreased, so too has children's utilization of dental services: "[AHCA's data submissions to the Federal Government] reveal declines in the percentage of FL Medicaid EPSDT enrollees who received any dental service, declines in the percentage of FL Medicaid children who received any preventative service, and declines in the percentage who received any dental treatment services[.]" Exh. 43 (Pl. Trial Exh. 418, Crall Report at 9); *see also* Exh. 19 (11/17/10 Rough Tr. at 31 (Crall, testifying that utilization was declining)). A former Medicaid Director explained that declining utilization rates indicate that "[c]hildren were getting less care over time, [and] we were aware that there were low utilization rates and provider participation rates, as well, and the concern was that children

weren't getting the dental care that they needed." Exh. 6 (11/16/10 Rough Tr. at 34 (Sharpe)). Simply put, the situation is deteriorating.

The empirical data are reflected in the day-to-day experiences of Florida's parents and dentists. When L.C. was placed on Medicaid, his dentist put him on a waiting list for an appointment while his brother, who had private insurance, was able to obtain an appointment without delay. Exh. 7 (Trial Tr. 1364 (S.C.)). N.V., another child on Medicaid, has to travel four hours round trip to receive dental care because his mother was unable to locate a provider closer to her home who would see N.V. and accept Medicaid. Exh. 20 (8/13/10 Rough Tr. at 7 (K.V.)). A pediatric dentist outside of Tampa testified that she used to see almost exclusively Medicaid patients when she practiced in Texas but has stopped accepting Medicaid since moving to Florida because reimbursement rates are too low and because it is so difficult to locate referrals for children on Medicaid. Exh. 21 (8/10/10 Rough Tr. at 68–69, 72, 77, 87 (Carr)). A dentist involved with the children's dental clinic at Shands in Gainesville testified that the clinic was "overwhelmed by requests for care" and that children travel from across the state to be seen there. Exh. 17 (8/10/10 Rough Tr. at 3, 26 (Primosch)). A pediatrician in Cocoa Beach testified that she enlisted a friend to provide free dental services to a child on Medicaid with an abscessed tooth after learning that it would take three months to obtain an appointment for the child. *See* Exh. 13 (Trial Tr. at 2574–75 (Cosgrove)). Even AHCA's own Area Field Offices have faced difficulties locating dental providers to care for children on Medicaid. *See* Exh. 49 (Pl. Trial Exh. 200, 3/28/07 Email from D. Metarko to E. Andrews).

During trial, AHCA officials admitted that there simply is no dispute that Medicaid reimbursement rates for dentists must be increased: "I don't think any of us disagree[s] that there needs to be an increase to the dental fees. And the arguments that we put forward for that

to the legislature are . . . as compelling as we could make them." Exh. 3 (Trial Tr. at 2757 (Kidder)); *see also* Exh. 18 (8/11/10 Rough Tr. 97 (Cerasoli)). A former Medicaid Director explained that the state of dental access in Florida was "poor" and characterized it as being in a state of "crisis." Exh. 6 (11/16/10 Rough Tr. at 55 (Sharpe)); *see also* Exh. 35 (Pl. Trial Exh. 205, List of Most Common Specialty Shortages).

Year in and year out, AHCA has implored the Florida Legislature to increase Medicaid reimbursement rates for dentists. *See, e.g.*, Exh. 50 (Pl. Trial Exh. 81, 2004–05 Dental LBR); Exh. 51 (Pl. Trial Exh. 80, 2005–06 Dental LBR); Exh. 40 (Pl. Trial Exh. 82, 2006–07 Dental LBR); Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR); Exh. 42 (Pl. Trial Exh. 85 (2009–10 Dental LBR). One former Medicaid Director testified that "the narrative that's in the budget issues speaks for itself." Exh. 1 (Trial Tr. at 1243 (Snipes)). Not only does it speak for itself, it speaks quite clearly, stating that "[a]ccess to dental services in many areas of the state is critically low, and in many rural counties, it is virtually nonexistent." Exh. 40 (Pl. Trial Exh. 82, 2006–07 Dental LBR). The LBRs have warned that "[a] fee increase for dental services is needed if services are to be available" and that "[d]entist participation will continue to decline if the remuneration remains under [dentists'] costs." Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR); *see also* Exh. 6 (11/16/10 Rough Tr. at 38 (Sharpe)); Exh. 18 (8/11/10 Rough Tr. at 84 (Cerasoli)). When asked whether AHCA could have used stronger language to describe the need for a fee increase for dental services, a former Medicaid Director suggested that he might have lost his job if the LBRs had been any more explicit. Exh. 6 (11/16/10 Rough Tr. at 39 (Sharpe)).

Nonetheless, AHCA's repeated pleas for increased reimbursement rates have fallen on deaf ears. *See* Exh. 1 (Trial Tr. at 423 (Snipes)); Exh. 18 (8/11/10 Rough Tr. at 81 (Cerasoli)); Exh. 6 (11/16/10 Rough Tr. at 51 (Sharpe)). AHCA's frustration with the Legislature's neglect

on this issue is perhaps best summarized in the following passage from an email sent by a Medicaid Program Administrator to her colleagues:

> [Dental] fees are extremely low. Considering that we have requested dental fee increases for dentists several years in a row, these requests have never translated into anything positive for dental providers. It is not clear if this serious barrier to dental care is not understood by decision makers . . . . I cannot pretend to understand the rationale behind the lack of action on this issue. To me this deficit in access to care is worthy of some serious attention[.]

Exh. 52 (Pl. Trial Exh. 166, 11/06 Email from O. Mazzoccoli to B. Kidder); *see also* Exh. 18 (8/11/10 Rough Tr. at 112 (Cerasoli)); Exh. 53 (Pl. Trial Exh. 167 (11/20/06 Email from B. Kidder to K. Sokoloski ("This is a serious barrier to dental care and is causing problems with access to dental care across much of the state.")); Exh. 18 (8/11/10 Rough Tr. at 114–15 (Cerasoli)).

ARGUMENT

"The focus [of a preliminary injunction] always must be on prevention of injury by a proper order, not merely on preservation of the status quo." *Canal Auth. of the State of Fla. v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974) (binding precedent in the Eleventh Circuit via *Bonner v. Prichard*, 661 F.2d 1206 (1981)). In fact, "[i]f the currently existing status quo itself is causing one of the parties irreparable injury, it is necessary to alter the situation so as to prevent the injury[, such as] by the issuance of a mandatory [preliminary] injunction[.]" *Id.* A district court may grant a preliminary injunction if the movant establishes (1) a substantial likelihood of success on the merits of the underlying case; (2) the movant will suffer irreparable harm in the absence of an injunction; (3) the harm suffered by the movant in the absence of an injunction would exceed the harm suffered by the opposing party if the injunction issued; and (4)

an injunction would not disserve the public interest. *See Osmose, Inc. v. Viance, LLP*, 612 F.3d 1298, 1307–08 (11th Cir. 2010). Each requirement is satisfied here.

I. PLAINTIFFS ARE SUBSTANTIALLY LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

The evidence overwhelmingly demonstrates that the Florida Medicaid program is violating the Medicaid Act, which requires, *inter alia*, that medical assistance, including EPSDT services, be furnished to children; that medical assistance be furnished with reasonable promptness; and that medical assistance be made available to children at least to the extent that such care and services are available to the general population in the geographic area. *See* 42 U.S.C. § 1396a(a)(8), (a)(10), and (a)(30)(A); *see also Ark. Med. Soc. v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993) (explaining that "general population" refers to the insured population).

With respect to physicians' services, the Court need look no further than the method by which AHCA sets reimbursement rates. It is undisputed that the State does not consider the Medicaid Act's mandates when setting those rates. *Supra* at 6–9. Indeed, but for this litigation, AHCA's own Rule 30(b)(6) designee would not even know that those federal requirements exist. *Supra* at 9. AHCA simply applies a conversion factor to the prevailing Medicare rates, arrives at a budget neutral fee schedule, and adopts it. *Supra* at 6–9. This undisputed evidence alone is sufficient to show that the State is violating the Medicaid Act with respect to children's medical services. For example, in *Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004), the court concluded that the children's Medicaid program in Cook County was violating the Medicaid Act where "Medicaid reimbursement rates [were] determined primarily by the amount of funds allocated to [the Illinois Department of Public Aid ('IDPA')] by the Illinois Bureau of the Budget ('the available pie')," and where "IDPA [did] not consider or study the effect of rate increases or decreases on provider participation nor [did] it compare Medicaid

rates to Medicare or private insurance rates." *Id.* at *11. Similarly, in *OKAAP v. Fogarty*, 366 F.Supp.2d 1050 (N.D. Okla. 2005), *rev'd on other grounds*, 472 F.3d 1208 (10th Cir. 2007),[4] the court found that Oklahoma was violating the Medicaid Act where the Oklahoma Health Care Authority "set[ ] its fee-for-service rates by determining its budget and setting a conversion factor on the basis of this sum." *Id.* at 1059. Here, too, it is undisputed that AHCA sets the Medicaid reimbursement rates by applying a conversion factor to achieve budget neutrality and that it fails to assess whether those rates are sufficient to satisfy the Medicaid Act's requirements.

The logic linking the State's use of a budget-neutral conversion factor to its non-compliance with the Medicaid Act is straightforward and unassailable: The Medicaid Act requires the states to structure their Medicaid programs for children so as to achieve certain standards, such as reasonably prompt delivery of services and equality of access as between beneficiaries and privately insured members of the population. *See* 42 U.S.C. §§ 1396a(a)(8), (a)(10), and (a)(30)(A). A State necessarily violates the Medicaid Act when it structures its Medicaid program to achieve a completely different objective, namely, budget neutrality, and

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[4] This Court may rely on *Fogarty* as persuasive authority as to the type of evidence that establishes a state's non-compliance with the Medicaid Act. The *Fogarty* decision was reversed when the Tenth Circuit Court of Appeals concluded that the § 1396a(a)(30)(A) does not confer upon children judicially enforceable civil rights and that §§ 1396a(a)(8) and (a)(10) require only that states make payments for Medicaid services, not that they take steps to ensure that such services actually are available. *See OKAAP v. Fogarty*, 472 F.3d 1208 (10th Cir. 2007). This Court, recognizing that it is bound by Eleventh Circuit precedent, has rejected the Tenth Circuit's reasoning, finding that § 1396a(a)(30)(A) does confer upon children judicially enforceable civil rights and that Florida cannot satisfy the mandates of §§ 1396a(a)(8) and (a)(10) merely by making payments for services. *See* D.E. 40 at 3 (Order Denying Motion to Dismiss); D.E. 672 at 3 (Order Denying Motion for Final Summary Judgment). In any event, the Tenth Circuit did not call into doubt the *Fogarty* court's assessment of the evidence presented in that case or the district court's conclusion that Oklahoma's Medicaid program for children was falling short of the standards set forth in the Medicaid Act. *See id.* at 1209 (noting "system-wide delays in treatment of Medicaid beneficiaries"); *id.* at 1214 ("[T]he district court concluded, perhaps correctly so, that low rates of reimbursement reduce the number of providers available to Medicaid beneficiaries, and in turn increase the time Medicaid beneficiaries must wait to receive medical services[.]").

when it fails to take adequate measures to assure that it is in compliance with federal law. In other words, states' Medicaid programs must be designed in accordance with the Medicaid Act's mandates, and must not be based solely on the states' own determination of how much they can afford to spend on children's health care. As federal courts have explained, "budgetary constraints alone can never be sufficient" in setting Medicaid reimbursement rates. *Amisub (PSL), Inc. v. State of Colo. Dep't of Social Servs.*, 879 F.2d 789, 801 (10th Cir. 1989); *see also Rite Aid of Penn. v. Houstoun*, 171 F.3d 842, 856 (3rd Cir. 1999) ("[B]udgetary considerations may not be the sole basis for a rate revision[.]"); *Indep. Living Ctr. of So. Cal. v. Shewry*, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008) (preliminarily enjoining Medicaid rate cuts where "the only reason for imposing the cuts was California's fiscal emergency"), *aff'd sub nom.*, 572 F.3d 644 (9th Cir. 2009) (noting that the state's rate-setting agency failed to consider the relationship between reimbursement rates and beneficiaries' access to Medicaid services and that its only concern was with budgetary constraints), *cert. granted sub nom. on other grounds*, -- S. Ct. --, 2011 WL 134272 (Jan. 11, 2011).[5]

The undisputed evidence of AHCA's rate-setting process provides a sufficient basis on which this Court can conclude that Plaintiffs are substantially likely to succeed on the merits of their claims with respect to children's medical services. Further analysis of the relationship between reimbursement rates, providers' participation in Medicaid, and children's access to Medicaid services only confirms that conclusion. Such analysis also shows beyond any doubt that the State is violating the Medicaid Act with respect to dental care. In fact, the State's own

[5] The Supreme Court granted *certiorari* in *Independent Living* to review whether the Medicaid Act is enforceable under the Supremacy Clause. Here, Plaintiffs rely on 42 U.S.C. § 1983 as providing a private right of action to enforce the Medicaid Act. Thus, the question before the Supreme Court of whether the Supremacy Clause creates a separate jurisdictional basis for such a suit has not been presented by this case.

top officials have acknowledged that the State is not complying with federal law in the area of dental care, *supra* at 15, and they have conceded that a rate increase for dental services is needed, *supra* at 18. Nonetheless, for years, no rate increases have been forthcoming from the Legislature, thus making this litigation – and this preliminary injunction motion – necessary.

There are striking parallels between the evidence presented in this case and the evidence presented in cases from other federal courts that have issued preliminary or final injunctions in the children's Medicaid context. For example, in *Memisovski*, children's advocates put forth evidence just like that presented here, and, based on that evidence, the court concluded that Cook County was violating the Medicaid Act. A handful of examples are illustrative:

Finding of Fact in *Memisovski*	**Example of Evidence Presented in this Case**
"Medicaid reimbursement rates are . . . on average, significantly lower than private insurance reimbursement rates for the same pediatric service in Cook County." Finding of Fact No. 18.	Florida Medicaid's reimbursement rates for dentists are 29% of median dental fees, a minimum benchmark used by private insurers. Exh. 43 (Pl. Trial Exh. 418, Crall Report at 4–5.
"Pediatric practices throughout Cook County have closed to new Medicaid patients due to economic problems caused by a high Medicaid pediatric population and low Medicaid reimbursement rates[.]" Finding of Fact No. 30.	The State's own documents state that "[l]ow reimbursement rates" resulted in "the closure of primary care practices to new CMS patients." Exh. 36 (Pl. Trial Exh. 319, Provider Access Survey).
"Medicaid recipients must often engage in extensive efforts to locate dentists and pediatric primary and specialty care providers willing to accept Medicaid, including seeking referrals from state agencies or local charities, calling physicians listed in the phone book, and paying for care out of their own pockets." Finding of Fact No. 54.	AHCA's Secretary admitted that it takes "many hours of work and essentially pleading on bended knee" for children on Medicaid to obtain care, but that such efforts result in "unacceptable delays (which translate into poor quality scores and sometimes the patient's [sic] have to travel for many miles even across the state for care)." *Supra* at 10.

Finding of Fact in *Memisovski*	Example of Evidence Presented in this Case
"When IDPA has increased rates for office-based medical services, there has been a corresponding increase in the number of office-based services billed by providers." Finding of Fact. No. 59.	The State's own documents state that a 1995 increase in CHCUP fees from $30 to $64.82 resulted in an increase in participation from 32 percent to 64 percent. *Supra* at 14.
"Dr. Darling's analyses show that . . . a significant number [of Medicaid-enrolled children] – one-third or higher – did not receive any preventative health care at all." Finding of Fact No. 80.	Dr. Darling's analyses show that more than 380,000 Medicaid-enrolled children in Florida do not receive *any* well-child screening services. *Supra* at 11.
"Approximately 75% of Medicaid-enrolled children in Cook County did not receive a dental screening." Finding of Fact No. 108(d).	Florida ranks last in the nation, with only 21% of its Medicaid-enrolled children receiving any dental services. *Supra* at 15.

The evidence presented both here and in *Memisovski* establishes the link between inadequate reimbursement rates, inadequate provider networks, and inadequate access to Medicaid services. As the *Memisovski* court explained, "[t]he starting point for the issue of equal access must be the rates Illinois Medicaid pays to medical providers for providing services to Medicaid patients [because] [r]ates and equal access simply cannot be divorced." *Memisovski*, 2004 WL 1878332, at *42. The *Memisovski* court concluded that Illinois was violating the Medicaid Act's "equal access" mandate because "the rates paid by the Illinois Medicaid program are insufficient to entice medical providers to provide services to Medicaid patients." *Id.* And, with respect to the Medicaid Act's "reasonable promptness" and EPSDT requirements, the *Memisovski* court concluded that Illinois had "not established a Medicaid program designed to provide all EPSDT services to all Medicaid-eligible children on a timely basis." *Id.* at *56. The extensive evidentiary record before this court compels similar findings.

Similarly, in *Ark. Med. Soc. v. Reynolds*, 834 F. Supp. 1097 (E.D. Ark. 1992), the court entered a preliminary injunction after concluding that the plaintiffs were likely to succeed on the merits of their claims based on evidence similar to that before this Court:

> Nor does it appear that the level of the new reimbursement rates are [sic] adequate. Plaintiffs have produced evidence showing that the effective reimbursement rate is only slightly above 53% of what Blue Cross and Blue Shield's insured patients bring to the physician in terms of reimbursement. This is significant, particularly considering that the providers in this case have testified that their overhead ranges from 58% at the one clinic in Jonesboro to 65% for Doctors Finan and Maris. As many of the providers have so testified, there simply is not great economic incentive to accept Medicaid patients under the new reimbursement rates, and it does not appear at this time that these rates are sufficient to assure access to the extent that such care and services are available to the general population in the geographic area.

Id. at 1103 (internal quotation marks omitted). Here, too, Plaintiffs have shown that reimbursement rates pale in comparison to competitors' rates, that they often fail to cover providers' costs, and that they do not provide an economic incentive for doctors and dentists to see children on Medicaid. *Supra* at 11, 15–16. The *Reynolds* court entered a preliminary injunction to prevent the state from reducing its Medicaid reimbursement rates, finding that the plaintiffs had "produced substantial evidence showing that the . . . reimbursement rates are not sufficient to assure full participation by providers in many areas of the State[.]" *Id.* at 1103; *see also Long Term Care Pharm. Alliance v. Ferguson*, 260 F. Supp. 282 (D. Mass. 2003) (entering preliminary injunction where reimbursement rates fell below rates needed to ensure access to Medicaid services), *rev'd on other grounds*, 362 F.3d 50 (1st Cir. 2004). Likewise, here, a preliminary injunction is warranted because Plaintiffs have produced overwhelming evidence establishing a link between inadequate reimbursement rates, inadequate Medicaid provider networks, and inadequate access to Medicaid services.

Finally, in *Fogarty*, the court concluded that "[t]he record in this case demonstrates that [the Oklahoma Health Care Authority] has frequently set rates below the levels which OHCA admits are adequate to assure there are enough providers to serve Medicaid enrolled children." *Id.* at 1106. The exact same thing could be said of AHCA here for similar reasons:

Finding of Fact in *Fogarty*	**Example of Evidence Presented in this Case**
"OHCA has consistently requested funding from the Legislature to raise physician payment rates to 100% of the Medicare rates but the Legislature has consistently denied that request." Finding of Fact No. 22.	AHCA repeatedly has requested additional funding for children's Medicaid services, even warning, in the dental context, that "[a] fee increase for dental services is needed if services are to be available." *Supra* at 14, 19.
"The 2003 data show that only 18% of Oklahoma's office-based primary care pediatricians in private practice fully participate in Medicaid." Finding of Fact No. 46.	AHCA's own data show that only 15% of licensed dentists actively participate in Medicaid and that less than 9% are considered significant providers. *Supra* at 16.
"The lack of pediatricians denies children needed diagnostic and treatment services." Finding of Fact No 49.	"Low Medicaid fees for dental services contribute to access to dental care" and "[d]entist participation will continue to decline if the remuneration remains under their costs." *Supra* at 15, 19.
"Several physician specialists who treat children testified that they either do not participate in the Medicaid Program or limit their participation primarily due to low reimbursement rates, among other complaints." Finding of Fact. No. 109.	Several pediatric service providers testified that they do not participate in Medicaid or limit their participation because reimbursement rates are not competitive. *Supra* at 13, 18.
CMS-416 reports showed that Oklahoma's ESPDT participation ratio ranged from 27% to 40% during the years in question. Finding of Fact No. 138.	CMS-416 reports show that Florida's participation ratio for dental services is around 21%, the worst in the country. *Supra* at 15.

Just as the *Fogarty* court found a link between low reimbursement rates and inadequate access to care, here, too, the evidence shows that Florida Medicaid's reimbursement rates provide an insufficient incentive for providers to participate in the program and that children's access to Medicaid services is lacking as a result.

With respect to Plaintiffs' dental claims, additional legal support is found in official guidance issued by the federal agency responsible for administering the Medicaid system. *See* Exh. 54 (Pl. Trial Exh. 447, 1/18/01 Letter from U.S. Dep't of Health and Human Services); *see also Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581, 598 (1999) ("[T]he well-reasoned views of the agency implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." (citing *Skidmore v Swift & Co.*, 323 U.S. 134, 139–40 (1944)). The federal government has explained that "significant shortfalls in beneficiary receipt of dental services, together with evidence of Medicaid reimbursement rates that fall below the 50th percentile of providers' fees in the marketplace, create a presumption of non-compliance with both of these statutory requirements [*i.e.*, reasonable promptness and equal access]." *Id.* Both prongs of that test are satisfied here. First, Florida ranks last in the country, with more than 1.2 million children on Medicaid receiving no dental services at all. *Supra* at 15. The State's own witnesses have admitted that the first prong of the federal government's test is met:

> Q: Do you agree that there is a significant shortfall in beneficiary receipt of dental services?
>
> A: Yes, I would say that.

Exh. 3 (Trial Tr. at 2728 (Kidder)). Second, the evidence shows that Medicaid reimbursement rates are, at best 40%, and, at worst, 29% of dentists' median fees. *See* Exh. 43 (Pl. Trial Exh. 418, Crall Report at 4); Exh. 41 (Pl. Trial Exh. 84, 2007–08 Dental LBR).

To summarize, Plaintiffs are substantially likely to succeed on their claim that the State is violating the Medicaid Act with respect to children's medical services because the State completely ignores the Medicaid Act's mandates when it sets physicians' reimbursement rates, instead employing a conversion factor to achieve budget neutrality. Evidence of the link between inadequate reimbursement rates, inadequate provider networks, and inadequate access to care further confirms the State's non-compliance with federal law. Moreover, with respect to dental care, the same relationship between rates, dentists' participation, and children's access to dental services establishes that the State is violating the Medicaid Act, and that conclusion finds further support in the application of federal guidelines issued by the agency in charge of administering Medicaid.

II. MEDICAID-ELIGIBLE CHILDREN IN FLORIDA WILL CONTINUE TO SUFFER IRREPERABLE HARM IN THE ABSENCE OF A PRELIMINARY INJUNCTION.

To obtain a preliminary injunction, a plaintiff must show that he "will suffer irreparable harm in the absence of [the] injunction." *See Osmose, Inc.*, 612 F.3d at 1307–08. And, to demonstrate irreparable harm, a plaintiff must show that he has no adequate remedy at law, meaning that his injury cannot be undone through monetary relief. *See Touchstone v. McDermott*, 234 F.3d 1133, 1159 n.4 (11th Cir. 2000); *Special Purpose Accounts Receivable Co-op Corp. v. Prime One Capital Co.*, 125 F. Supp. 1093, 1104 (S.D. Fla. 2000). Where a class has been certified, the Court may consider the prospect of irreparable harm to class members in deciding whether to issue a preliminary injunction. *See, e.g., In re Managed Care Litig.*, 236 F.Supp.2d 1336, 1344 (S.D. Fla. 2002) (considering harm to class members in granting preliminary injunction); *Tefel v. Reno*, 972 F. Supp. 608, 619–20 (S.D. Fla. 1997) (same); *see also* 3 Newberg on Class Actions § 9:45 (4th ed.) ("In the civil rights field, it is common to find

an immediate need for preliminary injunctive relief . . . to afford relief on a timely basis. Such relief commonly is granted individually or classwide as appropriate[.]").

Here, the class consists of "all children under the age of 21 who now, or in the future will, reside in Florida and who are, or will be, eligible under Title XIX of the Social Security Act for [EPSDT] Services." D.E. 671, Class Cert. Order at 8–9. There can be no question that such children suffer irreparable harm when they do not timely receive preventative care or necessary medical or dental treatment. *See, e.g.*, *Mitson v. Coler*, 670 F. Supp. 1568, 1577 (S.D. Fla. 1987) ("[T]he Plaintiff class will suffer irreparable injury unless an injunction issues in that many of the class members will otherwise be deprived of essential medical care either in whole or in part."); *Julia M. v. Scott*, 498 F.Supp.2d 1245, 1248 (W.D. Mo. 2007) ("A potential lapse in medical coverage for the children of the working poor who are otherwise unable to pay for needed medical attention is an irreparable harm of the highest order."). The State's own documents effectively concede this point, explaining that, if children are denied early identification and treatment services, their medical conditions can "become serious and disabling," Exh. 37 (Pl. Trial Exh. 703, 2006-07 CHCUP LBR), and that "untreated dental problems can lead to serious health conditions and hospitalizations," Exh. 55 (Pl. Trial Exh. 350, Florida Kid Care Coordinating Council 2008 Annual Report and Recommendations). The record is now replete with evidence of continuing – and worsening – Medicaid provider shortages and resultant problems with children's access to health care services. *Supra* at 10–19.

Courts across the country have entered injunctions in the health care context, recognizing that a lack of access to health care services poses a significant threat because children "cannot later go back and get health services which have been denied them." *Winkler v. Interim Servs., Inc.*, 36 F.Supp.2d 1026, 1033 (M.D. Tenn. 1999) (preliminarily enjoining a health care services

provider from discontinuing services to Medicare beneficiaries when they were "dumped" due to changes in Medicare reimbursement rules); *see also Memisovski*, 2004 WL 1878332, at *21 ("Preventive health care, early treatment of acute illnesses, and amelioration of chronic illnesses early in life may prevent more costly and personally challenging health problems later."); *Martinez v. Schwarzenegger*, No. 09–02306, 2009 WL 1844989, *5 (N.D. Cal. June 26, 2009) (enjoining a law that would cut an in-home service providers' wages, finding irreparable harm to the disabled individuals who would be without assistance as a consequence); *In re Healthmaster Home Health Care, Inc.*, No. 95–10548, 1995 WL 928920, *2–3 (S.D. Ga. April 13, 1995) ("There will undoubtedly be irreparable injury to the 12,000 Medicare beneficiaries currently receiving health care services from [the provider] if those services are terminated[.]"); *Indep. Living*, 572 F.3d at 644 (upholding preliminary injunction enjoining state from implementing a ten percent reduction in payments under the Medicaid fee-for-service program for physicians and dentists). In Florida, systemic problems with the State's Medicaid system are causing hundreds of thousands of children to go without the medical and dental care they need. *Supra* at 11, 15.

In addition to the irreparable harms caused by denials of medical and dental services, an "actual or threatened injury may exist by virtue of statutes creating legal rights, the invasion of which creates standing." D.E. 541 at 4 (internal quotation marks omitted). Thus, Plaintiffs face a "realistic danger" of future harm resulting from the State's continuing non-compliance with the Medicaid Act. *See* D.E. 541 at 6 (citing *Fla. State Conf. of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1161 (11th Cir. 2008)). The State's top officials have admitted that the State is violating the Medicaid Act, yet the Florida Legislature repeatedly has ignored AHCA's repeated requests for funding to make necessary increases to the Medicaid reimbursement rates. *Supra* at 10, 14, 15, 19. This Court has noted that "[t]his case is about the alleged systemic problem of delay and

denial of health care." D.E. 541 at 7. Without an injunction requiring the State to address those systemic problems, children's rights under the Medicaid Act will continue to be violated daily in Florida.

III. THE HARMS SUFFERED BY FLORIDA'S MEDICAID-ELIGIBLE CHILDREN IN THE ABSENCE OF A PRELIMINARY INJUNCTION WOULD FAR EXCEED THE HARMS, IF ANY, SUFFERED BY THE STATE IF THE INJUNCTION ISSUES.

Not only are Florida's Medicaid-eligible children suffering irreparable harm, but that harm is growing more palpable with each passing day as conditions within the Florida Medicaid system continue to deteriorate. Reimbursement rates are falling further and further behind providers' costs, not to mention inflation. *Supra* at 12, 16. While enrollment in the Medicaid program is rising, providers' participation is declining. *Supra* at 17. Medicaid-eligible children in Florida lack adequate access to health care services, and, in the absence of a preliminary injunction, that state of affairs is only going to get worse.

The State should not be heard to complain of any countervailing "harm" were the preliminary injunction to issue. The State would be enjoined from operating its children's Medicaid program in contravention of the Medicaid Act pending a final judgment by this Court. Being required to follow the law does not constitute "harm," and courts have "repeatedly recognized that individuals' interests in sufficient access to health care trump the State's interest in balancing its budget." *Dominguez v. Schwarzenegger*, 596 F.3d 1087, 1098 (9th Cir. 2010), *cert granted in part on other grounds sub nom*, --- S. Ct. ---, 2011 WL 134273 (Jan. 18, 2011); *see also Todd by Todd v. Sorrell*, 841 F.2d 87, 88 (4th Cir. 1988) (reversing denial of preliminary injunction where "the harm to the Commonwealth, while it may not have been negligible, was measured only in money and was inconsequential by comparison" to child's health care needs); *Mitson*, 670 F. Supp. at 1577 (S.D. Fla. 1987) (granting preliminary injunction against Florida

Medicaid program and finding "that the threatened injury, in human terms, outweighs whatever damage, in financial terms, the injunction may cause the state."); *McDaniel v. Betit*, No. 96–CV–00405, 1996 WL 426816, *2 (D. Utah May 17, 1996) (granting preliminary injunction against state's Medicaid program where "the balance of harm between the Plaintiff and the State is a balance of plaintiff's life against money to be expended by the state").

Although this is a time of fiscal difficulty for Florida and other states, it is imperative that the State's budget not be balanced on the backs of its youngest and most vulnerable citizens. This is doubly true when it is widely acknowledged that expenditures on the children's Medicaid program are as cost-effective as any the State could make. As AHCA has explained to the Florida Legislature, the return on investments in children's health care services is substantial because increasing access to services "increase[s] the early identification of medical conditions before they become serious and disabling [and] thereby decreas[es] future costly treatment services." *Supra* at 14; *see also* Exh. 57 (Pl. Trial Exh. 509 at 31, Medicaid Policy and the Substitution of Hospital Outpatient Care for Physician Care ("[W]here states have . . . constrain[ed physician] payment rates they appear to have suffered an increase in outpatient [emergency room] service use as a result."); Exh. 58 (Pl. Trial Exh. 31 at 24, Family Café Child Health Check-Up (children who receive check-ups are far less likely to require emergency room visits or inpatient hospital stays). Moreover, for every one dollar Florida invests in its children's Medicaid program, the federal government matches about $1.20. *See* Exh. 47 (Pl. Trial Exh. 682, 2009 KidCare Coordinating Council Recommendations at 6). In other words, Florida can purchase $100 in children's medical services for just $44.60 because the federal government will cover the balance. If Florida were to increase physicians' Medicaid reimbursement rates to Medicare levels and to increase dentists' reimbursement rates to the 50th percentile of usual and

customary charges, the State would receive more than $280 million in federal funds and would only have to increase its own Medicaid outlays by around $230 million, or approximately 2% to 3% of its annual share for the program. *See* Exh. 24 (Pl. Trial Exh. 685, HB 329 AHCA Bill Analysis); *see also* Exh. 56 (1/13/11 Bradford Presentation to House HHS Committee at 5 (*see* www.fdhc.state.fl.us/Medicaid/deputy_secretary/ recent_presentations)).

IV. A PRELIMINARY INJUNCTION WOULD SERVE THE PUBLIC INTEREST.

"[T]he public interest will not only *not* be harmed by the issuance of this injunction, but will be substantially benefitted in that" Florida's children will receive improved access to important Medicaid services. *Mitson*, 670 F. Supp. at 1577. There can be little question that the public interest "is overwhelmingly served" by efforts to ensure that health care services are made available to poor children. *Julia M.*, 498 F.Supp.2d at 1250. As discussed above, funding the children's Medicaid program serves the public interest because it reduces more costly expenditures in the future and because it triggers matching investments from the federal government. *Supra* at 14, 33. That improving children's access to Medicaid services advances the public interest is evident from AHCA's own efforts. Presumably, AHCA would not spend years pleading with the Florida Legislature to increase funding for children's Medicaid services if AHCA thought that such funding increases were inimical to the public interest. As then-Secretary Agwunobi said in a public speech in 2007:

> Access to care is the foundation for a family's happiness, well-being, and productivity. It is also a foundation for the prosperity and strength of any community, state, or nation. Winston Churchill put it well when he said, "There is no finer investment for any community than putting milk into babies. Healthy citizens are the greatest asset any country can have."

Exh. 28 (Pl. Trial Exh. 125, Agwunobi Speech); Exh. 27 (Pl. Trial Exh. 126, DVD of Dr. Agwunobi's Speech).

CONCLUSION

Plaintiffs ask this Court to enter a preliminary injunction that will **(1)** enjoin AHCA from relying upon a budget neutral conversion factor when setting Medicaid reimbursement rates for physicians' services and require AHCA to set those reimbursement rates in accordance with the mandates of 42 U.S.C. §§ 1396a(a)(8), (a)(10), and (a)(30)(A) (or, alternatively, to affirmatively require AHCA to raise the Medicaid reimbursement rates for children's physician services to 100% of Medicare rates, *see supra* at 4 n.2); and **(2)** require AHCA to set the Medicaid reimbursement rates for children's dental services at least the 50th percentile of dentists' usual and customary charges. These preliminary measures are necessary to protect Florida children's civil rights under the Medicaid Act pending final resolution of this lawsuit.

Dated: March 8, 2011

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on March 8, 2011, I electronically filed the foregoing document with the Clerk of the Court by using the CM/ECF system and that the foregoing document is being served this day on all counsel of record identified below via transmission of Notice of Electronic Filing generated by CM/ECF.

s/ Stuart H. Singer
Stuart H. Singer

SERVICE LIST

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

Case No. 05-23037-CIV-JORDAN/McALILEY
United States District Court, Southern District of Florida

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