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

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

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

Plaintiffs,

vs.

LIZ DUDEK, et. al.,

Defendants.

AMENDED FINDINGS OF FACT AND CONCLUSIONS OF LAW[1]

This is a class and representative action in which plaintiffs seek declaratory and injunctive relief from Florida officials responsible for the state's Medicaid program. Plaintiffs contend that the Florida Medicaid program has failed to provide Florida children with access to medical and dental care in accordance with the EPSDT, Reasonable Promptness, Equal Access, or Outreach requirements under the Medicaid Act, 42 U.S.C. § 1396 *et seq.*

I. PROCEDURAL HISTORY

This action was initiated in 2005 by the Florida Pediatric Society, the Florida Association of Pediatric Dentists, and on behalf of a number of individual children in the Medicaid program by their parents or legal guardians. The suit was brought against the Secretary of the Florida Agency for Health Care Administration ("AHCA"), the Secretary of the Florida Department of Children and Family

[1] All amendments to the prior findings of fact and conclusions of law are in **bold** type.

Services ("DCF"), and the Surgeon General and agency head of the Department of Health ("DOH"), in their official capacities.[2] AHCA "is designated as the single state agency authorized to make payments" for covered medical goods and services under Title XIX of the Social Security Act, to the extent that such services are provided to eligible individuals by qualified Medicaid providers. *See* Fla. Stat. § 409.902. DCF is responsible for making Medicaid eligibility determinations under Florida law. *See* Fla. Stat. § 409.963. DOH has been delegated the responsibility to administer the Children's Medical Services ("CMS") program, which is responsible for ensuring that Medicaid children with special health care needs receive Medicaid services.[3] Fla. Stat. §§ 391.016, 391.021(3), 391.026.

Plaintiffs' second amended complaint alleged various violations of the federal Medicaid statutes, arguing those statutes provide them a private right of action under 42 U.S.C. § 1983. Specifically, the second amended complaint alleged violations of (1) 42 U.S.C. § 1396a(a)(8) and (a)(10), requiring that children receive medical and dental services known as the Early Periodic Screening Diagnosis and Treatment ("EPSDT") ("EPSDT Requirements"), and to do so with reasonable promptness (Count I) ("Reasonable Promptness"); (2) 42 U.S.C. § 1396a(30)(A), requiring that rates for reimbursing medical and dental providers be set, *inter alia*, so as to secure access to care for children that is equal to that of other children in the same geographical area (Count II) ("Equal Access"); (3) 42 U.S.C. § 1396u-2(b)(5) regarding HMOs (Count III); and (4) 42 U.S.C. § 1396a(a)(43) requiring that the states conduct outreach programs to inform individuals determined to be eligible for Medicaid of the availability of services

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[2] For shorthand, I will sometimes refer to the agencies as defendants in this Order.

[3] "'Children with special health care needs' means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who also require health care and related services of a type or amount beyond that which is generally required by children." Fla. Stat. § 391.021(2) (2009).

and to insure such patients requesting those services are able to receive them (Count IV) ("Outreach").

Defendants filed a motion to dismiss all four counts, arguing that the Medicaid Act did not provide privately enforceable rights permitting such actions to be enforced under 42 U.S.C. § 1983. On January 11, 2007, I denied the motion to dismiss as to three of the four claims, dismissing Count III because I found that no enforceable right exists under § 1396u-2(b)(5). D.E. 40.

Following discovery, the issue of class certification was referred to U.S. Magistrate Judge McAliley for a report and recommendation. On July 30, 2008, Magistrate Judge McAliley recommended that certain additional plaintiffs be permitted to intervene. I affirmed that ruling as to K.V., S.C., K.S., and S.B. only. D.E. 268. Magistrate Judge McAliley, following briefing and argument, found the requirements of Rule 23 satisfied in an extensive report and recommendation. D.E. 613. After further briefing and argument, I overruled defendants' objections and certified a class for declaratory and injunctive relief consisting of all Florida children eligible for EPSDT services under the Medicaid Act. D.E. 671. As part of that decision, I found that at least one named plaintiff had standing to advance each of the three remaining counts with respect to each of defendants. *See* Class Certification Order. D.E. 671, p. 3-5. Defendants filed a request for interlocutory review of the class certification order, which was denied by the Eleventh Circuit on December 1, 2009.

Prior to trial, defendants filed a motion for summary judgment arguing that the Medicaid statutes failed to provide a private right of action and that none of plaintiffs had standing. I denied this motion on September 30, 2009. D.E. 672. Trial began on December 9, 2009, consisted of 94 trial sessions, and ended in January of 2012. Following the close of the evidence, the parties submitted proposed findings of fact and conclusions of law and presented closing arguments

on March 26-27, 2012. These findings relate to defendants' liability and plaintiffs' entitlement to declaratory relief. Federal jurisdiction exists under 28 U.S.C. § 1331, § 1343(a)(3) and § 1343(a)(4), as this is a civil action under §1983 for declaratory and injunctive relief under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*.[4]

II. SUMMARY OF PARTIES' POSITIONS ON ISSUES TRIED

Plaintiffs contend that the Florida Medicaid program has failed to provide Florida children with access to medical and dental care in accordance with the EPSDT, Reasonable Promptness, Equal Access, or Outreach requirements under the Medicaid Act. Plaintiffs allege that a number of structural, financial, and administrative barriers result in children not receiving the access to care to which they are entitled to under federal law. Plaintiffs categorize these violations into six categories:

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

Second, plaintiffs contend that Florida has violated the federal Medicaid Act by wrongly terminating thousands of young children from eligibility who were in fact entitled to "continuous eligibility." Moreover, when eligibility was restored, these children were often "switched" to a different primary provider than the one

[4] As the parties have agreed, an additional hearing on the issue of injunctive relief will be held at a later date.

whom the parent had initially selected. Plaintiffs contend these issues affect tens of thousands of Medicaid children each year, who are denied their rights to EPSDT services and their right to receive such care with reasonable promptness.

Third, plaintiffs argue the children are not receiving the primary care to which they were entitled under the EPSDT Requirements, as evidenced by the fact that hundreds of thousands of children do not receive any preventative health care according to the official EPSDT reports submitted to the federal government. Moreover, the percentage of children receiving certain aspects of preventative health care, such as lead blood screens, was extremely low. Plaintiffs point to legislative budget requests ("LBRs") that AHCA has submitted to the legislature calling for increases in reimbursement for child health check-ups, blood lead screening and outreach, as evidence that Florida's program was not in compliance with federal law.

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

Fifth, plaintiffs contend that Florida fails to provide children with access to dental care, which is one of the EPSDT Requirements under the Medicaid Act. They point to official government reports showing Florida was ranked the worst state in the country with only 21% of children on Medicaid receiving dental care.

Plaintiffs argue that low reimbursement rates for Florida dentists who accept Medicaid children were the principal reason for this failure. As a result, they argued, many dentists refused to treat Medicaid children.

Sixth, plaintiffs contend that the state has violated § 1396a(a)(43) by using an application form that was unnecessarily complex and eliminating the statewide outreach program designed to inform Medicaid-eligible children of their rights to services. Plaintiffs argue that over 250,000 Florida children are eligible for but not enrolled in the Medicaid program.

Defendants argue that the named plaintiffs lack standing because they did not have a problem receiving needed care and face no reasonable prospect of a future denial of care. Defendants further object to the certification of a class on multiple legal grounds, including that plaintiffs have failed to demonstrate adequate evidence of injury. Defendants also contend that the relevant federal Medicaid statutes do not create enforceable private rights of action. They argue the statutes lack clarity as to the meaning of "reasonable promptness" and "medical assistance."

As to the merits, defendants argue no systemic problems existed in the Florida Medicaid program. Defendants maintain that children who needed care were able to receive it. Indeed, defendants argue, plaintiffs failed to prove any injuries for some claims such as outreach to the uninsured, difficulties in applying for Medicaid, and issues with continuous eligibility or delays in activation of newborns.

With regard to any delays in receiving medical care, defendants argued that delays were not closely connected to defendants' custom or policy, nor that the delays were widespread and pervasive enough to support a finding of a custom or class-wide liability. Defendants further contended that plaintiffs' position was based on overstated statistical and unreliable anecdotal information.

Defendants assert that plaintiffs failed to prove they were harmed by low provider reimbursements. They contend that AHCA's prior LBRs are not adequate evidence that program funding was so low it violated federal law. Defendants similarly claim that surveys of the state's problems in accessing specialist care are inaccurate. They argue there is no reliable proof to show the availability of care in a geographic region. They fault plaintiffs for failing to provide a quantitative analysis or benchmarks against which the court could compare access to Medicaid with access to private insurance. Instead, they argue that plaintiffs' proof consists of isolated anecdotes that fail to support their claims.

In addition, defendants argued that the state now does a better job through managed care and other initiatives in making sure children receive access to care, claiming that the record shows abundant outreach by the state and its partners. They argue improvements have occurred, such as a recent increase in dental reimbursement.

III. THE NAMED PLAINTIFFS AND STANDING

A. Legal Requirements for Standing

To prosecute a case as a class action, "the named plaintiffs must have standing[.]" *Vega v. T-Mobile USA Inc.*, 564 F.3d 1256, 1265 (11th Cir. 2009) (citations omitted). For a plaintiff to have Article III standing:

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

Bloedorn v. Grube, 631 F.3d 1218, 1228 (11th Cir. 2011) (citations omitted). "In essence, the question of standing is whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues." *Warth v. Seldin*, 422 U.S. 490, 498 (1975).

Plaintiffs bear the burden of establishing the elements of standing. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992). Since standing is not a "mere pleading requirement[] but rather an indispensable part of the plaintiff's case, each element must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, *i.e.*, with the manner and degree of evidence required at the successive stages of the litigation." *Id.* (citations omitted). Thus, at trial, plaintiffs must set forth specific facts to prove standing. *Id.* And if controverted, those facts "must be supported adequately by the evidence adduced at trial." *Id.* (citation omitted).

Where a plaintiff seeks only prospective relief, as is the case here, he must prove not only harm, but also "a 'real and immediate threat' of future injury in order to satisfy the 'injury in fact' requirement." *Koziara v. City of Casselberry*, 392 F.3d 1302, 1305 (11th Cir. 2004) (citations omitted). In other words, he "must show a sufficient likelihood that he will be affected by the allegedly unlawful conduct in the future." *Id.* "To be likely enough, the threatened future injury must pose a 'realistic danger' and cannot be merely hypothetical or conjectural. How likely is enough[,] is a necessarily qualitative judgment." *Florida State Conference of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1161 (11th Cir. 2008).

An injury "may exist solely by virtue of 'statutes creating legal rights, the invasion of which creates standing[.]'" *Warth*, 422 U.S. at 500. As I have explained in my prior rulings, D.E. 541 and 671, the alleged injuries in this case are the delay and denial of healthcare and the lack access to medical services and information. D.E. 541 at 6-7. These injuries, I now find, resulted from defendants'

failure to satisfy their statutory obligations under the Medicaid Act. Specifically, as will be discussed more fully below in the findings of fact, defendants have engaged in several unlawful policies and practices, including: (1) failing to provide children with continuous eligibility as required by law; (2) switching children from one Medicaid program to another without their parents' knowledge or consent; and (3) failing to comply with Medicaid's equal access mandate by setting reimbursement rates so low that doctors refuse to participate in the Medicaid program.

Continued exposure to these policies and practices is sufficient to satisfy the injury-in-fact requirement. To prove a real and immediate threat of future injury, plaintiffs need only show that "the anticipated injury [will] occur with[in] some fixed period of time in the future, not that it [will] happen in the colloquial sense of soon or precisely within a certain number of days, weeks or months." *Browning,* 522 F.3d at 1161.

Moreover, as the Eleventh Circuit has recognized, when future injuries are the result of an injurious policy, as opposed to random unauthorized acts, "it is significantly more likely that the injury will occur again." *31 Foster Children v. Bush*, 329 F.3d 1255, 1266 (11th Cir. 2003); *see also Church v. City of Huntsville*, 30 F.3d 1332, 1339 (11th Cir. 1994) (holding that plaintiffs had standing where they "alleged that it is the custom, practice, and policy of the City to commit the constitutional deprivations of which they complain"). Because plaintiffs are unable to "avoid future exposure to the challenged course of conduct in which the [government] . . . engages," *id.* at 1338, the injury-in-fact requirement of standing is satisfied.

Plaintiffs have also demonstrated the second element of standing—causation. To prove causation, plaintiffs must show that their prospective harms are "fairly traceable" to defendants' non-compliance with the Medicaid Act. *See*

Sicar v. Chertoff, 541 F.3d 1055, 1059 (11th Cir. 2008). Here, there is a direct connection between defendants' failure to properly discharge their statutory duties and plaintiffs' injuries.

The Florida legislature designated AHCA "as the single state agency authorized to make payments for medical assistance and related services under" the Medicaid Program. Fla. Stat. § 409.902(1). It is responsible for assigning managed care providers and primary providers to Medicaid patients. AHCA is also tasked with setting reimbursement rates to Medicaid providers. *Id.* at § 409.908. The reimbursements must be "consistent with efficiency, economy, and quality of care and [must be] 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." 42 U.S.C. § 1396a(a)(30)(A).

DCF is responsible "for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility." Fla. Stat. § 409.902(1). In essence, DCF is responsible for any changes made to a Medicaid recipients' eligibility status.

DOH, through its Children's Medical Services ("CMS") program, must "[p]rovide essential preventive, evaluative, and early intervention services for children at risk for or having special health care needs, in order to prevent or reduce long-term disabilities." *Id.* at § 391.016(2). In administering the CMS program, DOH's duties are, among other things, to: (1) "provide or contract for the provision of health services to eligible individuals;" (2) "determine the medical and financial eligibility of individuals seeking health services from the program," *id.* at § 391.026(1), (3), (9); and (3) "reimburse healthcare providers for services

rendered through the [CMS] network[.]" *Id.* at § 391.045(1). Like AHCA, DOH must establish reimbursements rates that will encourage providers of health services to participate in Medicaid. *See* 42 U.S.C. § 1396a(a)(30)(A).

All three defendants bear the responsibility of informing Medicaid recipients of their rights to certain services under the Medicaid program. *See id.* at § 1396a(a)(43)(A).

The factual record indicates that plaintiffs' injuries are fairly traceable to defendants' failure to satisfy these statutory obligations. I find that several of the named plaintiffs experienced delay in receiving, or complete denial of, medical services because defendants did not provide continuous eligibility as required by law. Defendants have also erroneously "switched" some of the named plaintiffs from one Medicaid plan to another without the patient's knowledge or consent, which also caused delays or denials in the provisioning of healthcare.

I further find that plaintiffs experienced insufficient access to medical care because AHCA's and DOH's reimbursement rates are so low that they fail "to enlist enough providers so that care and services are available . . . at least to the extent that [they] are available" to those with private insurers. 42 U.S.C. § 1396a(a)(30)(A). Moreover, I find that defendants did not inform plaintiffs of services that are available to them, which resulted in several of the named plaintiffs being unable to take advantage of medical services to which they are entitled. The evidence presented at trial makes clear that plaintiffs' injuries are directly attributable to defendants' unlawful conduct.

With respect to redressability, "there is ordinarily little question" that where government action has caused a plaintiff's injury, "a judgment preventing or requiring the action will redress it." *Lujan*, 504 U.S. at 561-62. Redressability here is inherent in a declaration, and if necessary, an injunction, against future terminations of continuous eligibility or switching, or requiring the elimination of

barriers to enrollment and receipt of service, such as in the Florida ACCESS application or low reimbursement rates.

Previously, in a pre-trial ruling, I found that plaintiffs do not have standing to bring Count II (lack of access to medical care) against the head of DCF because they failed to meet the causation requirement. D.E. 541 at 8. DCF has no authority to set or modify Medical reimbursement rates. By law, the responsibility for settings rates resides in AHCA and DOH. *See* Fla. Stat. §§ 409.908; 391.045.

I further found that plaintiffs do not have standing to sue DOH for purposes of Count IV. D.E. 541 at 18. DOH has engaged in extensive outreach activities to ensure that eligible children living in each of the named plaintiffs' counties were referred to CMS for a determination of client eligibility.

In addition, I found that three named plaintiffs have standing to assert the claims alleged in this case. I concluded that: (1) S.M. has standing to assert Counts I against AHCA and DCF and Count IV against AHCA; (2) J.S. has standing to raise Count II against AHCA; and (3) T.G. has standing to pursue Counts I and II against DOH. D.E. 541 and 671.

Generally, if at least one named plaintiff has standing to assert each of the claims raised, a court need not analyze whether the remaining named plaintiffs have standing. *See Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.,* 648 F.3d 1235, 1243-44 (11th Cir. 2011) (finding that "[t]he law is abundantly clear that so long as at least one plaintiff has standing to raise each claim—as is the case here—we need not address whether the remaining plaintiffs have standing" and collecting cases.), *aff'd in part, rev'd in part sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius,* 132 S. Ct. 2566 (2012).

To preserve an adequate record for appeal, however, I will at this time analyze standing for all the named plaintiffs in this case.

B. The Named Plaintiffs

Previously, I ruled that S.M. had standing to proceed against AHCA and DCF. D.E. 541 at 4-9. I continue to adhere to my ruling, except with respect to Count IV against DCF. I find that S.M. no longer has standing to pursue Count IV against DCF given the recent expiration of § 409.9122(2)(c) of the Florida Statutes, which delegated to DCF certain outreach and informational responsibilities.

S.M. was "switched" from one Medicaid program to another without his mother's knowledge or consent. Because his doctor was not a participant in the new Medicaid plan, S.M. was unable to obtain his EPSDT screening, a critical appointment, at 18 months of age. S.M.'s screening was delayed for two months while his mother attempted to switch him back to his initial plan. This delay exposed S.M. to health risks.

On another occasion, S.M. was unable to take a lead blood screening test because the laboratory would take three hours to reach by bus, round trip. S.M.'s mother was unaware that she was entitled to free transportation services through Medicaid. Furthermore, S.M.'s mother was never informed that she was entitled to dental services. S.M.'s doctor was unable to recommend a dentist that would treat S.M. S.M.'s mother called several dentists who purported to accept Medicaid but was unable to find a dentist willing to treat her son.

S.M.'s injuries were the result of defendants' failure to comply with their statutory duties and, due to his continuous exposure to defendants' policies and practices, is substantially likely to experience these types of injuries in the future. **As such, he has standing to assert Count I against DCF and AHCA and Count IV against AHCA only.**

L.C. has standing to assert Count II against ACHA. L.C.'s psychologist recommended that he receive intense psychological services, including weekly play therapy, because of his severe behavioral issues. His psychiatrist would not

provide the therapy because she did not accept Medicaid. L.C.'s mother took him to Peace River Center ("Peace River" or "PRC"), the exclusive Medicaid mental health provider in L.C.'s area. PRC, however, was unable to provide play therapy, or any other type of therapy, on a weekly basis because the clinic had an unreasonable caseload.

L.C.'s mother had to pay out-of-pocket to provide her son with the proper care. **AHCA failed to satisfy its duty to ensure that a sufficient amount of psychologists that accepted Medicaid was available in L.C.'s area. As a result, AHCA is responsible for L.C.'s lack of access to medical care. There is a realistic danger that L.C. will not have equal access to psychiatric services in the future as compared to those that are privately insured because AHCA has a policy of setting inadequate reimbursement rates.**

K.K. has standing to bring Count I against DCF and AHCA and Counts II and IV against AHCA. After discussing the advantages of Staywell with one of its representatives, K.K.'s mother, A.D., voluntarily switched K.K to Staywell's insurance plan. Subsequently, A.D. took K.K. to the emergency room because his ear started to bleed. The emergency room advised A.D. to take K.K. to his then-current ENT specialist, Dr. John Donaldson, the following day so that K.K's ear could be drained. Upon making an appointment with the ENT specialist, A.D. was informed that Dr. Donaldson did not accept Staywell's insurance.

A.D. contacted Staywell to inquire about an ENT specialist in her area and was referred to a Staywell-affiliated doctor in Sarasota, which is located approximately two hours away from her home near Fort Meyers. Dr. Donaldson agreed to see K.K. later that day, at the risk of not receiving payment. Staywell did not have a sufficient amount of ENT specialists on its panel in the metropolitan area of Fort Myers. **This is a result of AHCA's failure to set sufficient reimbursement rates as required by 42 U.S.C. § 1396a(a)(30)(A).**

In another example, in 2010 K.K was not eligible for Medicaid because his mother's income exceeded eligibility requirements. In 2011, A.D. lost her job and once again enrolled K.K. in Medicaid. A.D selected MediPass as her son's plan. Without A.D.'s knowledge or consent, however, Medicaid assigned Staywell as K.K.'s provider. Staywell would not approve K.K. for his then-current medication, Vyvance, a drug necessary to control his behavioral issues. Before Staywell would approve the prescription, it required that K.K first try and fail on Adderall.

After K.K. took Adderall, his conduct significantly deteriorated, which had an adverse effect on his performance at school. Once A.D. was able to get K.K reassigned to MediPass, he was able to resume the proper medication. AHCA and DCF's failure to properly assign K.K. to the correct Medicaid plan resulted in an unreasonable delay in receiving the appropriate prescription. K.K is likely to experience these injuries again because defendants have switched Medicaid patients without their consent.

N.G. also has standing to pursue Counts I and II against DOH. Ms. Rita Gorenflo, N.G.'s adoptive mother, tried to obtain an emergency appointment for N.G. because he had severe pain in his ear. It was imperative for N.G. to receive treatment immediately due to his compromised immune system, which made him susceptible to infection. Initially, Ms. Gorenflo was informed that the next available appointment would be in six months. After numerous phone calls, an ENT finally treated N.G. five days after Ms. Gorenflo sought an appointment. This unreasonable delay in the provision of health services placed N.G.'s health at significant risk. Just as the other named plaintiffs in this case, N.G. is likely to suffer this type of delay in the future because DOH frequently fails to provide sufficient specialty services to Medicaid patients. **Additionally, DOH fails to provide Medicaid patients with equal access to care because privately insured**

patients suffering from the same symptoms are able to see an ENT either the same day or at the latest, the following day.

In my prior ruling on J.S., I focused on whether she had standing to bring Count II against AHCA. I find again that she does. The evidence, summarized below in Part VI, Section E, shows that children on Medicaid throughout Florida have difficulty accessing specialty care, and often must wait considerable periods or travel significant distances to obtain such care. J.S.'s experiences with Medicaid are no different.

Three times in the last 10 years or so, J.S. has broken her ankle or wrist, gone to the emergency room, and been directed to see an orthopedist for follow-up care. In all three instances, she had difficulty, in varying degrees, locating an orthopedist who would agree to treat her as a Medicaid patient. The evidence adduced at trial shows that J.S. faces a "realistic danger" of not being able to obtain equal access to specialty care, as compared to children with private insurance. *See Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979). **Many specialty providers currently do not participate in Florida Medicaid or sharply curtail their participation because of AHCA's low reimbursement rates.**

Likewise, N.V. is likely to experience future delays or denial of medical services and thus has standing to raise Counts I and II against AHCA. N.V. was diagnosed with Shwachman Diamond Syndrome, which causes pancreatic insufficiency and tooth decay. N.V.'s dentist refused to continue treating him because he needed caps. The dentist informed N.V.'s mother that Medicaid would not pay for a replacement if he lost a cap and it would be difficult to find anyone to perform the work through Medicaid. N.V.'s mother called several dentists in her area but did not find anyone who would accept Medicaid to perform the work.

Eventually, one month later, she was referred to a dentist two hours from her home that was willing to accept Medicaid.

In another instance, N.V. experienced trouble comprehending in school due to his illness. N.V. was referred to two neuropsychologists who accepted Medicaid but was not able to be treated until two months after his mother first sought the initial appointment. Again, AHCA's practice of reimbursing doctors at low rates is the cause for these delays in the receipt of medical care. As long as N.V. is eligible for Medicaid, there is a substantial likelihood that he will not receive timely care.

I also find that J.W. has standing to bring Count I against AHCA and DCF.[5] J.W.'s oncologist recommended a CT scan for the purpose of detecting whether J.W.'s cancer had spread from his leg to his neck. AHCA and DCF switched J.W.'s primary care physician, which prolonged J.W.'s ability to obtain authorization for the CT scan. Five weeks after the initial request for authorization, the oncologist conducted the CT scan. The scan revealed that J.W.'s cancer had spread and infiltrated to his spinal cord. As explained above, AHCA and DCF are responsible for improper switching. J.W. is likely to be, and indeed has been, switched again and experience significant delays in the provision of healthcare.

I previously found that T.G. had standing to assert Counts I and II against DOH. D.E. 541 at 13-17. T.G. is now deceased, however, and is no longer subject to future injury. *See Bowen v. First Family Fin. Servs., Inc.*, 233 F.3d 1331, 1340 (11th Cir. 2000) (finding that plaintiffs only have standing if they can allege the

[5] Previously, defendants argued that J.W.'s claims were moot because he was temporarily ineligible for Medicaid based on the fact that he was incarcerated in a high risk facility in November of 2011. *See* D.E. 1062. Since filing this motion, the parties have filed a joint stipulation of facts stating that J.W. was released from the high risk facility on April 16, 2012 and was subsequently approved for Medicaid. *See* D.E. 1190. Thus, J.W.'s claims are not moot.

possibility of a *future* injury). Because this is an action for prospective relief only, T.G. does not have standing and is dismissed as a named plaintiff.

I also find that N.A. does not have standing to sue defendants in this case. N.A. has a history of significant respiratory issues and awoke one morning coughing and congested. N.A.'s mother, C.R., called N.A.'s pediatrician to schedule an appointment but was told that N.A. had been switched to a new pediatrician under a different Medicaid plan. Although defendants improperly switched N.A., he did not suffer any meaningful delay in receiving care as a result of the reassignment. N.A.'s pediatrician agreed to treat him the same morning, despite the insurance issues. Similarly, later that day C.R. had to pay $70 out-of-pocket because the pharmacy was unable to process her Medicaid number. C.R., however, was reimbursed the next business day once the problem was resolved. N.A. did not experience any delay or denial of services because he was switched to another provider. Accordingly, he does not have standing and is dismissed as a named plaintiff in this case.

In sum, I find the following named plaintiffs have standing:

- **S.M. has standing to assert Count I against AHCA and DCF and Count IV against AHCA;**
- **L.C. has standing to assert Count II against AHCA;**
- **K.K has standing to assert Count I against DCF and AHCA and Counts II and IV against AHCA;**
- **N.G. has standing to assert Counts I and II against DOH;**
- **J.S. has standing to assert Count II against AHCA;**
- N.V. has standing to assert Counts I and II against AHCA; and

- J.W. has standing to assert Count I against AHCA and DCF.[6]

IV. CERTIFICATION OF THE CLASS

As noted earlier, I certified a class under Rule 23 for declaratory and injunctive relief consisting 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 Social Security Act for Early Periodic Screening Diagnosis and Treatment Services." D.E. 671 at 8-9. With the benefit of a lengthy trial, having received substantial documentary and testimonial evidence, I reaffirm my class certification ruling.

First, as to numerosity, I find that between October 2009 and the time of the trial's conclusion in 2012, anywhere between 1.5 million and 1.7 million children were enrolled in the Medicaid program throughout Florida. Accordingly, nothing presented during the trial alters my earlier conclusion that "joinder of unknown individual plaintiffs is certainly impracticable," if not impossible. *See Jack v. Am. Linen Supply Co.*, 498 F.2d 122, 124 (5th Cir. 1977) (finding numerosity existed for a proposed class that included unknown, future black employees). *See also* Fed. R. Civ. P. 23(a)(1).

Second, as to commonality, throughout the trial, plaintiffs presented evidence regarding the several legal questions that are common to the entire class and that Magistrate Judge McAliley identified in her report and recommendation. These include whether defendants are complying with their obligations under the federal Medicaid Act to provide eligible recipients with reasonably prompt medical care and services, equal access to such care and services, and outreach and information about care and services. *Vega*, 564 F.3d at 1268 (Commonality is

[6] I do not see the need to address the standing of the Florida Pediatric Society, the Florida Chapter of the American Academy of Pediatricians, or the Florida Academy of Pediatric Dentistry at this time. I, however, reserve the right to do so in the future in a revised order.

satisfied when there is one question of law or fact that is common to the class as a whole.). *See also Haitian Refugee Ctr., Inc. v. Nelson*, 694 F. Supp. 864, 877 (S.D. Fla. 1988) ("Class actions seeking injunctive or declaratory relief . . . by their very nature present common questions of law or fact.")

Third, as to typicality, the evidence presented at trial does not disturb my earlier conclusion that the claims and alleged injuries of the individual plaintiffs are typical of the class members. The individual plaintiffs described their inability to access promptly or without great difficulty medical services in a variety of areas of care throughout Florida, which they attribute to defendants' administration of Florida's Medicaid program. Even though their individual experiences in accessing care and services are varied, typicality is not defeated because they all share claims that they have been denied reasonably prompt and equal access to medical care and services due to defendants' failure to comply with their federal statutory obligations in administering Florida's Medicaid program. *See Prado Steiman ex. rel. Prado v. Bush*, 221 F.3d 1266, 1279 n.14 (11th Cir. 2000) (citations omitted) ("The typicality requirement can ""be satisfied even if some factual differences exist between the claims of the named representatives and the claims of the class at large."). The "strong similarity of [these] legal theories . . . satisf[ies] the typicality requirement despite [any] substantial factual differences." *Id.*

Fourth, the class named plaintiffs and class counsel continue to remain able to adequately represent the interests of all class members.

Finally, nothing that was presented during the course of the trial changes my conclusion that this case is the prototypical case for Rule 23(b) certification in that defendants are alleged to have "acted or refused to act on the grounds that apply generally to the class, so that the final injunctive relief or corresponding

declaratory relief [would be] appropriate respecting the class as a whole." *See* Fed. R. Civ. P. 23(b)(2).

V. APPLICABLE LEGAL STANDARDS

A. Civil Rights Action Under 42 U.S.C. § 1983

In relevant part, 42 U.S.C. § 1983, provides a private cause of action against state actors who deprive an individual of "any rights, privileges, or immunities secured by the Constitution and laws" of the United States. It is well-established that § 1983 provides a remedy for violations of federal statutory rights as well as constitutional rights. *See Maine v. Thiboutot*, 448 U.S. 1, 4 (1980). To maintain a cause of action under § 1983 for violations of federal statutory rights, a plaintiff first must establish that the pertinent federal statute provides an individually enforceable right. *See Blessing v. Freestone*, 520 U.S. 329. 340 (1997); *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283-85 (2002).

As I have previously explained in my prior orders, a court must analyze three factors in deciding whether the federal statute in question creates an enforceable individual right:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Blessing, 520 U.S. at 341 (citations omitted). The Supreme Court subsequently clarified in *Gonzaga* that as to the first factor the statute must contain an "unambiguously conferred right" to support a cause of action under § 1983. *Gonzaga*, 536 U.S. at 283. The statutory provision must have "rights-creating"

language, *id.* at 287, have an individual, not aggregate, focus, *id.* at 288, and be "phrased in terms of the persons benefitted." *Id.* at 284.

B. Medicaid Framework

"Medicaid is a cooperative federal-state program through which the Federal government provides financial assistance to States so that they furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Specifically, 42 U.S.C. § 1396a requires that states make medical services available to categorically eligible needy children and adults. A state's participation in the Medicaid program is voluntary, but if a state chooses to participate, it must comply with the requirements outlined in the Medicaid statute. *Id.* In order to qualify for federal Medicaid funds, a state must submit a state Medicaid plan to a federal agency, the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services. *See Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct 1204, 1208 (2012). That plan must comply with federal Medicaid statutory and regulatory requirements. *Id.*

Certain provisions of the federal Medicaid statutes are relevant here. First, a participating state plan for medical assistance must:

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

42 U.S.C. § 1396a(a)(8) (emphasis added) (the "Reasonable Promptness" provision).

Second, states must provide "for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) . . . [of §] 1396d(a) of this title, to . . . all individuals [who are eligible]." 42 U.S.C. § 1396a(a)(10)(A). In turn, § 1396d(a)(4)(B) defines "medical assistance" to include

"early and periodic screening, diagnostic, and treatment services [as defined elsewhere in this section] for individuals who are eligible under the plan and are under the age of 21[.]" The specific EPSDT services that must be provided are listed at 42 U.S.C. § 1396d(r).

Third, a state plan must also:

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

42 U.S.C. § 1396a(a)(30)(A) (the "Equal Access" provision).

Fourth, a state plan must contain provisions "[i]nforming all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance . . . of the availability of early and periodic screening, diagnostic, and treatment services . . and the need for age-appropriate immunizations against vaccine-preventable diseases[.]" 42 U.S.C. § 1396a(a)(43)(A) (the "Effective Outreach" provision).

With this framework in mind, I revisit whether these provisions create enforceable rights.

1. Reasonable Promptness & Medical Assistance Clauses: 42 U.S.C. §§ 1396a(a)(8) and (a)(10)

a. § 1396a(a)(8)

Count I of plaintiffs' complaint alleges a violation of the "reasonable promptness" clause of § 1396a(a)(8). The Eleventh Circuit, in *Doe v. Chiles*, 136 F.3d 709, 719 (11th Cir. 1998), expressly held that § 1396a(a)(8) provides a federal right to reasonably prompt provision of assistance, which is enforceable under §

1983. Looking to the first factor of the Supreme Court's three-factor *Blessing* test, the Eleventh Circuit noted that the plain language of § 1396a(a)(8)'s reasonable promptness clause was "clearly intended to benefit Medicaid-'eligible individuals.'" *Id.* at 715. It further concluded that § 1396a(a)(8)'s requirement that "assistance . . . be furnished with reasonable promptness to all eligible individuals" presented "a sufficiently specific and definite standard" that was "readily susceptible to judicial assessment," thus satisfying *Blessings*' second requirement. *Id.* at 717. Finally, in holding that the reasonable promptness clause met the third factor of the *Blessing* test, the Eleventh Circuit noted that "[t]he language of the statute [was] undoubtedly cast in mandatory rather than precatory terms[,]" and that "a state's receipt of federal Medicaid funds is expressly conditioned on its compliance with provisions of § 1396a." *Id.* at 718.

Doe is of course binding precedent. Whether *Doe* has been so eroded by *Gonzaga* that it should be overruled is for the Eleventh Circuit to decide. My job, as a district judge, is to follow *Doe* at this time. *See U.S. Valladares*, 544 F.3d 1257, 1264-65 (11th Cir. 2008); *United States v. Baxter*, 323 Fed. App'x 830, 831 (11th Cir. 2009) ("Because *Moore* [a prior Eleventh Circuit decision] has not been overruled by this Court sitting *en banc* or the Supreme Court, the district court was bound to follow its holding."). Nevertheless, I do not believe that *Doe* has been called into doubt by *Gonzaga*.

As several decisions following *Gonzaga* make clear, "[§] 1396a(a)(8) meets the standards set forth in *Gonzaga*" as well. *Romano v. Greenstein*, 721 F.3d 373, 379 (5th Cir. 2013). As the Fifth Circuit noted in *Romano*, the language of § 1396a(a)(8) is individually focused. *Id.* It is concerned with whether medical assistance has been furnished in a reasonably prompt manner to a particular class of individuals—those who are Medicaid-eligible. *Id.* "It does not 'speak only in terms of institutional policy and practice,' nor does it have an 'aggregate focus.'"

Id. (quoting *Gonzaga*, 536 U.S. at 288). The First, Third, Fourth, and Sixth Circuits have similarly held, post-*Gonzaga*, that § 1396a(a)(8) provides a federal right that is enforceable under § 1983. *See Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 193-94 (3d Cir. 2004); *Doe v. Kidd*, 501 F.3d 348, 357 (4th Cir. 2007); *Westside Mothers v. Olszewski*, 454 F.3d 532, 539-41 (6th Cir. 2006).

I therefore conclude that the "reasonable promptness" provision of § 1396a(a)(8) provides a federal right that is enforceable under § 1983.

b. § 1396a(a)(10)

Count I also alleges a violation of § 1396a(a)(10), which provides that a State plan for medical assistance must provide "for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of [§] 1396d(a)[,]" to "all individuals" meeting specified financial eligibility standards. The Eleventh Circuit has not addressed whether § 1396a(a)(10) provides a federal right that is enforceable under § 1983. I therefore draw upon the Supreme Court's *Blessing* test, as modified by *Gonzaga*, to determine whether § 1396a(a)(10) provides plaintiffs with a federal right enforceable by § 1983.

The first prong of the *Blessing* test instructs that I look to whether § 1396a(a)(10) reveals a congressional intent to create an individualized right. The Supreme Court in *Gonzaga* clarified that nothing short of an unambiguous conferred right can support a cause of action under § 1983. *Gonzaga*, 536 U.S. at 283. The appropriate inquiry, the Supreme Court noted, is "whether . . . Congress intended to confer individual rights upon a class of beneficiaries." *Id.* at 285. This requires that a statute be phrased in terms of the person or persons benefited. *Id.* at 284. As an example of such "rights-creating" language in a statute, the Supreme Court cited Title VI of the Civil Rights Act of 1964 and Title IX of the Education

Amendments of 1972, which were found to create individual rights because they were phrased "with an unmistakable focus on the benefited class." *Id.*

In my opinion, § 1396a(a)(10)'s requirement that medical assistance be made available to all individuals that meet its eligibility standards is phrased in terms of the individuals benefited. Its focus is on making medical assistance available to a specific class of beneficiaries, namely those who, like plaintiffs here, satisfy the financial eligibility standards it sets out.

Decisions from the Third, Fifth, and Ninth Circuits support my determination. *See Sabree*, 367 F.3d at 190; *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-03 (5th Cir. 2004); *Watson v. Weeks*, 436 F.3d 1152, 1159-60 (9th Cir. 2006). Indeed, the Fifth Circuit stated that the language of § 1396a(a)(10) "is precisely the sort of 'rights-creating' language identified in *Gonzaga* as critical to demonstrating a congressional intent to establish a new right." *Dickson*, 391 F.3d at 603. The Third Circuit similarly concluded that "it [is] difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant language—'A State Plan must provide'— from the 'No person shall' language of Titles VI and IX[,]" *Sabree*, 367 F.3d at 190. I noted earlier, Titles VI and IX were cited by the Supreme Court in *Gonzaga* as examples of statutes "with an unmistakable focus on the benefited class." *Id.* at 187 (emphasis omitted).

Moving on to the second prong of the *Blessing* test, I conclude that the rights sought to be enforced by plaintiffs are not "so vague and amorphous that [their] enforcement would strain judicial competence." *Blessing*, 520 U.S. 340-41. Plaintiffs seek to require that defendants make available the "medical assistance," including EPSDT services, that they are entitled to under § 1396a(a)(10) as individuals satisfying the specified financial eligibility standards listed. The

provision carefully details the specific services to be provided, and the services sought to be enforced by plaintiffs are specific and enumerated.[7]

Finally, the third prong of the *Blessing* test is easily satisfied because § 1396a(a)(10) unambiguously imposes on the participating states the requirement that they provide for making medical assistance available. *See* § 1396a(a)(10) ("stating that "[a] State plan for medical assistance *must* provide for making medical assistance available").

Accordingly, I conclude that § 1396a(a)(10) provides a federal right that is enforceable under § 1983.

2. Equal Access: 42 U.S.C. § 1396a(a)(30)(A)

States are required, under § 1396a(a)(30)(A), to provide adequate funding to ensure that Medicaid beneficiaries have equal access to medical services and care as available to the general population in their geographic area. Plaintiffs have filed suit under § 1983 because defendants have allegedly failed to satisfy that mandate. At issue is whether § 1396a(a)(30)(A) confers a private right of action.

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[7] To the extent defendants argue that § 1396a(a)(10) is not unambiguously worded, as required to confer a privately enforceable federal right, because the term "medical assistance" is "vague and amorphous," I disagree. I find the term to be sufficiently defined in § 1396d(a) to satisfy the second prong of *Blessing*. *See Doe*, 136 F.3d at 711 (upholding a claim that the Florida Department of Health & Rehabilitative Services violated § 1396a (a)(8) by failing to provide medical assistance, which consisted of the "therapies, training and other active treatment to which [the plan participants were] entitled"). I recognize that a circuit split exists concerning whether "medical assistance" encompasses only a right to payment for the care and services listed in § 1396d(a), or both a right to payment and a right to the care and services themselves. *Compare Katie A. ex rel. Ludin v. Los Angeles Cnty.*, 481 F.3d at 1154, *with Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724, 728-29 (5th Cir. 2009) (holding that medical assistance means payment for medical services); *Westside Mothers*, 454 F. 3d at 540-41 (same); *Bruggeman ex rel Bruggeman v. Blogojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (same); (dictum) *OKAAP*, 472 F.3d at 1214 (same). But that defendants' argument regarding what exactly is covered by the term "medical assistance" more accurately addresses the merits of what plaintiffs would need to show to establish that their rights have been violated. Accordingly, I address this argument further in the conclusions of law.

In 1990, the United States Supreme Court held that health care providers had a private right of action to challenge the method by which the states reimbursed them under the Medicaid Act. *See Wilder*, 496 U.S. at 498. The Court found a private right of action within the text of the Boren Amendment, which required states to

> provide . . . for payment . . . of the 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 (determined in accordance with methods and standards developed by the State . . .) *which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet that costs which must be incurred by efficiently and economically operated facilities* in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

Id. at 502-03 (emphasis in original). Health care providers could sue under § 1983 to enforce the Boren Amendment, the Court held, because they were the "intended beneficiaries" of a provision that imposed a "binding obligation" on states to adopt reasonable rates. *See id.* at 510.

Since *Wilder*, the Supreme Court has decided *Blessing*—creating a three-factor test to determine whether a federal statute creates an enforceable right—and *Gonzaga*—expounding on the first prong of the *Blessing* test, requiring the statute to contain "rights-creating" language and clearly impart an "individual entitlement" on plaintiff with an "unmistakable focus on the benefited class." *See Blessing*, 520 U.S. at 340-41; *Gonzaga*, 536 U.S. at 287. Despite so doing, the Court in *Gonzaga* expressly preserved the *Wilder* Court's analysis, stating that the Boren Amendment "left no doubt of its intent for private enforcement . . . because

the provision required States to pay an 'objective' monetary entitlement to individual health care providers[.]" *Gonzaga*, 536 U.S. at 280-81.

Thus, *Gonzaga* concluded that *Wilder* remains good law, and the Eleventh Circuit has not ruled otherwise. *See Agnostini v. Felton*, 521 U.S. 203, 237 (1997) (reaffirming that "[i]f a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the Court of Appeals should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions") (internal quotation marks omitted). And the Seventh Circuit has concluded that *Wilder* remains binding precedent. *See Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012) ("Although we have acknowledged that *Gonzaga* may have taken a new analytical approach . . . *Wilder* has not been overruled.") (internal quotation marks and citation omitted).

The statutory language in § 1396a(a)(30)(A) is nearly identical to the text of the Boren Amendment that the Court in *Wilder* found to create a private right of action. Under § 1396a(a)(30)(A), state programs are required to:

> Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to 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*[.]

§ 1396a(a)(30(A) (emphasis added).

Given the strikingly similar "rights-creating" language that mimics the test of the Boren Amendment, I conclude that § 1396a(a)(30)(A) imposes a mandate on the states. The Boren Amendment required states to create programs that provided reasonable payment to provide access to adequate medical assistance. And §

1396a(a)(30)(A) similarly requires states to create programs that provide sufficient payment to ensure that adequate access to medical assistance is "available under the plan."

The only significant distinction between the two provisions is that the Boren Amendment's beneficiaries were medical providers, while § 1396a(a)(30)(A)'s beneficiaries are Medicaid-enrolled individuals who utilize the care and services "available under the plan." *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538 (3d Cir. 2002) (*en banc*) (Alito, J.) (holding that § 1396a(a)(30)(A)'s provisions for quality of care and adequate access were "draft[ed] . . . with an unmistakable focus on [Medicaid beneficiaries]"). Granted, health care providers are explicitly mentioned within the text of the Boren Amendment, while plan participants are not expressly discussed in § 1396a(a)(30)(A). But this distinction does not compel a different conclusion. Under § 1396a(a)(30)(A), plan participants are given an enforcement right through the language requiring states to make services "under the plan" available.

I acknowledge that—as defendants argue—the majority of circuits have determined, post-*Gonzaga*, that § 1396a(a)(30)(A) does not expressly create an enforceable individual right. *See Equal Access for El Paso, v. Hawkins*, 509 F.3d 697, 703-04 (5th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers*, 454 F.3d at 542; *N.Y. Ass'n of Homes & Servs. for the Aging v. DeBuono*, 444 F.3d 147, 148 (2d Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005); *Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004).

These cases, however, are not persuasive or are distinguishable. *DeBuono* and *Long Term Care*, for example, involved claims by providers, not individual Medicaid beneficiaries. And, with the exception of *Long Term Care* and *Mandy R.*, the cases cited above fail to distinguish *Wilder*. *Long Term Care*

acknowledged that "the Boren Amendment and subsection (30)(A) contain[] nearly identical substantive requirements," but it dismissed the similarity and concluded that "*Gonzaga* requires clear statutory language for the creation of private rights enforceable under section 1983[.]" *Long Term Care*, 362 F.3d at 58.[8] *Mandy R.* similarly expressed incredulity that *Gonzaga* preserved *Wilder* and found that *Gonzaga* "tightened the first requirement" of finding a private right to enforce statutory violations and therefore no relief was available. *See Mandy R.*, 464 F.3d at 1147. *Long Term Care* and *Mandy R.* fail to give due weight to *Wilder*, a case that *Gonzaga* expressly recognized remained good law.

I find the reasoning of the Seventh and Eighth Circuits more persuasive. *See Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1015 (8th Cir. 2006) (holding that § 1396a(a)(30)(A) "is intended to benefit both CHMS recipients and providers, and creates enforceable rights for both groups"), *vacated in part on other grounds*, 127 S. Ct. 2000 (2007); *Bontrager*, 697 F.3d at 607 (finding *Wilder* remains good law post-*Gonzaga* and reaffirming its pre-*Gonzaga* ruling that a private right of action for individual beneficiaries exists, albeit under the medical assistance statute). *See also Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *8 (N.D. Ill. Aug. 23, 2004) (concluding that § 1396a(a)(30)(A) creates individually enforceable rights).

In light of the passage of time since my earlier rulings, I have also considered whether any subsequent pertinent and binding decisions have called into question my conclusions regarding the enforceability of § 1396a(a)(30)(A). My updated research, however, reveals no Eleventh Circuit decision addressing the

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[8] *Long Term Care* cites the repeal of the Boren Amendment in 1997 as a reason to ignore *Wilder*. *See* 362 F.3d at 58. That makes no sense. The subsequent repeal of an amendment to increase "the flexibility of the states" may shed light as to Congress' later views as to private enforcement of the Boren Amendment, but does not alter the Supreme Court's analysis that the text of the Boren Amendment was sufficient to confer a right subject to private enforcement.

individual enforceability of § 1396a(a)(30)(A) under § 1983. Thus, I remain convinced for the reasons expressed in my ruling on defendants' motion for summary judgment that the Supreme Court's decision in *Wilder* compels the conclusion that the statute is individually enforceable. While applying the *Gonzaga* test to § 1396a(a)(30)(A) on a blank slate might possibly render a different conclusion, I cannot ignore *Wilder*, which is directly on point and binding.

Defendants direct my attention to the Supreme Court's decision in *Douglas v. Independent Living Center of Southern California*, 132 S. Ct. 1204 (2012), which was decided after my earlier rulings. According to defendants, this decision supports their position against the individual enforceability of § 1396a(a)(30)(A).

In *Douglas*, Medicaid providers and recipients in California asked the Supreme Court to consider whether § 1396a(a)(30)(A) was enforceable through the Supremacy Clause, in the wake of the Ninth Circuit's holding in *Sanchez* that the statute was not enforceable through § 1983. *See Douglas,* 132 S. Ct. at 1207. Given intervening events in the case after certiorari had been granted, the Court declined to consider the Supremacy Clause question and instead remanded the case back to the circuit court to consider whether the case should be brought under the Administrative Procedures Act, 5 U.S.C. § 701. *Id.* at 1211. Although plaintiffs' allegations in *Douglas*—that California's Medicaid reimbursement rates did not comply with federal law because they were insufficient to enlist enough providers to ensure adequate care and services—tracked plaintiffs' claims here, the Supreme Court in *Douglas* was not asked to—nor did it—decide the legal question of the individual enforceability of § 1396a(a)(30)(A) under § 1983, raised by defendants in this case. Accordingly, *Douglas* does not impact my conclusion that § 1396a(a)(30)(A) is individually enforceable through § 1983.

The Eleventh Circuit's recent decision in *Martes v. Chief Executive Office of South Broward Hospital District*, 683 F.3d 1323 (2012), which addressed the individual enforceability of another Medicaid statute also does not alter my conclusion. In *Martes*, the Eleventh Circuit concluded that a billing provision within the Medicaid statutes, 42 U.S.C. § 1396a(a)(25)(C),[9] did not confer individually enforceable rights on Medicaid recipients against service providers for improper billing. The Eleventh Circuit reached this conclusion, in part, because it determined that the statutory provision's "focus is proscription of certain conduct by Medicaid service providers" as it relates to their billing practices rather than the rights on the individual Medicaid recipients. *Martes*, 683 F.3d at 1328. It pointed to the Supreme Court's acknowledgement in *Gonzaga* that "statutes that focus on the person regulated rather than the individuals protected" do not intend to confer individually enforceable rights. *Id.* at 1328-29 (citing *Gonzaga*, 536 U.S. at 287). Accordingly, because § 1396a(a)(25)(C) and its preceding subsections primarily address the obligations of third party service providers, the Eleventh Circuit concluded that the text and structure of § 1396a(a)(25)(C) did not speak to

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[9] The statute, in pertinent part, reads as follows:

A State plan for medical assistance must—

> Provide . . . that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1306o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service[.]

42 U.S.C. § 1396a(a)(25)(C).

individual rights, but rather to the obligations of service providers vis-à-vis third party liability. *Id.* at 1330.

The same, however, cannot be said of the text and structure of § 1396a(a)(30)(A), which requires a state Medicaid plan to assure that payments for care and services "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[.]" First, the focus of § 1396a(a)(30)(A) is making sure that "care and services" are available to eligible Medicaid recipients. The intended purpose in enlisting a sufficient number of providers is not for the sake of the medical providers, but rather for the individual beneficiaries of the Medicaid program so that these individuals have the opportunity to receive medical care in a manner similar to their counterparts in the private insurance sector. The essence of this statutory provision is making sure that a state's Medicaid program functions as Congress intended: ensuring eligible individuals receive the medical care and services that a state's plan entitles them to receive. Second, when § 1396a(a)(30)(A) is read in context with § 1396d(a), the subsection that details the individual "care and services" that a state plan *must* provide, it becomes even more apparent that the focus of subsection (30)(A)'s "sufficient" payment provision is on the individual's right to access medical care and services adequately.[10]

In sum, I again conclude that § 1396a(a)(30)(A) creates a private right of action for Medicaid beneficiaries.

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[10] Defendants raise several other arguments in their discussion of the individual enforceability of § 1396a(a)(30)(A), which I find are more accurately addressed to the merits of what plaintiffs would need to show to establish that their rights, assuming the statute confers individual rights, have been violated by defendants. Accordingly, I will address these arguments later where relevant in the findings of facts and conclusions of law.

3. Effective Outreach: 42 U.S.C. § 1396a(a)(43)(A)

In regards to § 1396a(a)(43)(A), defendants raise no new arguments but maintain that the provision under *Blessing* as modified by *Gonzaga*, does not "unmistakably focus" on a benefit class and is too ambiguous and general to contain an objective standard. I disagree.

Post-*Gonzaga*, the Eleventh Circuit interpreted the first *Blessing* factor, which requires that Congress must have intended the relevant statute to benefit plaintiffs, to mean that the provision "[must] contain[ ] individually focused, rights-creating language, (2) has an individual, rather than systemwide or aggregate focus; and (3) lacks an enforcement mechanism for aggrieved individuals." *Martes* 683 F.3d at 1326, *citing Arrington v. Helms*, 438 F.3d 1336, 1345 (11th Cir. 2006). In my view, § 1396a(a)(43)(A) clearly satisfies this test.

As part of a comprehensive Medicaid statute, § 1396a(a)(43)(A) requires state plans to provide for informing "all persons under the age of 21 who are eligible for medical assistance" of the availability of early and periodic screening, diagnostic, and treatment services and the need for age-appropriate immunizations against certain diseases. 42 U.S.C. § 1396a(a)(43)(A). Contrary to defendants' contentions, this provision contains the requisite "rights-creating" terminology. In *Gonzaga*, the statute at issue prohibited the Secretary of Education from distributing funds to any educational agency or institution that maintained a policy or practice of permitting the release of education records. *Gonzaga*, 536 U.S. at 287. The Court found that the provision failed to confer individual rights because it focused on the regulated party as opposed to those who would benefit from the statute. *Id.* at 288. Additionally, the Court determined that the statute's "non-disclosure provisions [spoke] only in terms of institutional policy and practice, not individual instances of disclosure," thereby giving it an aggregate focus. *Id.* at 288.

In contrast, here the Effective Outreach provision commands the State to inform all eligible children under 21 about available medical services. Its emphasis, unlike the statute in *Gonzaga,* is on the individuals who will receive the information rather than the regulated party. Thus, § 1396a(a)(43)(A) sufficiently evinces congressional intent to confer individual rights. *See Bonnie L. v. Bush*, 180 F.Supp. 2d 1321, 1346-47 (S.D. Fla. 2001), *aff'd on other grounds and vacated in part, 31 Foster Children v. Bush*, 329 F.3d 1255 (11th Cir. 2003).

The Effective Outreach provision also clearly meets *Blessing*'s second requirement—that the protected right cannot be "so vague or amorphous that its enforcement would strain judicial competence." *Gonzaga*, 536 U.S. at 282. This provision is wholly different from the ambiguous provisions that courts have found to be too generalized to enforce. For example, the Supreme Court has found that a statute imposes only a generalized duty when the "meaning of [the directive would] obviously vary with the circumstances of each individual case" and compliance with the directive was largely left up to the state. *See Suter v. Artist M*, 503 U.S. 347, 360-63 (1992). This is not the case here. Section 1396a(a)(43)(A) imposes precise requirements on the state and leaves no room for discretion.

Under the third *Blessing* factor, the questions is whether § 1396a(a)(43)(A) "unambiguously impose[s] a binding obligation on the State[ ]." *Blessing*, 520 U.S. at 341. "The provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms." *Id.* The Effective Outreach provision provides that "[a] State plan for medical assistance *must* provide for informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance . . . of the availability of early and periodic screening, diagnostic, and treatment services . . . ." § 1396a(a)(43)(A) (emphasis added). The language of § 1396a(a)(43)(A) is not precatory but requires a state like Florida to comply with its command.

Defendants are unable to identify any cases that hold that § 1396a(a)(43)(A) does not create a private right of action. In fact, since *Gonzaga*, at least one circuit court has held that § 1396a(a)(43)(A) creates enforceable rights. *See Westside Mothers*, 454 F.3d at 544. Likewise, district courts, post-*Gonzaga*, have also held that § 1396a(a)(43) confers individual rights. *See e.g.*, *Hunter ex rel. Lynah v. Medows*, No. CIVA 108CV-2930-TWT, 2009 WL 5062451, at *2-3 (N.D. Ga. Dec. 16, 2009); *Clark v. Richman*, 339 F. Supp. 2d 631, 640 (M.D. Pa. 2004); *Memisovski*, 2004 WL 1878332, at *5; *A.M.H. ex rel. P.H. v. Hayes*, No. C2-03-778, 2004 WL 7076544, at *6 (S.D. Ohio Sept. 30, 2004).

In light of this precedent, and for the reasons stated above, I conclude that § 1396a(a)(43)(A) is mandatory, precise, and sufficiently individualized under *Blessing* to permit a claim under § 1983.

VI. FINDINGS OF FACT

The findings of fact which follow are taken from direct or circumstantial evidence presented at trial or from inferences drawn from such evidence.

A. The Named Plaintiffs

1. S.M.

1. S.M. became eligible for Medicaid shortly after he was born in August 2006. PX 583-2 at TPF02294-98, TPF02305-07. S.B.,[11] S.M.'s mother,

[11] S.B. voluntarily sent S.M. to live with his father in August of 2011 so she could devote more time and energy looking for a job and an apartment where she could live with her three minor children. S.B. on 12/06/2011 Rough Tr. at 90, 135. Later, S.M. and S.B.'s two other minor children were removed from her legal custody as the result of a court order and proceedings initiated by DCF. *Id.* at 89-90, 135. While S.M. is living with his father about 25 minutes outside Tallahassee, S.B. continues to see her son every week. *Id.* at 136. Those weekly visits are not supervised by DCF. *Id.* at 154.

Even though S.B. currently does not have legal custody of S.M., S.B. is still a proper and appropriate next friend. An individual may serve as a "next friend" of a minor as long as the

chose Dr. Simmons, who practices with the Tallahassee Pediatric Foundation ("TPF") and who was her pediatrician for about 16 years, to be S.M.'s doctor. S.B. on 2/11/2010 Final Tr. at 1782:9-22. S.M. was on MediPass and assigned to TPF on October 1, 2006. PX 582 at 5. Since that time, S.B. has experienced difficulty obtaining medical and dental care for S.M.

2. On July 5, 2007, S.B. received a letter from TPF, which stated that S.M.'s Medicaid had been canceled on June 30, 2007. PX 583-2 at 15. Because S.M. was only eleven months at the time of the switch, the cancellation was in violation of his right to twelve months of continuous eligibility. *Id.*; PX 583-2 at TPF002308; S.B. on 2/11/2010 Final Tr. at 1787:1-2.

3. In response to the letter, S.B. called the Medicaid number to inform the agency that S.M.'s benefits had been improperly canceled. She requested that S.M.'s Medicaid be reinstated. S.B. on 2/11/2010 Final Tr. at 1786:18-22. Medicaid retroactively restored S.M.'s eligibility, making it appear as if his

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

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

benefits had never been canceled. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1491:3-7.

4. S.M. was again on Medicaid and again assigned to TPF from August 1, 2007 through September 30, 2007. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1486:21 – 1487:5, 1491:3-18. On, October 5, 2007, S.B. received yet another letter from TPF, informing her that S.M.'s Medicaid eligibility was terminated on September 30, 2007. This cancelation was two months after his Medicaid eligibility started on August 1, 2007 and constituted a violation of his right to 12 months of continuous eligibility. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1486:21 – 1487:5, 1491:3-18; 1494:2-17; McCormick on 8/12/2010 Final Tr. at 4132:24 – 4133:8; S.B. on 2/11/2010 Final Tr. at 1787:9 – 1788:1; PX 583-2 at TPF02295,TPF002310. Once again, his eligibility was retroactively restored. PX 582 at 5; St. Petery on 2/09/2010 Final Tr. at 1494:14 – 1495:11. Contrary to defendants' suggestion, I do not find that the cancellation was valid.

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

6. S.M. was scheduled to see Dr. Simmons in February 2008 for his 18-months well- child check-up. S.B. on 2/11/2010 Final Tr. at 1788:11 – 1789:14. Dr. Simmons' office told S.B. not to bring her son in for his appointment because S.M had been assigned or "switched" to a Medicaid HMO, an insurance plan that S.M.'s doctor did not accept. S.B. on 2/11/2010 Final Tr. at 1788:11-1789:14; St. Petery on 12/10/2009 Final Tr. at 1389:17 – 1391: 25; *see also* PX 658 at Simmons000002.

7. In February of 2008, sometime after her visit to Dr. Simmon's office, S.B. received a package from Universal, alerting her of the change. S.B. on 2/11/2010 Final Tr. at 1805:8-16. S.B. called Medicaid to resolve the issue.

8. An employee of Medicaid Options, which handled plan assignments for Medicaid in non-Reform counties, noted in S.M.'s records that S.B received a letter in February stating that S.M. was switched to another Medicaid plan and called to change the plan back to MediPass. PX 583-2 at TPF02312; S.B. on 2/11/2010 Final Tr. at 1790:4-25. A FMMIS print screen shows S.M. was assigned to a Medicaid HMO from February 1, 2008 through March 31, 2008. McCormick on 8/12/2010 Final Tr. at 4136:25 – 4138: 21; PX 583-2 at TPF02319.

9. The Medicaid Options employee also noted that Medicaid sent S.B. a letter, which gave her the option to choose a Medicaid plan but S.M. was auto-assigned to a Medicaid HMO when S.B. allegedly failed to make a choice. PX 583-2 at TPF02312-13. There is no evidence, however, that such a letter was actually sent. S.B. did not receive a selection letter from Medicaid or any other state agency prior to February of 2008. S.B. on 2/11/2010 Final Tr. at 1789:15 – 1790:3.[12]

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

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[12] Defendants suggest that S.B. did not receive the letter because she failed to update her mailing address with AHCA. *See* Defs. Corrected Proposed Findings of Fact and Conclusions of Law at 74. S.B. testified that she moved several times during the first two years of S.B.'s life. S.B. on 2/11/2010 Final Tr. at 1783:12 – 1784:7. S.B. admitted that she updated her address with TPF but never informed AHCA. During that time, S.B. received correspondence from TPF at her grandmother's address. S.B. on 2/11/2010 Final Tr. at 1784:15-18. Her grandmother would contact her if she received any mail. S.B. on 2/11/2010 Final Tr. at 1784:19-21. Despite this testimony, I still find that defendants are responsible for the switch. First, defendants have not submitted proof that the selection letter was actually sent to S.B. Second, S.B. would not have had to apply for reinstatement or select a Medicaid plan if Medicaid did not improperly terminate S.M.'s benefits short of the required 12 months of continuous eligibility. S.B. on 2/11/2010 Final Tr. at 1821:23 – 1822:7.

11. On another occasion, Dr. Simmons referred S.M. to a laboratory for a lead blood screening test. S.B. was not able to get her son's blood tested for exposure to lead because it would have taken her an hour and a half each way, traveling by bus, to get to the laboratory's location. S.B. on 2/11/2010 Final Tr. at 1793:17 – 1794:11, 1798:19 – 1799:17; S.B. on 12/06/2011 Rough Tr. at 111, 143, 146. She also missed appointments with Dr. Simmons because of transportation problems. *Id.* at 145-46. She did not know she was entitled to free transportation through Medicaid. *Id.* at 144-46.

2. L.C.

12. L.C. was hospitalized for seizures when he was about 15 months old and had seizures later in life as well. PX 655 at Tridas Center 000008; PX 651 at Peace River 000016. L.C. moved into S.C.'s home as a foster child when he was two years, eight months old, and S.C. later adopted him. S.C. on 1/11/2010 Final Tr. at 1319:21 – 1320:1; 1322:1-3. As a child adopted through foster care, L.C. is eligible for Medicaid regardless of income. *Id.* at 1322:4-9.

13. In August of 2004, when L.C. was about 7 years old, S.C. took him to be evaluated by a developmental pediatrician because of his developmental delays and anxiety, which manifested itself in panic attacks and other extreme behavior. *Id.* at 1327:13 – 1329:15; PX 655 at Tridas Center000001, 000003, 000007. The doctor recommended intense psychological services. S.C. on 1/11/2010 Final Tr. at 1331:21 – 1332:1; PX 655 at Tridas Center000011.

14. Based on her doctor's recommendation, S.C. took L.C. to see Elizabeth Craig, who had an extensive history working with children with attachment disorder. S.C. on 1/11/2010 Final Tr. at 1332:19 – 1333:10. Ms. Craig, who does not take Medicaid, recommended weekly play therapy. PX 652 at Craig000105; S.C. on 1/11/2010 Final Tr. at 1336:20-21. In September of 2004, S.C. took her

son to PRC, the exclusive Medicaid mental health provider in her area. *Id.* at 1336:22 – 1338:12; PX 651 at Peace River 000009. Peace River, however, was not able provide play therapy, and was not able to provide weekly therapy. *Id.* at 1338:13-17; 1338:20 – 1341:25; PX 740 at Defendants 011707.

15. Peace River referred S.C. to Dr. Jackie Reycraft for therapy. S.C. on 1/11/2010 Final Tr. at 1342:19 – 1343:25. Dr. Reycraft informed S.C. that she was leaving Peace River because, among other things, she had a case load of 110 patients. *Id.* at 47-48. A caseload of this magnitude is unreasonable and would hinder a therapist from proving adequate care to children. Sarkis on 1/19/2012 Rough Tr. at 48-49, 52-53, 79-80.

16. Dr. Reycraft also stated that she could not deliver weekly therapy to L.C. *Id.* Dr. Reycraft developed a treatment plan offering twice monthly therapy from Christy Bishop. *Id.* at 1333, 1345. Because her son could not get the care he needed at Peace River, L.C. paid for her son to attend weekly play therapy sessions with Ms. Craig. *Id.* at 1345:18 – 1346:6. Although these sums were ultimately reimbursed, Medicaid could not provide access to the care that L.C. needed.

17. In 2005, a developmental pediatrician recommended that L.C. begin taking certain medications. Dr. Helen Hubbard managed L.C.'s medication but in 2007 was unwilling to continue monitoring the drugs. *Id.* at 1355:2 – 1357:24. There is no evidence to support that Dr. Hubbard's unwillingness was related to the fact that S.C. was on Medicaid. S.C. returned to Peace River because she needed a psychiatrist to prescribe and monitor L.C.'s medications, one of which was Depakote. *Id.* at 1357:12-15; PX 651 at Peace River 000053; S.C. on 1/11/2010 Final Tr. at 1357:16-18; PX 651 at Peace River 000054 ("Current Mental Health Medications" include "Depakote 500 m.g."). S.C. informed PRC that she needed a psychiatrist to manage her son's medication because abrupt removal from Depakote could cause seizures. S.C. on 1/11/2010 Final Tr. at

1357:19-24. PRC's records do not reflect that S.C. ever advised PRC that the matter was urgent. Instead, PRC characterized the appointment as a routine visit. PX 651 at Peace River 000053-000056.

18. PRC required that L.C. go through the intake process and be evaluated by a therapist who would then determine whether L.C. needed a psychiatrist. S.C. on 1/11/2010 Final Tr. at 1358:3-7. As a result, PRC could not schedule L.C. for an appointment for a psychiatrist for a period of two months or more. *Id.* This wait was reasonable because PRC was not aware of the urgency of the situation. *See* Testimony of Dr. Sarkis, 1/19/12 ES 13-14, 62-64, 66-70, 72-78, 80-83, 86-87, 89-91, 104.

19. Unwilling to wait two or more months for an appointment, S.C. paid Dr. Hubbard out-of-pocket to monitor her son's psychotropic medications for about two years. *Id.* at 1358:17-25; 1359:7-9. Eventually, Medicaid reimbursed S.C. for these out-of-pocket expenses. *Id.* at 1349:13-14.

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

3. K.K.

21. A.D. is the mother of K.K., one of the named plaintiffs in this action. A.D. on 8/12/2010 Final Tr. at 4046:22 – 4047:13. K.K was born in December of 2003. At the time, A.D. was living in Lehigh Acres, near Ft. Myers. *Id.* at 4049:8-9. K.K. became eligible for Medicaid at birth. *Id.* at 4050:5-6.

22. A.D. periodically has to renew her son's Medicaid. To do so, she can either call and get a packet by mail or fill out the renewal form online. In either case, she has to figure out how to complete the form on her own. Sometimes she had to call five times per day for assistance. *Id.* at 4069:5-11; 4072:1-14.

23. One day while visiting the DCF office, A.D. met a Staywell representative who discussed the benefits of MediPass over Staywell. *Id.* at 4055:8-23. The representative followed A.D. to her car and convinced her that Staywell had more advantages than MediPass. *Id.* at 4074. On January 1, 2005, A.D. made a phone call to Medicaid to change K.K.'s Medicaid plan from MediPass to Staywell. *Id.* at 4074-4075. The change became effective on March 1, 2005. DX 49 at Defendants 10106; DX 54 at Defendants 10125.

24. Less than two weeks later, on March 9, 2005, K.K. went to the emergency room at Cape Coral Hospital because his ear started to bleed. 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. John Donaldson, Dr. Liu's partner, "w[ould] 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; A.D. on 8/12/2010 at 4082-83.

25. That morning, A.D. called and made an appointment with the office of Dr. Liu. *Id.* at 4059:1-13. She soon received a call back, informing her that the doctor could not see K.K. because he was on Staywell, one of the Medicaid plans that the doctor did not accept. *Id.* at 4059:14-21; 4087:8-15.

26. A.D. called the Staywell representative that convinced her to switch from MediPass to Staywell and complained that her current doctor did not accept Staywell. *Id.* at 4060:14-25. The Staywell representative referred her to a Staywell-affiliated ENT specialist in Sarasota. *Id.* at 4059:22 – 4060:25; 4061:1-6; 4081:3-7. A.D. did not own a car at the time and was not able to go to Sarasota because it was located an hour and 45 minutes to two hours away. *Id.* at 4061:1-20.

27. Dr. Donaldson agreed to see K.K. later that day, despite the insurance problem. PX 612 at K KEL 00006; Donaldson Depo. Desig. at 78:18 – 80:18; 206:21-25. Because Dr. Donaldson was not a Staywell provider, he risked not getting reimbursed for his treatment of K.K. Becker on 2/1/2012 Rough Tr. at 30, 59-61. Dr. Donaldson determined that K.K. had puss running out of his left ear, a displaced tube in his right ear, and an effusion behind the middle ear. PX 612 at K KEL 00006.

28. I find that defendants did not improperly switch A.D. from MediPass to Staywell and that A.D. requested the change. I find, however, that defendants did not provide sufficient access to ENT specialists under the Staywell plan. Ear, nose, and throat diseases such as otitis media, sinusitis, and tonsillitis are frequently encountered illnesses within the pediatric population, and Staywell should have had an ENT on its panel in a metropolitan area such as Ft. Myers. Becker on 2/1/2012 Rough Tr. at 27.[13]

29. Children on private insurance would not be subjected to the hardship of traveling to a different metropolitan area to obtain routine ENT care.[14] *Id.* at 28. The mother of a child with private insurance would not have experienced such difficulty in obtaining care. *Id.* at 30-31.

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[13] Dr. Marie Becker is a board certified otolaryngologist who has been in private practice since 1995, treating children and adults covered by both private insurance and Medicaid. Becker on 2/1/2012 Rough Tr. at 9-10. I find her credible and knowledgeable and certify her as an expert in otolaryngology. Defendants have objected to Dr. Becker and the other witnesses who have given expert testimony as to the named plaintiffs' lack of adequate and prompt care. I have considered these motions to exclude the expert witness testimony and deny them as each of these experts is competent to testify as an expert based on a review of the medical records and the trial testimony. Further, I find their testimony more credible than the conclusory opinion of defendants' expert, Ms. Catherine Sreckovich (who is a non-physician), regarding the care afforded each of the named plaintiffs.

[14] Defendants produced evidence, which showed that Staywell had ENT providers near Ft. Myers on its panel as of May 2009, *see* DX 65A. This evidence, however, is insufficient to establish that Staywell had available ENT specialist on its panel in 2005, the time that K.K. needed medical attention.

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

31. In November of 2009, K.K's doctor prescribed Adderall to treat his attention hyperactivity disorder. DX 55C at Associates in Pediatrics000366-67. A.D. on 1/25/2012 Rough Tr. at 54. A.D. and K.K.'s pediatrician went through a process of trial and error lasting several months to find out what medication and at what dosage was most beneficial for K.K. A.D. on 1/25/2012 at 55-56; DX 55C at Associates in Pediatrics 000278, 295-96, 300, 322, 324. Eventually, they settled on Vyvance at about 50 m.g. a day. A.D. on 1/25/2012 Rough Tr. at 56. At that dosage, K.K., who failed kindergarten the year before, became a straight A student. *Id.* at 56-57.

32. K.K. was not on Medicaid for a few months in late 2010 through early 2011 because A.D. did not meet the economic eligibility requirements during that time. *Id.* at 70. A.D. lost her job in January of 2011 and in February K.K. was, once again, eligible Medicaid. *Id.* at 70. Medicaid asked A.D. to select a plan for K.K. and she chose MediPass. *Id.* at 71-72. K.K., however, was assigned to Staywell, without A.D.'s consent. *Id.* at 58. A.D. did not know that K.K was assigned to Staywell. *Id.* at 58.[15]

33. The result of the switch was harmful to K.K. Staywell denied the prescription for Vyvance because it first required K.K. to fail on

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

Dextroamphetamine, the key ingredient in Adderall. DX 55C at Associates in Pediatrics000076.

34. While appealing Staywell's denial, *id.*; A.D. on 1/25/2012 Rough Tr. at 57-59, the pediatrician put K.K. back on Adderall as a "substitute" because it was the only medication that Staywell would approve. DX 55C at Associates in Pediatrics000076-77; A.D. on 1/25/2012 Rough Tr. at 59-60, 63. After K.K. began taking Adderall, his teacher complained about his conduct and his mother also saw a significant deterioration in his conduct. *Id.* at 64-65; DX 55C at Associates in Pediatrics000076-77.

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

4. Nathaniel Gorenflo

36. Rita Gorenflo is the mother of Nathaniel Gorenflo, one of the named plaintiffs in this action. Gorenflo on 5/18/2010 Final Tr. at 2290:23 to 2291:2. The Gorenflos live in Palm Beach County. *Id.* at 2298:3-4.[16]

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

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

38. Nathaniel's birth mother was on cocaine at the time Nathaniel was born. *Id.* at 2293:16-21. He later developed AIDS. *Id.* at 2293:20-22; 2294:11-12. He is developmentally delayed, has multiple psychiatric issues, *id.* at 2294:6-10, and sees a number of different medical providers and specialists. *Id.* at 2294:20-22.

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

40. When Ms. Gorenflo called CMS on July 13, 2005, to request an ENT appointment for Nathaniel, her son was in pain. *Id.* at 2299:2-23. Ms. Gorenflo told CMS that her son was in pain and needed to be seen right away.[17] *Id.* at 2300:7-13. She explained that her son could not tell her where the pain was but would "scream and bang his head" and put the whole house in "total chaos." *Id.* at 2299:24 – 2300:6.

41. Ms. Gorenflo wanted her son to be evaluated by the doctor quickly because of his compromised immune system and history of ear problems and chronic sinusitis. *Id.* at 2311:24 – 2312:5; 2294:17-19; 2311:14-23.

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[17] I find Ms. Gorenflo to be a credible witness and credit her testimony that her son was in pain and that she informed CMS of the same when she called CMS and the ENT's office in July of 2005 and asked for a prompt appointment for Nathaniel. Typically, the person who spends most time with the child is most knowledgeable about whether the child's behavior is normal, and because Nathaniel was developmental delayed and could not express through words whether he was in pain, what his mother said about his condition was particularly important. *See* Becker on 2/1/2012 Rough Tr. at 15-16.

Furthermore, Paula Dorhout, a nursing director at the Children Medical Service's office that serves Palm Beach Count, agreed that Ms. Gorenflo is a very dutiful caregiver and that if she said her son was in pain, Ms. Dorhout would accept Ms. Gorenflo's judgment. *See* Dorhout on 4/4/2011 Rough Tr. at 3, 144.

42. Ms. Gorenflo was informed that the next available appointment was in six months. *Id.* at 2300:14-18.[18] Ms. Gorenflo said a six-month wait was not acceptable because Nathaniel was in pain and needed an ENT evaluation immediately. *Id.* at 2302:10-20.[19] After numerous phone calls stretching out over several days, an ENT finally evaluated Nathaniel on July 18 – five days after his mother said he needed an immediate appointment. *Id.* at 2303:13 – 2304:8; 2305:11 – 2306:4; 2310:4-8; 2310:15 – 2311:13; PX 617 at NG_CMS00756. Proper procedure dictates that a child who is in a great deal of pain in his ear must see an ENT physician immediately. *See* Dorhout on 4/4/2011 Rough Tr. at 145.

43. Nathaniel has a history of chronic sinusitis, as evidenced by his medical records. Becker on 2/1/2012 Rough Tr. at 12; DX 43 N.G._CMS000717, 731, and 734. That history makes it more likely he will suffer from sinusitis again. Becker on 2/1/2012 Rough Tr. at 14. Because Nathaniel has AIDS, he was immune-compromised and susceptible to infection. *Id.* at 15. The fact that he had AIDS made it important that he be seen and diagnosed quickly, before any infection could spread. *Id.* at 14-15, 19-21. Pain is one of the key signs an infection is progressing. *Id.* at 15. Given his symptoms, the fact that he was in pain, and suffered from AIDS, Nathaniel should have been evaluated by an ENT physician the day his mother requested an appointment or at the latest on the next day. *Id.* at 19-21.

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[18] The July 14, 2005, entry in the CMS nursing notes, which indicates that Ms. Gorenflo called on July 13 and asked for an ENT appointment for Nathaniel ASAP, does not say Ms. Gorenflo was offered an appointment in six months. However, the notes are incomplete and in fact there is a 16 or 17 month gap at one point between entries even though Ms. Gorenflo never went that long without taking Nathaniel to a CMS clinic. Gorenflo on 5/18/2010 Final Tr. at 2300:23– 2302:7; PX 617 at NG_CMS 000756.

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

44. A patient with the same symptoms and private insurance would have been seen by an ENT either the same day or at the latest, the following day. *Id.* at 21-22.[20]

45. Nathaniel experienced much greater difficulty accessing care than would a similarly situated child with private insurance. *Id.* at 23. Having Nathaniel wait five days for an ENT evaluation was "unreasonable." *Id.* at 25. He should have received an ENT evaluation the same day his mother called or at the very the latest, the next day. *Id.* at 25.

5. J.S.

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

47. J.S. has variable immune deficiency, which means she lacks an immune system and can get sick very easily. *Id.* at 1958:11-19; 1958:23 – 1959:2. J.S. sees Dr. Gary Kleiner at the University of Miami for her immune deficiency. *Id.* at 1959:16-21. Dr. Kleiner restricts patients with Medicaid to Thursday appointments only. *Id.* at 1959:22 – 1960:4. Dr. Kleiner, however, sees patients with private insurance on other days of the week. *Id.* at 1960:13-18. At times, J.S. has had to wait up to a month for an appointment. *Id.* at 1960:19-21.

48. J.S. has broken her ankle on several occasions. The first time was in 2000. *Id.* at 1961:10-13. K.S. took her daughter to Jupiter Medical Center, where they splinted her ankle, and referred her to an orthopedist. *Id.* at 1961:10-19. The

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

orthopedist did not take Medicaid. For several days, K.S. called orthopedists in the phone book to find one to treat J.S. *Id.* at 1961:20 – 1962:5.

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

50. K.S. then called a 1-800 Medicaid number for suggestions for an orthopedist. *Id.* at 1965:17-22. She called all the doctors she was given but no one would agree to treat her daughter because she was on Medicaid. *Id.* at 1965:23 – 1966:5; 1967:10-13. She also called orthopedists listed in the Yellow Pages for Palm Beach County without success. *Id.* at 1966:6-18; 1967:10-13. She called St. Mary's Hospital for a referral but could not find an orthopedist that way either. *Id.* at 1966:19-22. None of the orthopedists she called would agree to treat her daughter as a Medicaid patient. *Id.* at 1967:17-19; 1996:22 – 1997:13; 2023:18 – 2024:1.

51. Finally, with help from a law firm, she obtained an appointment with an orthopedist. *Id.* at 1967:20 – 1968:7; 2024:2-3.

52. In 2007, J.S. injured her wrist, K.S. on 5/17/2010 Final Tr. at 1971:1-6; 2001:4-12, and was given a splint in the E.R. and referred to an orthopedist. *Id.* at 1971:7-13. K.S. called the orthopedist that the emergency room recommended, but she was unable to get an appointment, despite her diligent efforts. *Id.* at 1971:14–1973:6.

53. Eventually, the University of Miami gave K.S. some suggestions for an orthopedic doctor. *Id.* at 1973:7-14. Two of those doctors told her that they could not see J.S. for a couple of weeks, even though K.S. explained that her daughter had a broken wrist and needed follow-up care. *Id.* at 1973:15-16; 1973:22 – 1974:3. The third doctor, Dr. Aileen Danko, agreed to see J.S. three days after she broke her wrist. *Id.* at 1973:20-21; 1974:14 – 1975:9; 2023:1-3; PX 746 at DANKO 000001 to 000020. Dr. Danko's office is in Coral Springs and is about an hour and a half drive each way from K.S.'s home.[21] *Id.* at 1975:10-15. K.S. took her daughter to see Dr. Danko about four to five times. *Id.* at 1975:16-18.

54. The dentist, who used to treat J.S. and bill Medicaid for her treatment, refused to continue seeing her when she turned 14. *Id.* at 1976:25 – 1977:5. K.S. called a number of dentists trying to find a dentist who would accept Medicaid and treat her, but could not find a Medicaid dentist. *Id.* at 1977: 6-11. Eventually, J.S.'s former dentist agreed to continue seeing her.

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

6. N.V.

56. N.V. was born in February of 2004, in New Jersey. K.V. on 8/13/2010 Final Tr. at 4228:16-17. N.V. suffers from hydrocephalus and was ultimately

[21] I take judicial notice of the distance and purported driving time, according to Google and MapQuest, from Jupiter to Dr. Danko's office. D.E. 1127, 1136, and 1137. "A Court may take judicial notice of the driving distance between two points located in the record using mapping services whose accuracy cannot reasonably be questioned." *United States v. Williams*, 476 F. Supp. 2d 1368, 1378 (M.D. Fla. 2007) (citing Fed. R. Evid. 201(b); *Gordon v. Lewistown Hosp.*, 272 F. Supp. 2d 393, 429 (M.D. Pa. 2003); *Richard v. Bell Atl. Corp.*, 209 F. Supp. 2d 23, 27 n.2 (D.D.C. 2002)). Both the distance and driving time are farther if one starts from K.S.'s actual home address, not simply from Jupiter.

diagnosed with Shwachman Diamond Syndrome, which causes pancreatic insufficiency. *Id.* at 4229:6-20; 4243:3-9. Proper nutrition is therefore critical to N.V.'s health. *Id.* at 4242:23 – 4243:2.

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

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

59. K.V. took N.V. to Dr. Charles M. Robbins, who treated N.V. for his tooth decay and administered his cleanings from January to September of 2007. *Id.* at 4236:18-20. In September of 2007, however, Dr. Robbins advised that because N.V. needed caps, he would no longer treat him. *Id.* at 4238:18-22.[22] Dr. Robbins further explained that if N.V. lost a cap, Medicaid would not pay for a replacement; thus, it would be "very hard" "to find someone who will accept Medicaid to do that work." *Id.* at 4278:11-23.

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

61. Ultimately, she was referred to Dr. Howard Schneider who is located office is two hours from her home. *Id.* at 4231:11-16; 4242:8-19; 4243:22-25. A month later, N.V. had his first appointment with Dr. Schneider. *Id.* at 4242:13-17; PX 673. By this time, N.V.'s appetite had diminished because of the tooth decay

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

to the point that he was only drinking milk. *Id.* at 4243:15-19. Dr. Schneider was the only dentist K.V. could find who was willing to treat N.V. *Id.* at 4279:7-10; 4279:18-25. N.V. continues to see Dr. Schneider. *Id.* at 4231:11-20. K.V. takes N.V. to see Dr. Schneider four times a year due to his proclivity to tooth decay. *Id.* at 4243:22-25.

62. In the fall of 2011, N.V.'s neurosurgeon, Dr. Olivera, referred him to see a neuropsychologist after N.V. began to experience difficulty comprehending in school. K.V. on 2/1/2012 Rough Tr. at 73, 75. Dr. Olivera explained to K.V. that learning problems are a common issue for children with hydrocephalus and recommended that N.V. be evaluated by a neuropsychologist before the start of the school year. *Id.*

63. Dr. Olivera referred N.V. to a neuropsychologist group with two offices: one in Orlando, near N.V.'s home, and the other in Melbourne. *Id.* at 74-75. In early September, K.V. attempted to make an appointment, explaining that her son was on Medicaid. *Id.* at 74-75. The Orlando office did not have any available appointments and the Melbourne office could only offer an appointment in January with Dr. Lyons. *Id.* at 76-77. Moreover, Dr. Lyons's office did not commit to seeing N.V. in January, but instructed K.V. to call back for confirmation of whether N.V. could be seen. *Id.* at 76. K.V. called back to the office every week for the next six weeks to find out whether or not Dr. Lyons would agree to treat N.V. *Id.* at 77-78. During this period, K.V. asked both Dr. Lyons and Dr. Olivera for a referral for a neuropsychologist who would accept Medicaid, but neither could provide one. *Id.* at 77. Finally, with assistance from Dr. Olivera, K.V. was seen by Dr. Lyons in November of 2011, about two months after N.V. first sought an appointment. *Id.* at 77-79.

7. J.W.

64. In 2004 and until otherwise specified, J.W. resided in Pensacola, Florida with his grandmother, E.W., who serves as his next friend in this action. On December 21, 2004, E.W. took J.W. to see his pediatrician because he was complaining of a pain in his thigh. PX 629 at Whibbs 000008. The pediatrician ordered x-rays of his knee and femur, and found a tumor on J.W.'s thigh. E.W. 6/16/2010 Depo. Desig. at 11:24 – 12:10.

65. The pediatrician referred J.W. to an oncologist at the Nemours Hospital in Pensacola for an urgent consult. The oncologist examined J.W. a few days later and, because it was almost Christmas, agreed to let J.W. go home for the holiday. The oncologist began treatment immediately thereafter. PX 630 at JW_CMS000027.[23] On December 27, 2004, less than a week from the time when J.W. went to his pediatrician, the oncologist operated on and removed a tumor from his left thigh. PX 630 at JW_CMS000031; E.W. 6/16/2010 Depo. Desig. at 12:11 – 14:14.

66. On July 20, 2005, E.W. took J.W. to his previously scheduled appointment at Nemours to see Dr. Chatchawin Assanasen. EW 6/16/2010 Dep. Desig. at 134:1 – 135:7. J.W. complained of pain in his neck that resembled the pain in his thigh six months earlier. E.W. 6/16/2010 Depo. Desig. at 19:22 – 20:17. Dr. Assanasen suspected a recurrence of his tumor, saying the complaints of "neck pain" "were highly concerning of new disease," PX 634 at Nemours 000145, and wanted to perform an imaging study, either a CT scan or an MRI, to see if the tumor had returned. *Id.* at 000157.

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[23] The admission history states the x-ray was made on 10/22/04, PX 630 at JW_CMS 000027, but that is clearly a typographical error because the x-ray was done on 12/22/04.

67. The same day, Dr. Assanasen's office sought authorization from Health Ease to perform an imaging study. *Id.* at 000145; 000157. At that time, J.W. was on Medicaid, and assigned to Health Ease, a Medicaid HMO. On August 2, the request was still pending and Dr. Assanasen personally called the HMO to try to expedite authorization for the CT scan. *Id.* at 000157 (8/2/2005 note at 11:45 a.m.). Authorization was still delayed. Nemours 000145 ("difficulty obtaining authorization for imaging studies"); *Id.* at 000065 ("difficulty abtaining [sic] imaging studies"); E.W. on 6/16/2010 Depo. Desig. at 26:22-25; 31:6-19; 36:17-24; 137:2-24; 195:5-22.

68. E.W. and the rest of the family were deeply concerned, PX 634 at Nemours 000157, as J.W.'s pain was getting worse. E.W. on 6/16/2010 Depo. Desig. at 27:6 – 28:15. E.W. called Dr. Assanasen's office every day to see if he had been able to obtain authorization for an imaging study. *Id.* at 27:25 – 28:15; 29:9-20.

69. Part of the delay in approving the imagining study apparently resulted from the fact that the Medicaid HMO had switched J.W.'s primary care provider without the knowledge or consent of E.W. J.W.'s primary care provider was Dr. William J. Whibbs, PX 629 at Whibbs 000008; PX 630 at JW_CMS 000003; E.W. 6/16/2010 Depo. Desig. at 46:16 – 47: 8, but he switched to Dr. Patrick Murray. E.W. 6/16/2010 Depo. Desig. at 49:23 – 50:23.

70. As part of the process of getting Health Ease to approve the imagining study to see if the tumor had spread to J.W.'s neck, E.W. had took J.W. to be evaluated by Dr. Murray on August 10, 2005. PX 632 at Murray 00001-3; E.W. 6/16/2010 Depo. Desig. at 51:21 – 52:16. Dr. Murray, again, recommended the C.T. scan for J.W. The study was finally completed on August 24, about five

weeks after Dr. Assanasen's office initially sought authorization from the insurance company.[24] PX 634 at Nemours 000219-22.

71. The study revealed that the tumor had spread to E.W.'s neck and caused "significant bony disruption and tumor infiltration to the spinal canal." PX 634 at Nemours 000143. "The site of this new lesion was highly concerning for cervical instability as well as risk of spinal cord depression if the mass was allowed to spread." PX 634 at Nemours 000145. J.W. was "emergently admitted" for evaluation by both oncology and pediatrics. *Id.* The doctors began treating J.W. with chemotherapy and placed him in a Philadelphia collar to stabilize his neck. *Id.* at 000149.

72. His oncologist wanted to administer the chemotherapeutic agents through an infusaport because the agents are caustic and could burn his skin, but due to delay in receiving approval, this was not done. *Id.* at 000146 ("therapeutic agents which can if extravasated into peripheral skin cause significant burns"); *id.*

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[24] Defendants suggest that the delay in authorization was due to the fact that Dr. Murray, who was responsible for arranging and approving specialist care was not contacted until August 10. *See* Defs.' Corrected Proposed Findings of Fact and Conclusions of Law at 87-88. E.W. testified that Dr. Assanasen informed her that he would handle the authorization. E.W. 6/16/2010 Depo. Desig. at 136:15 – 138:12. She stated that she relied on Dr. Assanasen because she "figured that he'd know more than [she] did about who to talk to, so [she] left it up to him." Additionally, J.W.'s PCP was switched to Dr. Murray on August 1, 2005, without E.W.'s consent. *Id.* at 46:16 – 47: 8. I find that E.W. reasonably relied on Dr. Assanasen to obtain authorization for the C.T. scan. I further find that E.W. did not contribute to the delay of the CT scan by not contacting Dr. Murray.

Defendants also suggest that the CT scan was not urgent because Dr. Murray noted that "a Heating pad [was] all that is usually needed to make [the pain in J.W.'s neck] go away." Defs.' Corrected Proposed Findings of Fact and Conclusions of Law at 88. That the pain could be treated with a heating pad does not negate the fact that the scan was urgent to determine whether J.W.'s cancer had returned. I find that the five week period it took to authorize the CT scan constituted an unreasonable delay. A child with private insurance whose physician ordered an imaging test because he suspected the child had a tumor would likely be able to obtain an imaging study within a day or two, and in no event would have to wait more than a week. Having to wait five weeks for a study was below the standard of care. Middlemas on 1/31/2012 Rough Tr. at 5-6.

at 000150 ("The chemotherapy was given through a peripheral vein, as we have not yet received approval from Health Ease to have a surgical consultation for Port-A-Cath placement.") The doctors began administering the chemotherapy intravenously, through a syringe in late August, so there would not be a delay. *Id.* at 000149; E.W. 6/16/2010 Depo. Desig. at 57:5-15; 58:2 – 59:15; 149:8-19. The infusaport was subsequently approved by the Medicaid HMO, and installed on September 15, 2005, more than two weeks after the chemotherapy began. PX 631 at Sacred Heart 000117.

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

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

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

B. Florida Medicaid Reimbursement Rates (Fee for Service)

76. AHCA is responsible for setting the reimbursement rates paid to physicians who provide Medicaid services. *See* Fla. Stat. § 409.902.

77. AHCA sets Medicaid rates for physicians' services as a fraction of Medicare rates, which are determined by the federal government. *See* PX 128A, 1/3/08 Memorandum from B. Kidder to C. Snipes; PX 685, HB 329 AHCA Bill Analysis at AHCA 00755762; PX 495, Dr. Samuel Flint Report at 13-14. The "Medicare fee schedule is derived and updated through a complex process done in collaboration with . . . medical provider groups as well as health policy researchers." PX 495, Flint Report at 13. That process results in the Resource Based Relative Value System ("RBRVS"), by which all health care services are assigned a code and a total relative value based on physician work, practice expense, and malpractice expense. *See* PX 128A; PX 685 at AHCA 00755762. The federal government adjusts the Medicare rates for each procedure code to account for geographical practice cost variations. *See* PX 495, Flint Report at 13. Even though the resulting Medicare rates "historically have been below private market rates[,]" they are intended to "provide current, fair relative reimbursement rates through [a] quasi-public utility model driven by production cost theory and tempered by real world data and clinician review." *Id.* at 13.

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

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

PX 128A. *See also* PX 685.

79. In 2008, the conversion factor was 34.0682 for Medicare, compared with just 19.6332 for Medicaid. *See* PX 128A at AHCA 00981413; Snipes on 12/9/2009 Final Tr. at 357:7-23. Generally speaking, this means that Medicaid rates for children's primary care services are about 40% less than Medicare rates for comparable services, both in the fee-for-service and the managed care contexts. *See* PX 128A; PX 495, Flint Report at 14 (comparing Florida Medicaid rates for primary care and specialty care services to Medicare rates).

80. In discharging its responsibility to set physician reimbursement rates, AHCA does not consider whether the reimbursement rates are sufficient to ensure that children on Medicaid have access to health care services equal to that of other children in the general population. *See* Snipes on 12/9/2009 Final Tr. at 360:9-20; Kidder on 5/19/2010 Final Tr. at 2492:14 – 2494:19. Nor does AHCA consider whether the rates are sufficient to ensure that EPSDT services are made available with reasonable promptness. *Id.* Throughout this litigation, defendants have disavowed any legal responsibility for ensuring that health care services are made available to children on Medicaid, arguing that their duty is to provide payment with reasonable promptness when such services are rendered. *See, e.g.*, D.E. 548-3 (Def. Mot. for Summ. J. at 5).

81. AHCA has not conducted studies as to whether physicians' fees are sufficient to comply with the law. *See, e.g.*, Snipes on 12/9/2009 Final Tr. at 360:21 – 362:23. *See also* Kidder on 5/19/10 Final Tr. at 2649:2-18 (AHCA has

not conducted any studies since that referenced in a 2003 LBR stating that AHCA had "found critical shortages of Medicaid participating physicians in the state.").

82. Although certain codes for office-based and preventative health care visits are held outside the "budget neutrality" and conversion factor analysis, an overwhelming number of codes are not. *See* Williams on 10/17/2011 Rough Tr. at 133-134; Kidder on 5/19/2010 Final Tr. at 2502:5-14; DX 470. Even for those codes, trial testimony shows that current Florida reimbursement for Medicaid is substantially below the level provided for Medicare reimbursement for the same office-based services that are the most commonly billed codes. *See* Kidder on 5/19/2010 Final Tr. at 2497:16 – 2499:1.221. Plaintiffs presented credible evidence that for areas in Florida outside of Miami and Ft. Lauderdale, office-based services under Medicaid for primary care physicians serving children are compensated at rates that for most codes are less than half of the Medicaid rate. *See* PX 781, Louis St. Petery Demonstrative Exhibit A. 223. The cost of living adjustments to Miami and Ft. Lauderdale Medicare rates are higher in those areas, whereas Medicaid reimbursement is the same statewide. Thus, the differential between Medicaid and Medicare reimbursement is greater in the Miami and Ft. Lauderdale areas, with Medicaid paying an even lower percentage of Medicare reimbursement. *See* PX 780 (Medicare Rates); PX 781 (Medicaid Rates).

83. Medicaid reimbursement in Florida is even less than levels of private reimbursement programs. Andrew Agwunobi, former Secretary of AHCA, acknowledged that "one thing is very clear: [p]roviders are in general underpaid in contrast to commercial insurance and Medicaid." PX 126a at 6. A number of primary care providers testified that Medicaid reimbursement is substantially below private insurer reimbursement for the same procedures in the same geographical areas.

84. The difference between Medicaid reimbursement and private reimbursement is also true for specialists.

85. Primary care fees were increased in 2000 by a total of $1.8 million for 3 office visit codes; in 2002, the Florida legislature authorized a 4% increase for all providers treating children. No other increases for primary care providers for children have occurred since 2000.[25] PX 128A. Rather, in October of 2008, the legislature cut by one-third from $3 to $2, the monthly per child fee paid primary care providers participating in the MediPass system for managing the care provided to children on Medicaid. St. Petery on 12/10/2009 Final Tr. at 625:11-15; Williams on 10/17/2011 Rough Tr. at 141.

86. Certain specialists received an increase in 2004 of 24% for treating children on Medicaid. *See* PX 128A. This is the only adjustment in nearly 10 years, and it leaves specialist reimbursement substantially below the current Medicare levels for office-based services.

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

88. Florida's Medicaid reimbursement level was in the lowest quintile of states in the United States as of 2003 and it has continued to decline relative to other states. Flint on 8/5/2010 Final Tr. at 3521:2-20.

89. In LBRs over a number of years, AHCA has requested increases in Medicaid reimbursement rates. These LBRs included an increase in the compensation paid for healthy kid check-ups as well as for specialist care. As

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

explained by Carlton Snipes, former Deputy Secretary of Medicaid and Medicaid Director for AHCA, the agency singled out 4 specialty areas (dermatologists, neurologists, neurosurgeons, and orthopedists) for modest fee increases, not because these were the only areas in which an increase was needed, but in hopes that a modest request would be more politically acceptable. None of these proposed increases were enacted. The LBRs from AHCA made in each legislative year from the 2005-2006 legislative session through the 2009-2010 legislative session called for an increase in child-health check-up fees. PX 92-96; PX 702-703; PX 734. In addition, AHCA proposed increases in the 2008-2009 and 2009-2010 budgets of 40% for four specialty areas. Those, too, were rejected each year. PX 89-90; PX 727; Snipes on 12/9/2009 Final Tr. at 405:21 – 406:14. Finally, a $2 fee proposal made to incentivize physicians to collect lead blood specimens was also made but failed to pass each year for each legislative year from 2005-2006 through 2009-2010. PX 97-98; PX 704-705.

90. Defendants, and certain of their witnesses, claim that these LBRs were predicated on unsupported information. *See* Williams on 10/17/2011 Rough Tr. at 163-164; Kidder on 10/3/2011 Rough Tr. at 77. I find defendants' explanations unpersuasive. The LBRs were prepared by officials who recognized their obligation to be accurate and honest in presenting the views of their agency to the governor and the legislature. Moreover, these very witnesses admitted under oath as agency representatives during their depositions that the LBRs were truthful and correct. At trial, AHCA admitted that they never told the legislature that their LBRs were wrong. In addition, the agency itself repeatedly acknowledged the importance of reimbursement increases in submissions to the legislature. As Mr. Snipes acknowledged, these requests were indicative not of simply wanting to pay doctors more but of a substantial problem in current reimbursement levels. Snipes on 12/9/2009 Final Tr. at 380:4 – 381:10; Snipes on 1/8/2010 Final Tr. at 1243:6-

23. *See also* PX 701; PX 727. I find the agency's own testimony during depositions regarding their reasons for requesting budget increases is evidence that Medicaid reimbursement rates for primary and specialist care were inadequate. *See also Cockrum v. Califano*, 475 F. Supp. 1222, 1227 n.1 (D.D.C. 1979) (Secretary of Health, Education and Welfare estopped from asserting claimants responsibility for delays in administrative hearings by his admissions elsewhere that the delay problem was nationwide in scope.)

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

92. Dr. Flint measured the difference in 2008 rates between Medicaid and Medicare for common office based procedure codes and concluded: "Florida Medicaid reimburses primary care physicians at slightly more than one-half of what Medicare pays, and specialists receive about two-thirds of Medicare rates." *Id.* at 2. *See* also PX 782.

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

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

C. Newborns, Continuous Eligibility, and Switching

1. Continuous Eligibility

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

96. Thousands of children lose their eligibility during their first year of life when they should have continuous eligibility.

97. Ms. Sreckovich's initial report examined the period between 2004 and 2008 and focused on children under five years of age. The numbers in Ms. Sreckovich's report reflected only children whose eligibility was terminated and subsequently reinstated during a single fiscal year. Sreckovich on 1/12/2012 Rough Tr. at 96-97. Those figures are an underestimate since, among other reasons, they exclude children who never regained eligibility. St. Petery on 2/2/2012 Rough Tr. at 75-76.

98. According to Ms. Sreckovich's report, the Medicaid eligibility of children under one year of age for Medicaid was terminated 2.1% to 2.9% of the time. DX 607 at ¶ 22. Because those children had their eligibility reinstated, they could not have died or moved out of the state. Sreckovich on 1/12/2012 Rough Tr. at 97. Ms. Sreckovich acknowledged that for children under one all those terminations were improper. *Id.* at 98. That means, based on the range of improper terminations (2.1 to 2.9%) and the number of children enrolled in Medicaid, from 3,234 to 4,466 children were improperly terminated in one fiscal year in violation of their right to continuous eligibility. *Id.* at 98-99.

99. For children one to five years of age, their eligibility was terminated 6.8 % to 7.0 % of the time. DX 607 at ¶ 22. Ms. Sreckovich acknowledged that for these older children, some of those terminations were improper. *Id.* 97-98. In the case of children ages one to five, this would be approximately 65,000 children in the course of a year. *Id.* at 93-96.

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

101. Mr. Nathan Lewis, DCF bureau chief, acknowledged a "tremendous problem with the issue of maintaining continuous eligibility." He stated that "the problem was that [DCF's] eligibility system [did] not automatically know what period of continuous eligibility a child" was entitled to so that "it is dependent on staff" to recognize "that there's a child . . . who may be entitled to [a] continuous period of eligibility and should not be terminated." Lewis on 10/20/2010 Final Tr. at 4656: 2-4; 4657:18 – 4658:22. Mr. Lewis acknowledged at trial: "That problem continues to this day." *Id.* at 4658:23-24.

102. DCF conducted a Medicaid eligibility quality control analysis in 2010 for federal CMS, and reported, in a Sept. 20, 2010 letter to the acting regional administrator of CMS, that based on a review of 1200 cases, 7% of cases existed "in which the Medicaid coverage was not provided through the entitlement

period." DX 169a at 2; Lewis on 10/20/2010 Final Tr. at 4660:24 –4664:8. Mr. Lewis conceded that is not an "acceptable" error rate. Lewis on 11/29/2011 Rough Tr. at 16-17. Some of these wrongful terminations resulted from a Medicaid category being closed without a new one being simultaneously opened. Lewis on 10/20/2010 Final Tr. at 4666:14-25.

103. DCF in the same analysis also looked more generally at whether or not there had been wrongful denials of coverage or terminations and found that 29% of the terminations for both children and adults were erroneous. DX 169a at 3-4; Lewis on 10/20/2010 Final Tr. at 4667:16-25, 4671:1-12. Mr. Lewis knew of no reason why adults or children would have different termination rates. *Id.* at 4671:13-18.

104. DCF states it has been trying since 2002 to fix the problems that cause some children to be terminated in violation of their rights to continuous eligibility. Poirier on 10/5/2011 Rough Tr. at 71-72. For years, DCF has been considering implementing a computerized system for monitoring continuous eligibility of Medicaid Children, but has not done so—even though there is no technical problem that would prevent DCF from instituting an automatic system for ensuring continuous eligibility. Lewis on 10/21/2010 Final Tr. at 4800:10 – 4801:15.

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

inadvertently terminate a child's eligibility when the mother's pregnancy Medicaid terminated. St. Petery on 12/10/2009 Final Tr. at 572:18 –573:10.

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

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

108. As the executive director of Tallahassee Pediatric Foundation (TPF), Dr. St. Petery has access to FMMIS print screens which provide certain information regarding a child's eligibility and assignment to a primary care provider. St. Petery on 12/10/2009 Final Tr. at 554:19 – 555:10. Dr. St. Petery has personally seen cases of improper termination of continuous eligibility with patients of TPF by studying those patients' FMMIS print screens from which he could tell their eligibility had been incorrectly terminated and then restored retroactively. *Id.* at 555:1-21, 575:18 – 576:11.

2. Switching

109. "Switching" occurs when a child has been switched to a different Medicaid plan. Often times this is discovered when the child goes to their pediatrician's office for care, and the pediatrician queries the Medicaid system and determines that the child, without the parent's knowledge or consent, has been switched to a different Medicaid plan for which that physician is not a provider. St. Petery on 12/10/2009 Final Tr. at 548:13-19. Improper termination is a

common cause of switching. Children whose eligibility has been terminated and then reinstated within a 60 day period are required to be reassigned back to the plan they originally chose. This requirement, however, is not always followed, leading to more "switching." McCormick on 8/12/2010 Final Tr. at 4148:3 – 4149:14.

110. Getting a child switched back to the original primary care provider can be a time-consuming process because the system only allows a change once a month. *Id.* at 562:14 – 563:15. "Many times the provider's staff spends a lot of time trying to fix the problem so that the child can come back to their practice." *Id.* at 558:1-4. A primary care doctor from whom a child has been switched no longer can authorize a referral for further care, even for an x-ray. *Id.* at 559:6 – 560:9. Generally, if a child has been switched to an HMO, the HMO will not pay the physician to whom the child was previously assigned. *Id.* at 558:5-19.

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

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

113. Robert Sharpe was AHCA Medicaid Director from 2000 to 2004 and assistant Medicaid Director from 1998 to 2000. Sharpe on 11/16/10 Final Tr. at 4926:19 – 4927:2; 4929:24 – 4930:8. Mr. Sharpe testified that during his time as AHCA Medicaid Director he received a low number of complaints about switching. Dr. St. Petery, however, met with him on multiple occasions to discuss switching. *Id.* at 4932:22 – 4933:2. Mr. Sharpe had his staff investigate cases

brought to him by Dr. St. Petery, and they determined that the children were indeed switched without the parent requesting a change of provider. *Id.* at 4933:2:2 – 4933:12.

114. Phyllis Sloyer, then Assistant Director of CMS, also complained to Mr. Sharpe about switching and how it affected continuity of care for children in the CMS program. *Id.* at 4933:13 – 4935: 9. Mr. Sharpe was not able to eliminate switching, which remained a problem during his tenure. *Id.* at 4935:10-15; 4936:13-15.

3. Reasons for Switching

115. One way switching occurs is when DCF, which determines eligibility, incorrectly terminates a child's eligibility and then, realizing the error, re-establishes the child's eligibility. Since eligibility information is transported nightly from DCF's computer to AHCA's FMMIS computer system, these actions cause AHCA's FMMIS system to send a letter to the child's parent, as it does to any new Medicaid beneficiary, telling the parent that he or she must choose a plan for the child.

116. Sometimes the parents do not receive the letters because as many as 40% of the letters directing Medicaid beneficiaries to choose a managed care plan come back as undeliverable. Brown-Woofter on 11/8/2011 Rough Tr. at 149-151. At least in some instances when AHCA investigated examples of switching, it was not able to confirm that a choice letter was indeed sent to the beneficiary. Depo. Desig. of Hamilton on 11/6/2008 at 184:9 – 186:12. Sometimes the parents do not understand the letter, perhaps because the parent does not even know the child was terminated and reinstated. St. Petery on 12/10/2009 Final Tr. at 565:10 – 566:6. In either event, the parent does not respond.

117. When AHCA does not hear back from the child's parent with a plan choice within the allotted time, it auto-assigns the child to a plan. Brown-Woofter

on 11/8/2011 Rough Tr. at 148. By statute, 65% of the assignments are to Medicaid HMOs, which may not be a plan in which the child's pediatrician is enrolled. St. Petery on 12/10/2009 Final Tr. at 570:1-25; Plaintiffs' Demonstrative Exhibit C on Switching used with Dr. St. Petery.

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

119. During the course of this litigation, DCF discovered that when it deletes the Medicaid eligibility category code for a child and places the child in a new eligibility category, AHCA sometimes interpreted that change as a termination of the child's Medicaid eligibility, even though the second Medicaid category began immediately after the first category was terminated. Lewis on 10/20/2010 Final Tr. at 4645:15 – 4646:22. DCF learned this not only during the course of this litigation, but ***because of*** this litigation. Lewis on 11/29/2011 Rough Tr. at 12-13.

120. To avoid that situation, DCF case workers were instructed to close the old category and open a new category simultaneously so that AHCA would not confuse a category change with an eligibility termination. Lewis on 10/20/2010 Final Tr. at 4646:23 – 4647:6.

121. DCF has not taken any steps to measure what impact their change in practice has had on "switching." Lewis on 10/20/2010 Final Tr. at 4654:7-9.

4. Evidence of switching

122. Several of the named plaintiffs in this case—S.B, K.K. J.W.— were switched, some multiple times, and their switching led to delayed or interrupted

care. S.B.'s 18-month check-up was delayed. Because K.K. was switched, he had to change from Vyvance, an ADHD drug that worked for him, to Adderall, one that did not. In J.W.'s case, on one occasion switching contributed to a five-week delay in performing an imaging study to see if a tumor had reappeared on his neck, and in another, it caused his family to have to pay out of pocket for his ADHD medication. *See supra* at 55-58.

123. Testimony at trial also showed that switching is a regular occurrence for primary care providers. Dr. Lisa Cosgrove is a primary care physician who practices in Merritt Island, Florida, in Brevard County. Cosgrove on 05/19/2010 Final Tr. at 2550:8-9, 2552:15-25. Dr. Cosgrove's Medicaid patients are switched to other plans on a "regular basis"; it occurs on a daily basis. *Id.* at 2575:16 – 2577:19. Some of Dr. Cosgrove's patients who get switched end up in the emergency room. *Id.* at 2579:1-4, 2580:14-20. Switching interferes with her patients' continuity of care. *Id.* at 2581:15 – 2582:13. Switching also consumes the time of office staff who try to assist patients in getting switched back to her practice, for which there is no compensation. *Id.* at 2583:13 – 2584:5.

124. Dr. Nancy Silva is a pediatrician who practices in Brandon, Florida. Silva on 5/20/2010 Final Tr. at 2767:19-21; 2768:1-2. Dr. Silva's Medicaid patients are switched "all the time" from one primary care provider to another and one insurer to another. *Id.* at 2796:11-21. Seldom does the child's new doctor authorize Dr. Silva's office to see the child unless there is an acute significant illness. Without authorization from the new doctor, Dr. Silva cannot get paid for any care provided. *Id.* at 2798:16 – 2799: 3. Thus, switching interferes with her patients' continuity of care. *Id.* at 2799:4-20. Switching also results in lost staff time for pediatricians and is a deterrent to participating in Medicaid. *Id.* at 2799:21 – 2800:11. It takes approximately six weeks to get a Medicaid child who has been

switched to another provider reassigned to her practice. Silva on 1/19/2012 Rough Tr. at 147-48.

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

126. Dr. Delores Falcone Tamer is a pediatric cardiologist at the University of Miami Medical School. Tamer on 10/19/2010 Final Tr. at 4494:13-23. Dr. Tamer currently has a CMS clinic, a private clinic, and a clinic for the Jackson Memorial Hospital. *Id.* at 4496:8 – 4497:5. Dr. Tamer encounters switching when a child is referred to her by a primary care doctor who lacks authorization to make the referral. *Id.* at 4531:9-18; 4532:21 – 4533:13. When such switching occurs, it usually means the procedures are postponed a month. *Id.* at 4533:14-17. Common diagnostic tests that are delayed for a month by switching are: echocardiograms and electrocardiograms, which test the competency, anatomy, and function of the heart. *Id.* at 4533:25 – 4434:12.

127. Dr. Tommy Schechtman is a pediatrician who practices at three offices in Palm Beach County: Palm Beach Gardens, Jupiter, and Boca. Schechtman on 5/20/2010 Final Tr. at 2832:8-13; 2833:7-14; 2833:18-22. Dr. Schechtman's Medicaid patients are frequently, and without their knowledge, switched from one primary care provider to another or from one Medicaid product to another. *Id.* at 2847:6-20. Dr. Schechtman encounters switching several times a day and he has a "person in his business office who spends 50% of her time dealing with Medicaid eligibility, Medicaid switching and issues along those lines." *Id.* at 2847:21 – 2848:4. According to Dr. Schechtman, switching causes a number of adverse

consequences on the health and well-being of the switched child including: interrupting continuity of care and delaying check-ups and vaccinations. *Id.* at 2848:5 – 2849:8. Although Dr. Schechtman's figures have some reliability problems, they are consistent with the testimony of other doctors with respect to switching.

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

129. In the practice Dr. St. Petery shares with his wife, switching is "almost an everyday occurrence." St. Petery on 12/10/2009 Final Tr. at 561:11 – 562:5; Dr. Julia St. Petery Depo. Desig. on 11/11/2008 at 108:2-12. As executive director of TPF, Dr. St. Petery sees a higher rate of switching among the more than 7,000 TPS patients. St. Petery on 12/10/2009 Final Tr. at 561:24 – 562:5.

5. "Baby Of" Process

130. A "presumptively eligible" newborn is a child whose Medicaid eligibility is presumed by DCF based on the pregnant mother's Medicaid eligibility. Lewis on 10/20/2010 Final Tr. at 4650:12-21. The purpose of "presumptive eligibility," also known as the "baby of" process, is to make a child eligible for Medicaid as soon as possible. St. Petery on 12/10/2009 Final Tr. at

602:3-15. It is called the "baby of" process because it describes the practice of a pregnant mother applying to DCF for a Medicaid number for her unborn child. *Id.* at 601:1-11. When the child is born, the Medicaid number is supposed to be activated. *Id.* at 602:16 – 603:1.

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

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

133. Carol McCormick is the administrator and nursing director of TPF. McCormick on 8/12/2010 Final Tr. at 4110:9-19. At the time of her testimony, TPF had about 7,400 children enrolled, 7,300 of whom were enrolled in Medicaid. *Id.* at 4114:22-25. Nurse case managers at TPF frequently encounter presumptively eligible newborns whose Medicaid is not activated or whose eligibility has been terminated in less than a year's time. *Id.* at 4118:8-24. In the fall of 2008, when a subpoena for documents was served on TPF, Ms. McCormick instructed her staff to provide her with all the charts of children who were currently experiencing eligibility problems. In response, she received 90 charts. *Id.* at

4120:8 – 4121:20. Twenty-four of those charts involved an issue of continuous eligibility, 15 concerned presumptive eligibility, and 47 were cases in which the parent's choice of health care plan had not been implemented or had been switched. *Id.* at 4121:21 – 4122: 25. Some of these files reflected more than one problem. *Id.* at 4123:1-5.

134. Prior to 2008, a mother was assigned a different personal identification number and case number than her baby. Under this system, babies were sometimes given two personal identification numbers because it was difficult to match the "baby of" application with the subsequent newborn child. Poirier on 10/5/2011 Rough Tr. at 39; 43. *See also* PX 738. As soon as DCF found out there were two numbers for a child, it would cancel one. St. Petery on 12/10/2009 Final Tr. at 603:18-25. If, however, a number that a provider was billing under was the number that was cancelled, AHCA would deny payment for the services billed under that number. *Id.*

135. In 2008, DCF reprogrammed its computers to allow a pregnant woman applying for Medicaid for herself and her unborn child to be assigned the same case number, even though the mother and eventually the child would each be assigned a separate Medicaid personal identification number. The new policy was set forth in a July 2008 memorandum to DCF workers. PX 738. Under that policy, workers must manually input data at 12 different steps. Poirier on 10/5/2011 Rough Tr. at 43-45. If a worker makes a mistake in that manual process, a child may be improperly terminated. *Id.* at 45-47, 68-69.

136. DCF's new procedure has not resolved the problems with the "baby of" process. St. Petery on 12/10/2009 Final Tr. at 607:2 – 607:9. Moreover, the change of placing newborns into the mother's "case" has the potential to increase the amount of switching because it increases the chances that a change in the

mother's eligibility category at DCF will trigger AHCA's FMMIS system to deem the child's eligibility cancelled. St. Petery on 2/2/2012 Rough Tr. at 82-83.

137. Despite the issuance in 2009 by DCF of a memo directing that babies be kept in their original Medicaid category for 13 months regardless of household circumstances, interruptions of eligibility for such children continue to occur. *Id.* at 136.

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

D. Provision/Utilization of Primary Care (*e.g.*, EPSDT)

139. The purpose of EPSDT is to identify and correct medical conditions in children and young people before the conditions become serious and disabling; to provide entry into the health care system and access to a medical home for each child; and to provide preventative/well-child care on a regularly scheduled basis. PX 31 at AHCA 00963753; St. Petery on 12/10/2009 Final Tr. at 518:11 – 519:8.

140. Medicaid eligible children are entitled to check-ups from birth through age 20 in accordance with Florida's periodicity schedule. They should receive check-ups at 2 to 4 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and then once per year from 2 to 6, one at 8, one at 10, and one per year from 11 to 20. A check-up includes a comprehensive medical history, a dental screening, vision screening, hearing screening, appropriate immunizations, and other services. PX 31 at AHCA 00963754 – AHCA 00963757; St. Petery on 12/10/2009 Final Tr. at 519:9 – 522:6.

141. Children who do not receive check-ups are more than twice as likely to require emergency room care. PX 31 at AHCA 00963773; St. Petery on 12/10/2009 Final Tr. at 522:11-23. As defendants have stated in one of their

LBRs, more child check-ups "may increase the early identification of medical conditions before they become serious and disabling." PX 95.

1. The CMS 416 Reports

142. More than 380,000 children on Medicaid in Florida who should have received at least one screening examination according to Florida's periodicity schedule did not receive any preventative care in the federal fiscal year ending on Sept. 30, 2007. *See* PX 8 at AHCA 0000087 (compare Line 9, the total eligibles who should have received at least one initial or periodic, with Line 10, the total eligibles receiving at least one initial or periodic screen); Snipes on 12/9/2009 Final Tr. at 369:4 – 370:8. The 380,000 figure represents, not simply the number of children enrolled in Medicaid who did not receive a well-child check-up during the year, but rather the number of children who were expected to receive a check-up—given the length of their enrollment in Medicaid and the periodicity schedule for children their age—but did not receive one. Snipes on 1/8/2010 Final Tr. at 1261:7 – 1264:19; PX 8 at AHCA 0000087; PX 25 (see instructions for line 4 and line 8).

143. These figures come from a formal report, the CMS 416 report, which Florida and all other states must submit annually to the federal Centers for Medicare and Medicaid Services. *See* 42 U.S.C. 1396a(a)(43)(D) and Snipes on 1/7/2010 Final Tr. at 1146:25 – 1147:7. The report for the federal fiscal year ending Sept. 30, 2007 is the most recent CMS 416 report in the record.

144. The figures expressed in the CMS 416 report are "participation ratios" – the total eligible children receiving at least one initial or periodic screen divided by the total eligible children who should receive at least one initial or periodic screen. PX 25 (see instructions for line 10). For the federal fiscal year ending on September 30, 2007, Florida had a participation ratio of 68%. PX 8 at AHCA 0000087; Snipes on 12/09/2009 Final Tr. at 370:10-14. That means 32% of the

children enrolled in Medicaid who were expected to receive at least one preventative screen did not receive any. The federal government has a goal of an 80% participation ratio. Snipes on 12/09/2009 Final Tr. at 370:15-17.

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

146. While there is some criticism of the methodology underlying the CMS 416 report, and some evidence that the data underlying the reports are not complete, the CMS 416 report is widely considered the best data source available regarding the number of children on Medicaid who receive preventative care as well as the number of children eligible for preventative care through Medicaid but who do not receive such care. The CMS 416 reports are considered reliable by the federal government and by the health services research community, and defendants' attacks on the reports are not generally convincing. Flint on 1/24/2012 Rough Tr. at 154.

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

148. As to potential delay with reporting claims, the federal fiscal year ends on September 30, and the CMS 416 report is not due until April of the following year, providing at least five months for submission of claims or encounter data for services provided on September 30, and proportionally more, for services provided earlier in the year. Flint on 1/24/2012 Rough Tr. at 162.

149. While physicians compensated on a fee for service basis have up to one year from the date of service to submit a claim for reimbursement to AHCA, there is no evidence that physicians wait to submit their claims, and it would be economically irrational for them to do so. *Id.* at 161. Tellingly, while AHCA could submit an amended CMS 416 report to account for any claims omitted during the initial submission because of a so-called "claims lag," AHCA has never done so, though it is in its clear interest, especially during this litigation, to do so if that would improve its performance on the CMS 416 report. Snipes on 12/9/2009 Final Tr. at 368:15-21; Snipes on 1/8/2010 Final Tr. at 1275:23-25, 1276:7-15; Flint on 1/24/2012 Rough Tr. at 161.

150. For physicians to provide well-child screenings and then bill under an alternative CPT code would be economically irrational because almost all the alternative codes pay less than the CHCUP codes. Flint on 1/24/2012 Rough Tr. at 155-58.[26] Often the compensation for the physician is twice as high under the EPSDT code than under the alternative codes Ms. Sreckovich claims the doctors actually billed. *Id.* at 158. In any event, defendants have provided no evidence that such miscoding is systemic or widespread. Ms. Sreckovich admitted she could not quantify any such alleged coding errors. Sreckovich on 1/10/2012 Rough Tr. at 43-44.

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

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

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

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

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

154. If anything, as explained by Dr. Tom Darling, the results in the CMS 416 reports overstate the number of children who get care, especially with respect to the screening ratios that compare the total number of healthy kid check-ups to the number of expected examinations. Dr. Darling is an associate professor at the University of Baltimore's School of Public Administration and a director of government technology for the Schaefer Center for Public Policy. Darling on 1/6/2010 Final Tr. at 813:24 – 814:9. He has a Ph.D. in public administration and policy from the University of Albany. *Id.* at 815:21 to 816:6. Dr. Darling has also

served as an expert witness in other cases involving children's Medicaid and has consulted for the State of Maryland's state agencies. *Id.* at 817:3 to 819:24. He is qualified and was accepted as an expert, *id.* at 819:25 – 821:10, and I again accept him as an expert and find his testimony to be credible.[27]

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

156. Second, the federal instructions for compiling the CMS 416 report results in over-reporting of screening ratios for the "less than one" and "one to two year" age groups because the periodicity schedule does not require screenings at set intervals, but the CMS reporting requirements assume that the schedule does. Darling on 1/6/2010 Final Tr. at 850:5-17, 857:25 – 859:10. The screening ratio that Florida reports is 28.92% higher than what it should be because the error in reporting results in the expected number of screenings being too low. *Id.* at 859:11 – 865:21; PX 461 at 32-33.

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

158. Once the data are adjusted to account for Dr. Darling's recommended corrections, the screening ratios go down to .62, .61, .62, .66, and .68 for 2003 to

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[27] I recognize that Dr. Darling was not able to conduct an analysis based on services actually provided as he did in *Memisovski ex rel. Memisovski v. Maram,* No. 92 C 1982, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004), which is the better approach, because he was not provided with the necessary claims data. I also recognize that Dr. Darling was not able to compare how children in the private market are treated.

2007 instead of .67, .66, .73., .78, and .81. *Id.* at 869:5-20; PX 461 (Table 2-8). These results reflect that Florida children on Medicaid consistently receive substantially fewer screens than they should under the state periodicity schedule.

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

160. There are serious problems with this analysis. First, the credibility of Ms. Sreckovich and her report were undermined by the fact that her initial report wrongly confused "visits" with "services." Sreckovich 1/10/2012 Rough Tr. at 23-24. She made the identical error in her analysis of dental care provided to children on Medicaid. *Id.* Because, as Ms. Sreckovich admitted, it is customary for multiple services to be performed during a child's visit to a doctor or dentists, *id.* at 23, the result significantly overstate how much care children in Medicaid were receiving. *Id.* 30-35. She did not learn of this error until she read Dr. Darling's rebuttal report. *Id.* at 23-24. She did not know how she made such a significant error that was repeated throughout the report. *Id.* at 26-27. She also admitted that she did not realize that her analysis, which purported to include only claims data, also improperly included some encounter data, until she read Dr. Darling's rebuttal report. *Id.* at 22-23. Repeated errors such as these undermine Ms. Sreckovich's credibility.

161. Second, even in her revised tables, Ms. Sreckovich continued to combine the total number of well-child examinations with certain sick child examinations. She calls the combined services "preventative assessment and evaluation services," a category she created, which lacks a basis in the CPT codes. Flint on 1/24/2012 Rough Tr. at 163. She justified that approach by saying that for

those sick child visits, the children received at least some components of a well-child exam, even though they did not receive all components of a well-child exam. Sreckovich on 1/17/2012 Rough Tr. at 109. She acknowledged that she is not aware of any peer review study that has endorsed such an approach. Sreckovich on 1/10/2012 Rough Tr. at 38-40. Dr. Darling, who works extensively with CMS 416 reports, has not seen anyone combine well and sick child visits as Ms. Sreckovich did. Darling on 01/23/2012 Rough Tr. at 40-42.

162. Plaintiffs' experts, Drs. Flint and Darling, criticized that approach, stating that a sick visit was usually focused around a particular presenting condition, and there was no evidence that during such visits children receive preventative care. They further stated that such visits were not a substitute or proxy for well-child visits. Darling on 1/23/2012 Rough Tr. at 35-38; Flint on 1/24/2012 Rough Tr. at 163-67.

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

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

165. Because of Ms. Sreckovich's methodology, sick or ill child care provided to certain children can make it seem as if other children obtained care, when in actuality they did not. Sreckovich on 1/12/212 Rough Tr. at 46-47. Both Dr. Darling and Dr. Flint are strongly critical of Ms. Sreckovich's averaging approach, which they claim presents a misleading picture of how much care

children on Medicaid are receiving. Darling on 1/23/2012 Rough Tr. at 36-38; Flint on 1/24/2012 Rough Tr. at 163-65. I agree that when it comes to determining the scope of preventative care provided to children in Florida, an average approach is misleading, and I do not place weight on it.[28]

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

2. HEDIS Reports

167. The CMS 416 report is not the only report that shows children enrolled in Florida Medicaid do not receive the primary care to which they are entitled under federal law. AHCA requires its Medicaid HMOs, in accordance with 42 C.F.R. § 438.358, to collect and report on certain performance measures on an annual basis. PX 733 at 1-1. AHCA chose to use Healthcare Effectiveness Data and Information Set ("HEDIS") measures, a set of performance data that is broadly accepted in the managed care environment as the industry standard to compare and

[28] As part of her analysis, Ms. Sreckovich focused on the care provided to the named plaintiffs. While some of the named plaintiffs with chronic medical conditions received a significant amount of specialty care, they did not always receive all their well-child check-ups. For instance, J.W. did not receive numerous well-child check-ups, according to Ms. Sreckovich's own analysis. Her analysis shows he should have received 5 well-child visits during certain years when he was enrolled in Medicaid, but only received one such visit. DX 410 at Table 2B. Similarly, J.S. should have received 6 well-child visits but only received three. DX 418 at Table 2B. And S.M. did not receive his 18-month well-child check-up on time because he had been switched. *See supra* ¶¶ 1-11.

measure health plan performances. *Id.* "AHCA expects its contracted HMOs to support health care claims systems, membership data, provider files, and hardware/software management tools, which facilitate accurate and reliable reporting of HEDIS measures." *Id.* The agency contracts with Health Services Advisory Group, its external quality review organization, to evaluate how Florida Medicaid's HMOs perform against certain HEDIS measures. Brown-Woofter on 11/8/2011 Rough Tr. at 12; PX 733 at 1-1.

168. All Florida HMOs are required to have their results confirmed by a HEDIS compliance audit. PX 733 at 2-4. The results are within a 5 point sampling error at the 95% confidence level. *Id.* HEDIS measures track the care provided to beneficiaries who are continuously enrolled in Medicaid for a certain period of time—typically eleven months in a year. Crall on 2/7/2011 Final Tr. at 5213:2-6.

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

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

171. Of the 12 Florida HMOs operating in non-reform counties, 11 HMOs scored below the national median, and six scored below the low performing level. Brown-Woofter on 11/8/2011 Rough Tr. at 19. For Healthy Palm Beaches, 5.9%

of the infants received no well-child screenings in the first 15 months of their lives; for Preferred Medical Plan, Inc. 6.0%; for Humana Family c/o Human Medical Plan, Inc. 6.7%; for Vista Health Plan Inc.–Vista South Florida 7.6%; for Vista Health Plan, Inc.–Buena Vista Medicaid 7.7%; and for Jackson Memorial Health Plan 9.2%. PX 733 at 3-4. For 2007, six of the HMOs had 5% or more of the infants receiving no well-child check-ups in the first fifteen months of life. DX 361 at Defendants 022774. These figures indicate that many infants received no preventative care at all.

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

173. Other HEDIS measures also show that in both reform and non-reform counties children on Medicaid HMOs receive less primary care than children enrolled in the average HMO nationally. All 13 Medicaid HMOs operating in non-reform counties fell below that national mean in 2007. DX 361 at Defendants 022775. Five of the HMOs had results that clustered around the 25th percentile, and eight of them had results around the 10th percentile. *Id.* In reform counties, for the same year, seven of nine Florida Medicaid HMOs fell below the national mean. DX 334 at Defendants 021293.

174. As for adolescent preventative care, Florida Medicaid HMOs again generally ranked below the national mean with only 43.6% of enrolled members 12 to 21 years of age with at least one well-child visit with a primary care provider or an OB/GYN practitioner during the measurement year. DX 361 at Defendants

022757. Five of the 13 HMOs in Florida operating in non-reform counties were at or above the mean, eight were below it, with six clustered near the 25th percentile and two near the tenth percentile. *Id.* In reform counties, the results were similar. Six Medicaid HMOs scored above the national mean; nine were below it. DX334 at Defendants 021277.

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

176. Florida Medicaid HMOs also scored low in terms of the percentage of pregnant women who received prenatal care. Some of these pregnant women on Medicaid are teenage mothers. For these mothers, prenatal care is a type of primary care. Seven of Florida's Medicaid HMOs have more than one-third of pregnant women failing to receive a single prenatal visit during the study period.

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

E. Primary Care Providers Participation in Medicaid

178. There is generally a shortage of pediatricians in Florida. *See* DX 290c at 1. The shortage gives pediatricians the ability to treat higher paying patients and either not treat or limit the number of Medicaid patients they treat. The shortage of pediatricians in rural areas is especially acute. There are 10 Florida counties with no pediatricians, and seven more counties with only one pediatrician. DX 290c at 2-7; Swanson Rivenbark on 11/15/2011 Rough Tr. at 50. This shortage disadvantages children on Medicaid who must compete with higher paying patients for the services of pediatricians in other counties.

179. The number of children on the Medicaid rolls has grown sharply, but the number of pediatricians willing to treat them has not. The number of Florida children enrolled in Medicaid increased from 713,540 in October of 1998 to approximately 1.2 million in October of 2005. By December of 2008, 1,272,342 of children were enrolled in Medicaid. PX 682 at FL-MED 07816; DX 262; Snipes on 1/8/2010 Final Tr. at 1274:15 – 1275:5. As of 2011, the enrollment had risen to 1.7 million children. Lewis on 11/29/2011 Rough Tr. at 48-49. Thus, the percentage of children on Medicaid has increased by more than 33% in just under three years, from December of 2008 to November of 2011. There is no indication that the number of primary care providers has increased at all, let alone proportionately, thus placing an increased demand on existing providers. *See* PX 682 at FL-MED 07816; DX 262. In fact, Florida has an overall shortage of physicians per 100,000 residents, compared to the United States as a whole, PX 742 at Defendants 026980, and a shortage of pediatricians, DX 290c; PX 742 at Defendants 026979, thereby placing more demand on Florida physicians to treat children on Medicaid, even though Medicaid pays far less than other payors.

180. More than 20% of pediatricians in Florida were accepting no new Medicaid patients, according to a 2009 physician workforce survey. PX 742 at Defendants 027039; Swanson Rivenbark on 11/15/2011 Rough Tr. at 40-41. More than 60% of family practitioners were not accepting a single new Medicaid patient. *Id.* This is significant because family medicine practitioners provide well care for older children. St. Petery on 2/9/2010 at 1514:9-13.[29]

[29] The percentage of physicians who accept no new Medicaid patients is 46%. This is significantly larger than the percentage that accepts no new Medicare patients, which is 22%. This disparity further illustrates the inadequacies of Medicaid reimbursement rates. PX 742 at Defendants 027033, Defendants 027037.

181. In addition, numerous pediatricians limit the number of children on Medicaid that they will accept. *See* Cosgrove on 5/19/2010 Final Tr. at 2553:15 – 2557:12 (limiting practice for financial reasons to about 20% children on Medicaid); Silva on 5/20/2010 Final Tr. at 2768:23 – 2775:23 (only two of the non-for-profit company's seven pediatric sites accept new children on Medicaid, and for Dr. Silva's site, the company has limited the number of new Medicaid patients by (1) not accepting Medicaid HMOs; (2) only accepting new patients under 5; and (3) further limiting new patients to newborns, siblings of existing patients, or existing patients who go on Medicaid; about 20% of her patients are on Medicaid compared to 50% in 2001); Isaac on 8/11/2010 Final Tr. at 3855:13-17; 3856:4-12; 3861:5-25 (limits number of Medicaid patients he accepts; doesn't take any Medicaid HMOs; approves new MediPass patients on a case-by-case basis; about one-third of his patients are on Medicaid); Ritrosky on 11/10/2008 Depo. Desig. at 8:13 – 9:12; 11:1-11 (to remain economically "viable" practice, limited number of Medicaid patients by only accepting as new Medicaid patients (1) siblings of existing patients; (2) existing patients who lose private insurances; and (3) limited number of newborns); Orellana on 11/23/2008 Depo. Desig. at 99:24 – 100:11 (had to stop accepting Medicaid patients in his Gainesville but not his Lake City location).

182. The principal reason pediatricians do not participate in Medicaid (or limit their participation in the program) is because of Medicaid's low reimbursement rates. Flint on 8/3/2010 Final Tr. at 2949:21 – 2950:5 ("The fundamental issue that drives participation, that determines physician, physicians' decisions to participate in the program at all, or to limit their participation, is the rate of reimbursement."); Tamer on 10/19/2010 Final Tr. at 4512:21 – 4518:9 (describing a consensus expressed by CMS office medical directors throughout the

state that "Medicaid rates were so low that specialists were reluctant to take patients who were sponsored under the Medicaid program.").

183. Defendants have pointed to the availability of care at county health departments (CHDs) and federal qualified health centers (FQHCs). The CHDs, while providing some primary care, are not an alternative to private pediatricians. Collectively, CHDs only employed 27 pediatricians and no pediatric subspecialist as of 2009. Swanson Rivenbark on 11/15/2011 Rough Tr. at 57-58. Similarly, FQHCs had just 32 pediatricians and one pediatric subspecialist. *Id.* Moreover, all well-child visits provided by CHDs and FQHCs are included on the CMS 416 report. Crall on 2/8/2011 Rough Tr. at 83-84. There is no reason to believe CHDs will provide increased care in the future. Indeed, the Florida Legislature reduced the budget for the CHDs by $30 million as of July 2011, leading to 300-400 positions being cut at the CHDs. Sentman on 10/6/2011 Rough Tr. at 11-13.

F. Child Health Check-Up Rate Increases

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

185. AHCA highlighted the effect of the 1995 well-child check-up rate increase on the participation rate when it proposed a child health check-up rate increase from $71.59 to $90.97 for the 2007-2008 budget year. Williams on 10/13/2011 Rough Tr. at 88-89; PX 734. AHCA then predicted that same pattern would hold in the future. "Increasing the Child Health Check-up reimbursement rate will increase access to service, which will increase the early identification of

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

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

187. While continuing to support LBRs to increase the Child Health Check-Up rate, AHCA changed the language of its proposal to indicate that a fee increase "may," not will "increase access to services, which may increase the early identification of medical conditions." PX 96. *See also* DX 600. That change was made during the course of this litigation and was not based on any study or formal analysis. Kidder on 5/19/2010 Final Tr. at 2519:21 to 2520:5. Mr. Snipes, never reached a different conclusion than that set forth in the "will increase" language. Snipes on 12/9/2009 Final Tr. at 351:3-9; 382:11-24.

188. Even with the modified language, however, the LBRs continued to state: "In 1995, there was a fee increase from $30 to $64.82 and the [Child Health Check-Up] participation rate increased from 32 percent to 64 percent." PX 96. *See also* DX 600. The Agency used that same language in LBRs for five consecutive

years. Kidder on 10/3/2011 Rough Tr. at 33-35. Two senior level agency administrators testified in depositions that the statements in the 2007 final LBR regarding the proposed increase in reimbursement rates for child health check-ups were true and correct. One witness, Beth Kidder, was Bureau Chief for Medicaid Services at AHCA, and had held that position since 2005. Ms. Kidder testified at a deposition in 2008, three years after this action began. Kidder on 10/3/2011 Rough Tr. at 28-30. At trial, she acknowledged her prior testimony, including her testimony that the language in the LBR was meant to indicate "causation, a causative effect here, that if you increase the rates, you will increase physician participation and in turn that will result in more kids receiving checkups." *Id.* at 29.

189. The second witness, Melanie Brown-Woofter, AHCA's designee under FED. R. CIV. P. 30(b)(6), testified that the following statement was true and correct: "In 1995, there was a fee increase from $30 to $64.82 and the [Child Health Check-Up] participation rate increased from 32 percent to 64 percent." Brown-Woofter on 11/9/2011 Rough Tr. at 2-3; PX 96.

190. At trial, Ms. Kidder changed her testimony when she was called as a defense witness, but not when she was called as an adverse witness by plaintiff. She testified that the 1995 fee increase from $30 to $64.82 did not cause the increase in the participation rate from 32% to 64%, because the fee increase did not lead to an immediate increase in the participation rate and because the increased participation rate might have resulted from other factors, such as better reporting by Medicaid HMOs. Kidder on 6/1/2011 Rough Tr. at 118-19. She changed her testimony based on information she was provided by defense counsel after testifying in May of 2010, as an adverse witness in plaintiffs' case. Kidder on 10/3/2011 Rough Tr. at 39-43. Generally, given her change in testimony, I did not find Ms. Kidder's testimony as a defense witness credible.

191. Ms. Brown-Woofter similarly changed her views and on redirect examination provided an amended answer similar to Ms. Kidder's. *See* Brown-Woofter on 11/9/2011 Rough Tr. at 122-26.[30] She too, was not very credible as to this matter.

192. While a Rule 30(b)(6) witness may modify his or her testimony because it does not constitute a judicial admission, a court may consider any such change in assessing the credibility of the testimony. Defendants' only explanation to support admission of (and to credit) Ms. Kidder's and Ms. Brown-Woofter's undisclosed and untimely decision to contradict their prior testimony, is that they had further time to scrutinize certain LBRs. Ms. Kidder was deposed on August 27, 2008, more than two and one-half years after this action commenced. Ms. Brown-Woofter was deposed on November 24, 2008. Defendants had adequate time and a duty to prepare these witnesses on the designated topics prior to their Rule 30(b)(6) deposition.

193. I find the statements in AHCA's LBRs—repeated over five years with different secretaries and staff in place and repeatedly reported to the governor and Florida Legislature—credible and illustrative of AHCA's belief that there was a cause and effect relationship between an increase in the reimbursement rates for well-child check-ups and the percentage of children eligible for Medicaid who received a well-child check-up. I find Ms. Kidder's and Ms. Brown-Woofter's trial testimony does not meaningfully call into question AHCA's belief as to this cause-and-effect relationship.

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

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

194. Several of defendants' witnesses—particularly Ms. Sreckovich, Ms. Kidder, and Ms. Brown-Woofter—testified regarding the various processes AHCA has in place to monitor and evaluate primary care providers (PCP) enrolled in MediPass and managed care organizations (MCO).

195. AHCA devotes considerable resources to monitoring. This monitoring, however, does not demonstrate that children are receiving the care to which they are entitled under federal law.

196. First, though there was extensive testimony regarding the monitoring processes, there is little in the record about the substantive results of those processes. Indeed, much of the monitoring took place during the very time that AHCA's own documents demonstrate that children were not receiving care.

197. Second, there is little evidence in the record that any PCPs or MCOs were fined, sanctioned, or expelled from the Medicaid program for failure to provide care to children on Medicaid or meet any contractual requirements relating to the provision of care.

198. Third, process-oriented monitoring does not establish that children receive care. For instance, the fact that a PCP does not have more than 1,500 children on Medicaid as patients and does not work more than 30 miles from where his or her patients live, does not demonstrate that those children are able to see that PCP on a timely basis. AHCA's monitoring shows the system could work on paper, but it does not prove that it works in practice.

199. There is nothing persuasive in Ms. Sreckovich's testimony to establish that timely care and access to the appropriate array of pediatric doctors was actually provided rather than theoretically available. This is especially true if PCPs affiliated with MediPass or an HMO chose to treat a large number of children on Medicaid, despite the low Medicaid reimbursement rates. Flint on 1/24/2012

Rough Tr. at 153. Further, Ms. Sreckovich's general opinion that she has not seen evidence of a systematic problem, Sreckovich on 1/12/2012 Rough Tr. at 54-55, is contradicted by statements made by AHCA in LBRs and CMS 416 reports, as well as by the testimony of plaintiffs' experts. I do not find Ms. Sreckovich's opinions persuasive.

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

201. Ms. Brown-Woofter offered a lay opinion that there are enough PCPs enrolled in MediPass to comply with the contractual requirement that no provider have more than 1,500 children on MediPass. Brown-Woofter on 10/24/2011 Rough Tr. at 67-69. Her testimony does not indicate whether children are actually receiving care from PCPs, who are not obligated to accept any children on Medicaid merely because they enrolled as a MediPass provider. Nor does her testimony indicate whether that care is timely and comparable to care provided to children on private insurance. Moreover, defendants failed to show that the 1,500-to-1 ratio was actually met in practice. Ms. Brown-Woofter did not know the average number of Medicaid patients that a typical PCP enrolled in MediPass accepts. Brown-Woofter on 11/8/2011 Rough Tr. at 81. Thus, if the number is substantially smaller than 1,500, then the 1,500-to-1 ratio is effectively meaningless. In sum, I am not persuaded by Ms. Brown-Woofter's lay opinions.

202. According to Ms. Kidder's lay opinion, AHCA is able to deliver the care children on Medicaid need, when they need it, and close to where they need it (with limited exceptions), for both primary care and specialty care. She also opined that the increased number of children enrolled in Medicaid has not impacted AHCA's ability provide such care. Kidder on 10/3/2011 Rough Tr. at 122-123, 150. Her opinion, however, is based largely on what she was told by others. It is also contradicted by AHCA's own statements in numerous LBRs, her

own testimony at her deposition, the testimony of various other AHCA witnesses (including former Secretary, Dr. Agwunobi, and former Medicaid Directors Mr. Snipes and Mr. Sharpe), the testimony of pediatricians, and numerous AHCA documents. Accordingly, I do not find Ms. Kidder's lay opinion credible or persuasive.

H. Children's Medical Services (CMS)

203. CMS is a branch of the DOH dedicated to helping children with special health care needs. Consistent with the problems experienced by children on Medicaid in accessing primary care, CMS has experienced problems in finding primary care providers to treat CMS children on Medicaid.

204. In 2004, DOH conducted a Provider Access Survey, which showed that "[e]very CMS area office or regional office reported that some CMS-enrolled private primary care practices were closed to new CMS patients during calendar year 2003." PX 319 at DOH 00077968; St. Petery on 12/8/2009 Final Tr. at 228:5 – 229:12.

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

206. The survey also showed that "[e]very CMS provider recruitment office attempted to recruit primary care practitioners to become CMS-enrolled providers during calendar year 2003. Almost three-fourths (72%) of the contacted private primary care providers declined to enroll as CMS providers. Low reimbursement rates and lack of capacity were the main reasons cited for declining to participate." *Id.* There is no indication in the record that these problems have disappeared or have been substantially ameliorated.

I. Blood Lead Screening

207. As part of an EPSDT exam, children on Medicaid must be screened for blood lead poisoning at 12 and 24 months, and if they did not have a test earlier, they must be screened for blood lead poisoning between 36 and 72 months. PX 71 at AHCA 00148486. Doctors can comply with the blood lead screening requirements by either doing the testing themselves or referring their patients to a laboratory for testing. Snipes on 12/9/2009 Final Tr. at 391:12 – 393:2.

208. There is no safe level of lead in the blood. PX 77 at FL-MED 07068. The higher the lead level, the more severe the consequences. *Id.* Higher levels have an even greater impact on the health and cognitive development of children, including lower IQ, behavioral problems, hearing loss, neurological impairments, and death. *Id.*

209. Screening children for blood lead poisoning at an early age is important. As defendants have stated, "[s]creening for blood lead can lead to effective early interventions, decreasing overall treatment costs later." PX 98.

210. According to the CDC, Florida ranks 8th in the nation for the number of estimated children with elevated blood lead levels. PX 71 at AHCA 00148485; Snipes on 12/9/2009 Final Tr. at 399:12-16. Jacksonville and Miami rank 21st and 32nd respectively among large cities in the United States, with an estimated 1,900 children with lead poisoning. PX 71 at AHCA 00148485.

211. A primary source of lead exposure in children is lead-based paint, which was used in many homes built prior to 1978. PX 77 at FL-MED 07070. Homes built prior to 1950 pose an even greatest risk for children, as the amount of lead in paint from that era is generally greater and the structural condition of the homes often facilities greater risk of lead exposure. *Id.* The portion of pre-1950 homes in Florida varies by county from 3% to just over 15%. *Id.*

212. Florida's diverse population of immigrants, refugees, and foreign-born children are at further risk for lead poisoning because of specific high-risk behaviors and customary use of foreign products containing unsafe levels of lead. PX 71 at AHCA 00148485; Snipes on 12/9/2009 Final Tr. at 399:8-11.

213. The CMS 416 report submitted in April of 2008 showed that only 60,000 blood lead screenings had been conducted for the 250,000 eligible children between the ages of 1 and 2. PX 8 at AHCA 0000087-88. Mr. Snipes testified, "I would say personally to me that's not acceptable." Snipes on 12/9/2009 Final Tr. at 372:5-11.

214. In 2006, the most recent year for which there is figures in the record, there were 389 new reported cases of blood lead poisoning in Florida, with 20 or more new cases reported in Broward, Duval, Hillsborough, Miami-Dade, Orange, Pinellas, and Polk counties. PX 77 at FL-MED 07073.

215. For fiscal years 2005-06, 2006-07, 2007-08, and 2009-10, AHCA requested an increase in reimbursement rates for blood lead screening for children, stating: "Because physicians are not reimbursed for the collection and handling of lab specimens during an office visit, Medicaid children are being referred to a laboratory for the required blood lead test rather than the physician collecting the specimen and forwarding it to the laboratory for analysis. Lack of reimbursement has fragmented care, due to the fact that many recipients do not follow through with the lab trip."[31] PX 704; PX 705; PX 97; PX 98; Snipes on 12/9/2009 Final Tr. at 391:12 – 397:8.

216. Mr. Snipes supported the agency's request for an increase in fees for handling blood and believed that it would improve beneficiaries' ability to get

[31] One of the named plaintiffs, S.M., has not been tested for blood lead exposure, because the first time his mother took him to the lab it was closed, and she subsequently was not able to take him back because of difficulties in securing transportation. *See supra* at ¶ 11.

blood lead tests. Snipes on 2/9/2009 Final Tr. at 397:2-8. He consistently proposed increases in reimbursement rates for blood lead testing, because he believed that there was a problem that had to be addressed. *Id.* at 399:22 – 400:2.

J. Provision/Utilization/Timeliness of Specialist Care

217. Under the EPSDT requirements, children on Medicaid should have access to preventative care screenings and treatment for the conditions identified. 42 U.S.C. § 1396a(a)(43)(C). Often specialist care is required. Brown-Woofter on 10/18/2011 Rough Tr. at 135.

218. Dr. Agwunobi, speaking as Secretary of AHCA at the time, acknowledged the problem of access to specialists for the Florida Medicaid population, including children:

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

PX. 126A at 5. Dr. Agwunobi, in the same speech, referred to the problem as "a crisis in access to specialty coverage for this population." *Id.* at 6.

219. Defendants object to these statements on the grounds that they were not applicable to children. Dr. Agwunobi, however, expressly stated in his speech that he was speaking about access for specialty care for children as well as adults: "We have children and people right now that need access to specialty care." PX 126A. He illustrated the point by stating:

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

> experience confirms that we have a serious access to healthcare problem in the state of Florida and, we have to address it.

Id. at 5.

220. Dr. Agwunobi said that while there are many reasons for the problem of access to specialists, "one thing is very clear[, p]roviders are in general underpaid in contrast to commercial insurance and Medicare." *Id.* at 6. *See also* PX 305 at L-STP 012841.

221. I find Dr. Agwunobi's admissions regarding insufficient access to specialty care to be highly probative. Dr. Agwunobi was the highest ranking individual in the agency primarily responsible for Medicaid, and he was not testifying in the midst of litigation. He could not have been more clear as to the seriousness of the issue, characterizing it as a "crisis." This admission is sufficient evidence of an access problem with respect to specialists.

222. Other AHCA secretaries presented similar views in documents. Secretary Tom Arnold observed that "we have a system that is growing by double digits, where providers are paid less and less each year, access is limited, outcomes are not measured, racial disparities in health access continue, and participants are stigmatized. I'd say that's a bad system." PX 277A. *See also* PX 195 (email of Mr. Arnold, then Deputy Secretary for Medicaid and later Secretary of AHCA, asking "can we do anything that may reduce the reluctance of specialists in participating in Medicaid?").

223. Dr. Agwunobi's views are reinforced by a 2007 survey of the AHCA regional offices, which showed a majority of regional offices reporting an "acute shortage" of specialists for most specialty types:

AREA OFFICES – List of Most Common Specialty Shortages *

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

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

PX 205.

224. The survey responses from a number of the AHCA area offices confirm, and in certain instances, provide more detail than the statewide summary. *See* PX 200 (Area 10; Broward County); PX 201 (Area 1 shortages – Pensacola); PX 202 (Area 9 specialist shortages – Palm Beach county); PX 203 (Area 6 specialist shortages – Tampa); PX 204 (Area 7; Central Florida); PX 722 (Area 2; Florida panhandle counties); PX 708 (Area 8; Southwest Florida). For example, the response form Area 11, which includes Miami-Dade and Monroe counties, states that there is a shortage of "pediatric specialists of every kind" and that "there are no specialists of any kind willing to treat Medicaid recipients" in Monroe county. PX 199. AHCA, through two agency representatives, testified that there was no reason to believe that the problems identified in the survey were problems for adults, but not for children. Kidder on 5/19/2010 Final Tr. at 2529:20 – 2530:10; Brown-Woofter on 10/25/2010 Final Tr. at 83-96.

225. AHCA ranked the different specialty practices experiencing shortages. PX 710. These "priority rankings" of shortages were applicable to children as well as adults. Nieves on 5/17/2010 Final Tr. at 2068:9-11.

226. Other internal AHCA documents and communications are consistent with the existence of difficulty in accessing specialists for the Medicaid population throughout the state. *See e.g.*, PX 210 (October 2007 letter from Secretary Agwunobi inviting providers to a Medicaid Access to Specialty Care Summit, noting he had traveled the state, speaking about Florida Medicaid with providers, community-based organizations, and AHCA staff, and stating: "With rare exception, when asked what the most critical issue facing the program was, they identified the increasing lack of access to specialty medical care for Medicaid beneficiaries."); PX 181 (shortage of dermatologists, neurologists and neurosurgeons for kids and adults in Jacksonville); PX 182A (documenting access problems for children seeking orthopedics gastroenterologists, neurologists, and cardiology in Area 2); PX 188 (2006 AHCA survey showing lack of readily available specialist care); PX 211 at 7-11 (relative number of specialists providing Medicaid services to total specialists); PX 221 (2000 survey of access to care shows relative lack of access for Medicaid population and also geographic differences in access); PX 187 (Area 3B Ocala area services not readily available in number of specialty types); PX 319 (no or very limited access to certain specialty care for Medicaid children in CMS); PX 338 ("significant crisis in Panama City area with orthopedic coverage").

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

lowest and highest estimate of needs based on the literature. Each physician specialty was then given an access score from 1 to 5. The following services ranked either "1 (indicating access under 50% of the lowest estimate of need); or "2" (access under the low estimate of need"): allergy, dentists, dermatology, endocrinology, hematology, infectious disease, nephrology, neurology, oncology, orthopedic surgery, pulmonary disease, rheumatology, and urological surgery. PX 563 at Flint 01131, 01135. This survey also showed the comparative lack of access per county.

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

229. First, some of these witnesses directly contradicted their own sworn deposition testimony or prior written statements. For example, Ms. Kidder testified at trial that she did not believe the shortages noted in the AHCA survey "were as systematic as they appear on that chart [PX 205]." Kidder on 5/20/2010 Final Tr. at 2751:1-6. At deposition, however, Ms. Kidder—testifying as the AHCA-designated agency representative on these issues—acknowledged that the agency believed "there was a critical access to care problem in these specialty types" as to which a LBR was made, and that remained true at the time of her deposition. *Id.* at 2751:7 – 2752:5. Serious credibility issues exist when a witness significantly changes her testimony from that given as a sworn Rule 30(b)(6) witness. Similarly, testimony by Ms. Kimbley-Campanaro, AHCA's Tampa-area program director, directly contradicted her email, PX 203, which found

"challenges" in her area for ten different areas of specialists. "Challenges" connotes difficulty in finding sufficient specialist providers.

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

231. Third, AHCA area administrators' testimony was based on complaints they received about difficulties in accessing care. If they did not receive complaints, because beneficiaries or providers did not contact the area office, they would not know about difficulties in accessing care. *See, e.g.*, Gray on 11/28/2011 at Rough Tr. 29; Nieves on 5/18/2010 Final Tr. at 2268:6-22; Kidder on 5/20/2010 Final Tr. at 2753:2-19. The area office also does not follow up to determine whether care was received, or if received, whether it was unduly delayed or involved extensive travel. *See, e.g.*, Gray on 11/28/2011 Rough Tr. at 30-32; Albury on 11/16/2011 Rough Tr. at 48; Fuller on 11/29/2011 Rough Tr. at 87, 119-120. Similarly, the inability of an AHCA employee to recall any discussions in the office concerning a child going without specialty care is weak evidence at best of the lack of a specialty access problem. Albury on 11/15/2011 Rough Tr. at 121. This is especially true given documentary evidence from the same area office attesting to a shortage of specialists. Albury on 11/15/2011 Rough Tr. at 121. *See aslo* PX 202 (specialist needs in Area 9 where Mr. Albury works); PX 198

(shortage of pediatric specialists of every kind in Area 11 where Ms. Gray works). As one AHCA witness acknowledged, he could not say whether or not children were actually denied care, just that he was not made aware that care was denied. Albury on 11/16/2011 Rough Tr. at 46.

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

233. Fifth, none of the testimony provides an explanation to support defendants' argument that the "acute shortages" in most specialty areas statewide has suddenly disappeared. There have been no changes in reimbursement rates for specialists during this time period, Nieves on 5/18/2010 Final Tr. at 2262:7-16, although demand for services continued to increase.

234. For all of these same reasons, I place little weight on the conclusory lay opinions offered by Ms. Kidder and other AHCA witnesses that there was no difficulty with regard to access to specialist care for children on Medicaid.

235. The existence of a severe problem in access to specialists is also reflected in AHCA's LBRs submitted to the governor and legislature to increase the reimbursement rates for dermatology, neurology, neurosurgery and orthopedic surgery, each of which are specialists that children utilize. Kidder on 5/19/2010 Final Tr. at 2528:12-17. The given reason for the requested increase was a critical access to care problem in those areas. PX 89; PX 90, PX 10; Kidder on 5/19/2010 Final Tr. at 2527:8 – 2528:7. One AHCA LBR stated: "The Medicaid area offices have identified a physician specialty provider shortage and *critical access to care* problem" in these specialty areas. Ex. 727 (emphasis added). These areas were selected because a modest proposal was believed to have the best chance politically for passage. Snipes on 12/9/2009 Final Tr. at 405:6-13; Isaac on 8/11/2010 Final Tr. at 3883:4-24 (testifying to statement of Sec. Agwunobi).

236. Mr. Snipes confirmed that these LBRs reflected the views of the agency. Snipes on 12/9/2009 Final Tr. at 403:11-22. He testified: "[W]e supported the issues; we felt the issues were important, even critical." *Id.* at 459:1-10.

237. The LBRs requested increases in specialist reimbursement for several years. An AHCA witness testified that they take the statements in those requests "extremely seriously" and "do their best to give [the legislature] accurate information." Kidder on 5/20/2010 Final Tr. at 2741:4-6. The LBRs went through a review process by a number of individuals and bureaus inside AHCA, including the secretary. They were then reviewed by the governor's office and were listed as one of the priorities for legislative action. PX 719 (for 2009-2010 fiscal year, physician specialty fee increase was number one AHCA priority in Governor

Crist's recommendations). I find the agency's consistent position expressed in these LBRs persuasive evidence as to the conditions in Medicaid relating to access to specialty care.

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

239. A number of pediatricians throughout the state also gave consistent and persuasive testimony as to the difficulties they faced in referring children on Medicaid to specialist. Dr. Cosgrove, whose practice consists of approximately 20% Medicaid patients, has difficulty referring children on Medicaid to dermatologists, allergists, orthopedic surgeons, neurologists, and endocrinologists, difficulties she does not face with privately insured patients. Cosgrove on 5/19/2010 Final Tr. at 2563:12-17, 2566:11-15, 2569:11 – 2571:14, 2573:1-6. These difficulties have continued with regard to referring Medicaid children to

rheumatologists, orthopedics, and dermatologists; Cosgrove on 1/31/2012 Rough Tr. at 149-152.[32]

240. Dr. Silva, who had approximately 20% of her practice with Medicaid patients, also testified that she has trouble referring Medicaid patients to dermatologists, ENTs, ophthalmologists, orthopedists, endocrinologists, general surgeons, rheumatologists, and infectious disease specialists, among others. Silva on 5/20/2010 Final Tr. at 2779:6-15. Medicaid children have to wait three to five months in Brandon and one to three months in Tampa, whereas commercial-insurance patients can be seen within one to two weeks. *Id.* at 2779:17 – 2780:8. In rebuttal testimony, Dr. Silva confirmed recent difficulties and travel times experienced by Medicaid patients she refers to specialists, such as allergists, dermatologists, and endocrinologists, difficulties not experienced by her private patients. Silva on 1/19/2010 Rough Tr. at 140.

241. Dr. Schechtman, whose practice consists of 23% children on Medicaid, similarly testified that it is "much more difficult to find a specialist who is willing or has an open panel to see Medicaid patients." Schechtman on 5/20/2010 Final Tr. at 2836:1-5. For example, a child with a potentially precancerous mole could not see a dermatologist for at least six months. *Id.* at 2838:2-13. Orthopedic surgeons would only see Medicaid patients with limited diagnoses. *Id.* at 2839:3-11. By contrast, there were "no barriers" with respect to commercially-insured patients. *Id.* There were no pediatric neurologists in Palm Beach County willing to accept Medicaid patients, requiring those patients to travel to Miami to seek care. *Id.* at 2840:16 – 2841:12. On one occasion, Dr. Schechtman had to admit a child on Medicaid into the hospital to receive cardiac care that could have been managed in a low-cost outpatient setting if the child's Medicaid HMO plan had

[32] I recognize that Dr. Cosgrove usually called the first three to four specialists on her list, and have taken this limitation into account in assessing the weight of her testimony.

been accepted by pediatric cardiologists. *Id.* at 2842:25 – 2844:14. Access for Medicaid patients to ENT specialists is also "extremely limited," although privately insured patients have "no problem" being seen. *Id.* at 2844:15 – 2845:17. Dr. Schechtman's rebuttal testimony showed that the obstacles in providing access to specialty care for children on Medicaid continue. Schechtman on 1/26/2012 Rough Tr. at 14-21, 30-33.

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

243. Other PCPs have also experienced trouble referring children on Medicaid to specialists—an issue that those with private insurance do not face. *See e.g.*, Seay Depo. Desig. on 11/14/2008 at 15:9 – 16:24, 20:2-9, 57:7-21, 103:7-10; St. Petery Depo. Desig. on 11/11/2008 at 191:1-4, 195:7 – 196:11, 197:15-25, 198:21 – 199:10; Ritrosky Depo. Desig. on 11/10/2008 at 17:17 – 18:14, 27:18-22, 39:9 – 40:3, 45:2 – 47:7, 50:8-23, 50:8 – 51:1; Curran Depo. Desig. on 10/7/2008 at 30:4 – 31:8, 32:16 – 34:14, 37:13 – 38:11, 55:8 – 56:4; Chiu Depo. Desig. on 11/25/2008 at 103:19 – 106:1; Knappenberger Depo. Desig. on 11/20/2008 at 32:9 – 33:5, 99:12 – 100-8.

244. Barriers to access to specialist care were confirmed by testimony from various medical specialists. Dr. Duncan Postma, who is the supervising partner at Tallahassee ENT, testified that their practice limits the geographical area from which they accept Medicaid patients, declining to accept patients from outside the 7 county area and limiting the number of new Medicaid patients to two new

patients per week, per doctor. Postma on 8/4/2010 Final Tr. at 3152:2-19. As a result, Medicaid patients requiring non-emergency ENT care face a two-month delay, as opposed to the two-week delay experienced by non-Medicaid patients. *Id.* at 3153:7-23, 3155:7-16. These limitations are imposed because Tallahassee ENT "lose[s] money on Medicaid patients and can only afford to lose so much." *Id.* In 2006, the average cost of an ENT patient encounter was $138, but Medicaid paid approximately $88 per encounter; in 2007, the average encounter cost was $135, and Medicaid paid approximately $85. *Id.* at 3187-89. For a Medicaid child patient, Tallahassee ENT lost an average of $45-$50 per patient in 2006 and 2007. *Id.* at 3190:5-17.

245. Dr. Brett Baynham is an orthopedic surgeon in Palm Beach County, whose practice is 95% children. Twenty-five percent to 30 percent of his patients used to be children on Medicaid. In 2004, however, he limited the number of Medicaid patients he would see because of the low reimbursement rates. Baynham on 1/24/2012 Rough Tr. at 8-9, 12. *See also* PX 770 (March 2010 email from pediatric otolaryngologist, stating he is the only pediatric ENT in the West Palm Beach area seeing Medicaid patients in an office setting and that he is presently scheduling Medicaid patients more than 2-3 months out.).

246. Dr. Adam Fenichel, an orthopedic surgeon in the Orlando area, testified similarly. While 80% of his patients are children, only 5% are on Medicaid. Dr. Fenichel sees 2,000 new patients a year, but he limits his practice to only a couple hundred Medicaid patients, because "the reimbursement for Medicaid is lower than our cost to care for patients." Fenichel on 10/18/2010 Final Tr. at 4301:20 – 4302:4, 4306:2-24. *See also* Phillips Depo. Desig. on 11/24/2008 at 14:9-17, 33:2-10, 34:2-16, 83:8-18;.

247. Dr. Ricardo Ayala, a specialist in pediatric neurology, testified that: (1) he limits the number of new Medicaid patients he sees in his Tallahassee practice;

(2) he loses money on treating these children; and (3) these children face a four to five month wait, as opposed to a two-week wait for privately insured children. Ayala on 8/9/2010 Final Tr. at 3569:21 – 3570:1, 3580:4-16, 3589:2-11. Furthermore, when he needs to refer children on Medicaid to other specialists, such as orthopedists, psychiatrists, sleep disorder specialists, and rheumatologists, the referrals are not accepted. *Id.* at 3594:1-14; 3615:6 – 3620:24.

248. Plaintiffs also presented the testimony of Dr. Rex Northup, who in addition to being a critical care pediatrician, served as the CMS regional medical director for Northwest Florida. Though he does not know of any CMA child who has been denied access to specialty care, there are a number of areas within that region where there is "an inability to obtain access to care without augmenting or supplementing the Medicaid rate." Northup on 2/10/2010 Final Tr. at 1598:13-21. CMS has supplemented the Medicaid rate so as to obtain dermatology care, because no providers routinely see children for the Medicaid rate. Northup on 2/10/2010 Final Tr. at 1617:8-25. *See also* Curran Depo. Desig. on 10/7/2008 at 45:1 – 46:9; Knappenberger Depo. Desig. on 11/20/2008 at 22:17-25; Seay on 11/12/2008 Depo. Desig. at 106:14 – 108:6. There are no orthopedists to treat children on Medicaid in the Panama City area, except in the emergency department of the hospital. *Id.* at 1620:17-20, 1622:6-22. Children requiring orthopedic specialty care must travel to other areas, such as Jacksonville or Gainesville, while there are orthopedists willing see privately-insured patients in the area. *Id.* at 1630:19 – 1631:23.[33] ENTs in the area limit the number of Medicaid children they will see, requiring these patients to drive three hours or more for care. *Id.* at 1638:2-12. For pediatric neurology care, the wait for Medicaid patients is two to

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

three months, as opposed to a couple of weeks for other patients. *Id.* at 1643:23 – 1645:18.

K. Provision/Utilization/Timeliness of Dental Care

249. Dental care is especially important for children on Medicaid because low-income children are at substantially higher risk for dental disease, and primary tooth decay, and have higher levels of untreated dental disease. PX 85, PX 707.

250. States are required to provide eligible children with dental services including "relief of pain and infections, restoration of teeth, and maintenance of dental health." 42 U.S.C. § 1396d(r)(3)(B). They are also required to report on the number of children receiving dental services. The CMS 416 report fulfills that reporting requirement.

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

252. Children on private insurance receive dental care at a far higher rate. Nationally, 55% of children with private insurance visited a dentist within a given year, while only 37% of the children on Medicaid visited a dentist over the same time period, according to a 2008 GAO report. PX 452 at Crall01734; Crall on 11/17/2010 at Tr. 5093:20 – 5094:9; 5161:9 – 5162:25. Only 49% of children

under 18 from families with incomes above the poverty line had a dental visit at least once during a 12-month period. That figure rose to 26% and perhaps as high as 73% for families with incomes above 200% of the poverty line, according to a 2001 report by the federal DHHS. PX 447 at Crall000750.

253. AHCA, in a series of LBRs and other documents, has acknowledged for nearly a decade that access to dental care for children on Medicaid is inadequate and that rates must be increased. AHCA, through its LBRs, further acknowledged that:

- Dental participation in the Florida Medicaid program is declining, *e.g.*, PX 82, PX 83, PX 84, PX 85, PX 88, PX 109, PX 726. *See also* Sharpe on 11/16/2010 Final Tr. at 4947:1-8; Cerasoli on 8/11/2010 Final Tr. at 3934:18-25;
- Florida's Medicaid reimburses dentists at less than 40% of their usual and customary costs, *e.g.,* PX 80, PX 81, PX 82, PX 83, PX 109, PX 715, PX 718, PX 726. *See also* Cerasoli on 8/11/2010 Final Tr. at 3935:12 – 3939:14;
- Florida's Medicaid reimbursement rates are very low compared to other states, *e.g.*, PX 80, PX 85; PX 88, PX 155; PX 718. *See also* Cerasoli on 8/11/2010 Final Tr. at 3957:16 – 3961:18; Sharpe on 11/16/2010 Final Tr. at 4954:8-21; and
- Florida dentists say the state's Medicaid rates do not cover their costs. PX 80, PX 81, PX 82, PX 83, PX 84, PX 88, PX 109.

254. The LBRs repeatedly called for a rate increase, and state, in almost the exact same language, year after year: "A fee increase for children's dental services is needed if service is to be available." PX 78. *See also* PX 80 (same), PX 82 (same), PX 83, PX 109 (same). The LBRs also state that "[a]n increase of fees is expected to increase provider participation, and subsequently, increase access to

dental care." PX 80. The testimony about these LBRs is consistent. *See, e.g.,* Sharpe on 11/16/2010 Final Tr. at 4945:18 – 4949:8; 4952:16 – 4953:19; 4956:16 – 4963:19; at 4964:19 – 4966:19; 4968:5 – 4970:25; Snipes on 12/9/2009 at 411:15 – 414:10; at 415:10 – 416:8; Kidder on 5/19/2010 Final Tr. at 2534:12-24.

255. None of the above recommendations to increase dental fees was adopted by the legislature. Snipes on 12/9/2009 Final Tr. 423: 20-22. For every fiscal year since 2005-2006, the KidCare Coordinating Council has recognized the inadequacy of Florida's dental rates and recommended increases in dental reimbursement rates. PX 697, 698, 699, 349, 350, 682. From 1987 through 2010, Florida Medicaid dental rates were increased once, by 13% in 1998. Cerasoli on 8/11/10 Final Tr. at 3951:10-25. Meanwhile, children's enrollment in the Florida Medicaid program rose by approximately 78% from 1998 to 2008, thus widening the gap between the services needed and the services available. PX 682 at 12; Kidder on 5/19/2010 Final Tr. at 2485:4 – 2486:4.

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

257. The reason for these declines is Florida's inadequate dental reimbursement rates. A 2004 study by the American Dental Association, which AHCA relied upon when drafting its LBRs, showed that Florida ranked 48th in the

nation for preventative services and 49th in the nation for treatment services. PX 155 at 13-14; Cerasoli on 8/10/10 Final Tr. at 3960:22 – 3961:18. That same study showed that for 15 dental procedures, Florida's Medicaid reimbursement rates ranked at or below the 5th percentile nationally. For ten procedures, Florida's reimbursement rates were below the first percentile nationally. PX 155 at 6; PX 109 at AHCA 00719087 to 88 (showing reimbursement rates were below dentists' costs for 6 of 7 procedures analyzed); Cerasoli on 8/10/11 Final Tr. at 3957:3 – 3959:24.

258. In 2001, the Health Care Financing Agency, the predecessor to federal CMS, stated: "In general, HCFA believes that significant shortfalls in beneficiary receipt of dental services, together with evidence that Medicaid reimbursement falls below the 50th percentile of providers' fees in the marketplace, create a presumption of noncompliance with both these statutory requirements. Lack of access due to low rates is not consistent with making services available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at Crall 00751. Significantly, Ms. Kidder admitted that if Medicaid reimbursements for dentists were below the 50th percentile (which they were), then Florida was presumptively out of compliance with the Medicaid Act. Kidder Testimony on 5/20/2010 Final Tr. at 2733:5-11.

259. Numerous other agency officials, including the AHCA secretary, have acknowledged substantial problems with Florida's Medicaid dental program. Former AHCA Secretary, Alan Levine, sent an email lamenting that "only 16 percent of our children in Medicaid fee-for-service got any preventative dental care last year." PX 277A. Former Deputy Secretary and later Secretary of AHCA, Mr. Arnold, gave a speech at the 2007 Medicaid Access to Specialty Care Summit, in which he presented charts showing that a small fraction of dentists participated in

Medicaid and even fewer actually billed for Medicaid services. St. Petery on 12/8/2009 Final Tr. at 240:3 – 245:15. Documents show that only 7.8% of the 9,021 licensed dentists in Florida were enrolled in Medicaid, and only 502 or 5.6%, actually billed Medicaid. PX 218 at 4. *See also* PX 211 at p. 9.

260. Mr. Sharpe testified that he did not believe AHCA was in compliance with the reasonable promptness standard as to dental care. *Id.* at 4976:15 – 4977:9. He testified: "Well, we're acknowledging that for a federally required service, at least for the children's portion of dental care, that the state is not even meeting federal requirements for the provision of that care." *Id.* at 4970: 20-25; PX 108. He said he could not have made a stronger statement without being fired. *Id.* at 4962:11 – 4963:19; 4941: 8-25.

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

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

reimbursement rates. *Id.* at 3933:7-11. Fewer and fewer dentists are enrolling in Florida Medicaid and treating Medicaid beneficiaries. *Id.* at 3934:18-25.

263. The DOH also acknowledged that "a common barrier to access to services is a lack of specialty and dental providers, primarily attributable to the low Medicaid reimbursement rates." PX 315 at DOH 00079770.

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

265. The first large HMO to provide dental care to Medicaid beneficiaries was Atlantic Dental Inc. ("ADI"). From FY 2003 through FY 2007, the most recent year for which there is data in the record, ADI never provided more than 23.12% of eligible recipients with any dental services. PX 14, PX 15, PX 16, PX 22. Reports from individual dental providers, covering 2007 and 2008 in six-month blocks, show that for each period, the majority of providers treated fewer than 15% of the children assigned to them. Several provided no dental care whatsoever for the children assigned to them. DX 519.

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

267. Dr. Cosgrove testified that it takes six months to refer a Medicaid child enrolled in MediPass or in the Wellcare HMO to a dentist. Cosgrove on 5/19/2010 Final Tr. at 2573:7 – 2574:2. She had a patient on Medicaid with an abscess that could not get an appointment with a dentist for three months. *Id.* at 2574:3-23. In rebuttal testimony, she testified that these problems continued. Cosgrove on 1/31/2012 Rough Tr. at 147-152.

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

269. Dr. Schechtman testified that most of his Medicaid patients do not see a dentist. *Id.* at 2845:18 – 2846:5; 2846:6-18.

270. Dr. Northup testified that there are waiting lists of "several months' time" for CMS children to receive specialized dental care at Sacred Heart's dental clinic. *Id.* at 1600:9 – 1601:6; 1602:19 – 1603:9. At the time Dr. Northup testified, the clinic had just become operable again after a "several months' period of seeing no patients," because there was no dentist available. *Id.* There is high demand for services at the clinic, because it "is the only dental clinic or dental provider in the four-county area specifically seeing pediatric patients that will take Medicaid[.]" *Id.* at 1603:12-18. Other dentists in the area accept children on private insurance. *Id.* at 1603:19-21.

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

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

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

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

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

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

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

Crall on 11/17/2010 Final Tr. at 5093:20 – 5094:9; 5161:9 – 5162:24; PX 452 at 13.

278. Despite defendants' multiple attacks on the use of the CMS 416 report data to measure access to dental care, the report remains the method which CMS uses to measure state performance. Crall on 2/7/2011 Final Tr. at 5208:1-22; PX 440 at 3; Crall on 1/26/2012 Rough Tr. at 155. HEDIS data are available only for managed care companies (Crall on 2/7/2011 Final Tr. at 5243:12-14) and are based on survey data, while the CMS 416 report relies on all the data. Crall on 2/7/2011 Final Tr. at 5243:12-22. Defendants suggested that CHDs and FQHCs were sufficient to compensate for the lack of dental providers accepting Medicaid patients. Based on the instructions for the CMS 416, however, all dental care provided to children by CHDs and FQHCs are counted on the CMS 416 report. Crall on 2/8/2011 Rough Tr. at 82-83. Thus, I find that the number of children receiving dental care at either CHDs or FQHCs, which ranged from about 65,000 children in FFY 2003 to about 103,000 children in FFY 2007, as shown on PX739 (last page, table 3), are included in the total number of children receiving dental care as shown on the CMS 416 reports for those years. And the numbers on the CMS 416 reports demonstrate that, notwithstanding the important role played by CHDs and FQHCs, 79% of the children on Medicaid in Florida did not receive any dental care in FFY 2007.

279. Defendants' expert Ms. Sreckovich confused dental procedures with dental visits, despite her own back-up materials showing she was counting procedures. Sreckovich 1/10/2012 Rough Tr. at 23-24, 26-27. This significantly undermines her analysis because dentists often perform several procedures during one visit, *id.* at 23, and her analysis made it appear as if children on Medicaid were receiving twice as much care, if not more, than they really were. *Id.* at 31-34. Ms. Sreckovich also computed an average number of dental visits among all patients

that obscured the fact that the vast majority of children received no dental visits. 2/8/2011 Rough Tr. at 102-03.

280. I conclude that Dr. Crall is justified in relying upon the CMS 416 reports, and that the figures in those reports are more telling than Ms. Sreckovich's average dental visit analysis.

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

282. Dr. Crall considered the dental service component of the Consumer Price Index and determined that since 2003, inflation was about 40%, at a compound rate, *id.* at 5138:19 – 5139:15, and that the literature shows that 60-68% of dental office revenues, exclusive of any compensation to the dentists, are spent on overhead. *Id.* at 5139:17 – 5140:6.

283. Dr. Crall examined not only the 50th percentile of dentists' charges, but also 70th-75th percentile of dentists' charges because of the use of that percentile as a benchmark for Medicaid rates in Indiana, South Carolina, Connecticut, and Tennessee and in connection with settlement of litigation. *Id.* at 5140:15 – 5141:20; PX 418 at 11. A sizeable increase in dentists' participation followed Medicaid dental rate increases to at least the 75th percentile of charges. *Id.* at

5141:11 – 5144:19; PX 418 at 11. Dr. Crall knows of no state which had an increase of 58% or more in dental participation without a contemporaneous increase in Medicaid rates to at least market levels. *Id.* at 5145:6-12.

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

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

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

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

PX 418 at 12. (The first, second, and fourth columns should read "number with Dental Visits," not "% with Dental Visits."). The 2007 Connecticut settlement led to an increase to the 70th percentile of dentists' charges, and that in turn resulted in a tripling of dentist participation in Medicaid and an increase of 38-45% in utilization in the most recent two year period. Crall on 11/17/2010 Final Tr. at 5140:15 – 5141:10, 5150:12-24.

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

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

289. "Dentists cite as the primary reason for their not treating more Medicaid patients that payment rates are too low." Crall on 2/7/2011 Final Tr. at 5341:3-13; 5380:15-16; PX 450 at Crall 01638. Defendants argue that low dental provider participation is the result of other factors, such as high rates of missed

appointments and higher rates of dental disease. While this may be true, such factors do not detract from plaintiffs' contention, rather they favor dentists being given financial incentives to see Medicaid children. Crall on 2/8/2011 Rough Tr. at 77-78.

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

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

292. Defendants suggested that Dr. Crall failed to take into account that a number of Florida counties are designated health shortage areas. But Dr. Crall's analysis is consistent with the Federal Health Resources Services Administration (HRSA), which considers as dental shortage areas those areas where population per dentist ratio exceeds 3,000 to 1. Crall on 2/7/2011 Final Tr. at 5348:21 – 5349:17. Based on the data on HRSA's website, only 15 % of Florida's population lives in an area considered underserved. Crall on 2/7/2011 Final Tr. at 5349:10-22.

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

294. Effective July 1, 2011, following an appropriation by the Florida Legislature, AHCA increased the rates paid by Florida's Medicaid Program for dental services by 48%. D.E. 962, p. 2. Dr. Crall prepared a supplemental report dated May 24, 2011, in which he assessed the impact of Florida's 48% increase in rates. PX 786, Crall on 1/26/2012 Rough Tr. at 87. Dr. Crall concluded that "the increase of 48% still leaves Florida dental Medicaid rates severely below adequate market-based rates," and he continues to believe these rates must be increased. *Id.* at 88. Dr. Crall took the increased rates and compared them to two of the three measures which he used to evaluate the charges in his initial expert report *i.e.*, the 2008 NDAS comprehensive fee survey and the 2008 data he obtained from the commercial dental plan. *Id.* at 88. The following chart shows that after considering the 48% increase, Florida's dental reimbursement is still very low as compared to normal dentistry charges, even without accounting for inflation since 2001.

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

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

295. From 2001 to 2010 the dental component of the Consumer Price Index increased 51%. *Id.* at 93. PX 786, par. 15. Dr. Crall in his supplemental declaration concluded that: "given the woeful inadequacy of the current rates, a 48% increase in Florida's Medicaid dental reimbursement rates might slow the exodus of providers from Florida's Medicaid program, but is not sufficient to induce a significant number of providers to enter or re-enter the program, or to stimulate current providers to substantially increase the number of children on Medicaid that they are willing to treat. As I previously indicated, doing so would require raising reimbursement rates to a least the 50th percentile of dentists' prevailing charges." *Id.* at 93. PX 786 par. 16.

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

297. Ms. Sreckovich has not done any analysis on the effect of the 48% increase in dental rates. Sreckovich on 1/17/2012 Rough Tr. at 45-46. Ms. Sreckovich's analysis of whether Florida's Medicaid rates may be sufficient to cover the variable costs of treating a Medicaid patient is unpersuasive because she did not address the dentists' opportunity cost or consider whether actual rates above variable costs but below average costs would motivate dentists to see Medicaid patients. Crall on 2/7/2011 Final Tr. at 5334:19 – 5337:6; 5342:4-6. In her analysis of the Florida dental rates, Ms. Sreckovich reached no conclusion as to whether the rates paid to dentists by the Florida Medicaid program were adequate to ensure children had access to care. Sreckovich on 1/17/2012 Rough Tr. at 33-34.

298. The Florida Legislature authorized AHCA to expand Medicaid prepaid dental plans statewide. Brown-Woofter on 10/25/2011 Rough Tr. at 50-52. The prepaid dental plans will be required to pass along to providers the 48% increase in dental fees. Brown-Woofter on 11/8/2011 Rough Tr. at 126-127. Ms. Sreckovich

knows of no evidence and offered no opinion regarding the likely effects of the prepaid dental plan, which Florida is putting into effect in 2012. Sreckovich on 1/17/2012 Rough Tr. at 48. Defendants did not submit any evidence by Ms. Sreckovich or otherwise that the 48% increase in dental rates or the statewide prepaid dental plan will be sufficient (a) to raise Florida's Medicaid dental rates to private market rates; (b) induce substantial additional numbers of Florida dentists to offer services to children enrolled in Medicaid; or (c) increase the percentage of children enrolled in Medicaid to the 30% level, which CMS has considered a minimum threshold for compliance. *See* PX 447 at 3. Defendants did not call any dentists to testify.

299. After reviewing the evidence and weighing the expert opinions, I find that until the recent 48% increase, Florida's Medicaid reimbursement rate was among the lowest in the nation, and not surprisingly, Florida's Medicaid dental utilization rate was also among the very lowest if not the lowest in the country.

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

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

L. Provider Enrollment

302. While beneficiaries and not providers hold the rights provided by federal law, any analysis of beneficiaries' ability to access care must take into

account the relationship between provider reimbursement rates and participation by providers in the program.

303. Subsection (a)(30)(A) itself reflects an understanding that reimbursement is directly related to access to medical care by directing that rates be set so as to ensure equal access to care for Medicaid children—a statutory provision which would make no sense in the absence of a relationship between the two.

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

305. Both sides spent considerable time at trial reviewing specific studies in this academic literature. Defendants quote passages from some studies, which they claim casts doubt on the strength or the universality of the causal relationship between fee levels and provider participation. The consensus of academic literature, however, reflects a causal relationship between reimbursement rates and physician participation. *See e.g.*, PX 498; PX 501; PX 504; PX 505; PX 512; PX 513; PX 524. Ms. Sreckovich admitted that she had identified no professional literature that Dr. Flint had not considered. Sreckovich on 1/10/2012 Rough Tr. at 116. Reliance on peer-reviewed studies, especially from multiple sources, is the

gold standard and far more reliable than non-peer reviewed work commissioned for litigation.

306. Both sides treated the work by Peter Cunningham as authoritative. Mr. Cunningham reported that 84% of physicians surveyed identified low Medicaid reimbursement as a moderate or very important reason for not accepting new Medicaid patients. PX 512 at Flint 01123, Flint 8/3/2010 Final Tr. at 2960:4 – 2961:2. Mr. Cunningham also conducted a regression analysis that "showed that higher Medicaid fees relative to Medicare were associated with a higher probability of accepting new Medicaid patients." PX 513 at Flint 00152; Flint at 2961:16-25. A third study by Mr. Cunningham considered community norms, professional attitudes, and other factors, nonetheless identified physician fees as the "driving force" in physician decision-making. PX 514; Flint on 8/3/2010 Final Tr. at 2963:3-21, 3514:11 – 3515:23. Mr. Cunningham studied a projected 20% increase in Medicaid reimbursement relative to Medicare. He found a significant relationship among all communities studied, one of which was Miami, where he projected an increase of 11.8 % in provider participation. PX 514 at Flint 00155 Flint; Flint on 1/24/2012 Rough Tr. at 173. The Cunningham study of 12,000 physicians and 60 communities also showed that higher reimbursement rates were associated with a statistically significant reduction in unmet medical needs of the Medicaid population, increased satisfaction with choice of specialists, and reduced use of emergency care. PX 513; Flint on 1/24/12 Rough Tr. at 174-75.

307. These results are consistent with the surveys and empirical data that Dr. Flint relied upon. A survey of Florida physicians who were members of the American Academy of Pediatrics reported a significant number of physicians would increase their willingness to take Medicaid patients with higher reimbursements. PX 535. While this survey is methodologically limited by a small sample, it is consistent with the other evidence presented. The more

providers who participate in Medicaid, the more access children on Medicaid will have to care. Flint on 8/4/2010 Final Tr. at 3348:17 – 3350:13; Crall on 11/17/2010 Final Tr. at 5106:23 – 5107:15.

308. The relationship between fees and provider participation is also illustrated by Defendants' 2009 survey of Florida's physicians. According to that survey, 46% of Florida physicians were accepting no new Medicaid patients, while only 22% were accepting no new Medicare patients. PX 742 at 62, 66. Medicaid pays significantly more than Medicaid.

309. In Polk County, Florida, physician reimbursement for treating uninsured patients was increased to Medicare levels during FY 2007-2008. The result was a substantial increase in access to care. Flint on 1/24/2012 Rough Tr. at 182-184. While this occurred among a population of uninsured individuals, the example remains relevant for our purposes. Flint, Rough Tr. 1/3012 at 113-114.

310. Even Ms. Sreckovich did not opine that there was no relationship between rates and provider participation. Instead, she pointed to other factors—including physician attitudes toward Medicaid patients and administrative issues—as undermining that relationship. Sreckovich on 1/6/2012 Rough Tr. at 83-84. Ms. Sreckovich, however, could not deny—indeed, she admitted—that for a significant number of physicians, those obstacles can be overcome by higher reimbursement levels. Sreckovich on 1/9/2012 Rough Tr. at 119-120.

311. These studies are confirmed by AHCA's LBRs, which sought increased reimbursement for physicians and dentists. The LBRs relied upon the causal relationship between increased reimbursement rates and increased provider participation on the one hand, and increased provider participation and increased access on the other hand. *See* PX 92 ("Increasing the Child Health Check-Up reimbursement rate will increase access to services"); PX 93 (same); PX 94 (same). AHCA repeatedly observed that when reimbursement rates for child

health check-ups doubled in 1995, the participation rate doubled as well. *See* PX 734; PX 92; PX 93; PX 94; PX 95; PX 96; PX 702; PX 703.[34]

312. In addition, AHCA, in multiple LBRs over several years, proposed a fee increase for certain specialists as a solution for a "specialty provider shortage" and the "critical access to care problem." *Id.* The LBRs recognize the obvious existence of a relationship among reimbursement rates, physician participation, and Medicaid participant access.

313. Federal CMS also recognized the relationship between reimbursement rates, provider participation, and access. It declared in a Dear State Medical Director letter: "Lack of access due to low rates is not consistent with making services available to the Medicaid population to the same extent as they are available to the general population, and would be an unreasonable restriction on the availability of medical assistance." PX 447 at Crall 00751.

M. Managed Care

313. As of October of 2009, more than 1.5 million children were on Medicaid in Florida. Approximately 650,000 were assigned to an HMO in a non-Reform County, and approximately 120,000 were assigned to an HMO in a Reform county. DX 262a.

314. AHCA remains ultimately responsible as the designated agency that administers Florida's Medicaid program, regardless of whether it chooses to provide care for children on Medicaid through a fee-for-service arrangement or through a Medicaid HMO.

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[34] At trial, defendants sought to question this relationship, even though it was repeatedly submitted to the legislature and acknowledged as correct under oath in depositions. Defendants claim there was a certain time lag before the higher rates had the observed effect. Such a time lag between raising rates and an effect on participation and rate of check-ups is not surprising. Defendants also claim that certain other steps may have contributed to increased participation rates, but no one suggests those other factors, such as educational efforts, were the principal case. *See* PX 524; Flint on 1/24/2012 Rough Tr. at 186-93, GAO Report citing increase as example of effect of increased reimbursement rates.

315. AHCA pays HMOs on a capitated basis and determines how much to pay Medicaid HMOs on an annual basis. The amount of AHCA's Medicaid HMO payments is driven in substantial part by the amount paid to providers on a fee-for-service basis through the MediPass system and historical rates of utilization. Williams on 10/12/2011 Rough Tr. at 101-03; Brown-Woofter on 11/8/2011 Rough Tr. at 124-26; *id.* at 11/9/2011 at 25. AHCA discounts aggregate payments to HMOs to account for the HMOs' presumed efficiencies.[35] Williams on 10/17/2011 Rough Tr. at 171-73.

316. Florida is one of the lowest paying states in terms of its managed care compensation. *Id.* at 2999:20 – 3000:4.

317. In 2005, AHCA obtained federal and state approval for a Medicaid Reform pilot project. Brown-Woofter on 10/20/2011 Rough Tr. at 96-98. Medicaid Reform was instituted in July of 2006 in Broward and Duval Counties and expanded in 2007 to Baker, Clay, and Nassau Counties. *Id.* at 97. Medicaid Reform allows AHCA to use managed care almost exclusively for services provided to Medicaid recipients. Brown-Woofter on 10/18/2011 Rough Tr. at 9.

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

319. Florida's Office of Program Policy Analysis & Governmental Accountability ("OPPAGA") in June of 2009 reported on the progress of Medicaid Reform through December of 2008 and found the data did not show that Medicaid Reform had improved access, quality of care, or saved the state money. PX 683:1. OPPAGA recommended the legislature not expand Medicaid Reform until more data was available to evaluate claims of its success. *Id.* That was the most recent

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

OPPAGA report concerning Medicaid Reform. Copa on 4/5/2011 Rough Tr. at 127-29. In September of 2007, AHCA's Office of the Inspector General made a similar recommendation, after former Secretary of AHCA Dr. Agwunobi called for an "independent, objective and thorough analysis" to delay the expansion of Medicaid Reform. AHCA adopted that recommendation. Agwunobi 2/13/2009 Depo. Desig. at 183:7 – 187:1.

320. The three largest Medicaid HMO's operating through Medicaid Reform in Broward County in 2008 had approximately 50% of the Medicaid enrollment in that county. But two years later, none of the three plans remained in operation in the county. *Id.* at 182-85.

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

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

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

324. AHCA's monitoring process of HMOs fails to show that children are receiving the care to which they are entitled under federal law for three fundamental reasons. First, though there is extensive testimony regarding the monitoring process in the record, there is very little in the record about the substantive results of that monitoring, and nothing to indicate that children are receiving timely or adequate care. Flint on 1/24/2012 Rough Tr. at 153.

325. Second, most of the monitoring focuses on process, and even if the monitoring results were in the record, they would not demonstrate the children were getting the requisite care. For instance, the fact that an HMO has no more than 1,500 children per PCP, or has a number of specialists on its panel does not demonstrate that the doctors will see the children at all, let alone promptly.

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

327. Ms. Brown-Woofter, Acting Assistant Deputy Secretary for Medicaid operations, did not know whether AHCA had *ever* issued any financial sanctions to a Medicaid HMO for having a low percentage of enrollees who received a blood lead screening exam. Brown-Woofter on 10/18/2011 Rough Tr. at 116-18; Brown-Woofter on 11/8/2011 Rough Tr. at 131-32. While she testified that AHCA had issued some fines against HMOs for failing to meet a state requirement for a 60 % screening ratio for children continuously enrolled in the HMO for six months, she had no information regarding the amounts of the fines. *Id.* at 118. AHCA did not issue any fines against HMOs for low child health check-up screening rates until 2008, years after this action began. Brown-Woofter on 10/18/2011 Rough Tr. at

131-32. Ms. Brown-Woofter testified that a financial sanction was levied against Universal in 2011, but was not even sure why the sanction was levied. Brown-Woofter on 10/20/2011 Rough Tr. at 60.

328. Ms. Brown-Woofter offered a lay opinion that children in Medicaid HMOs do not have trouble accessing primary or specialty care, and that any trouble with specialty care is limited to a few individuals. Brown-Woofter on 10/19/2011 Rough Tr. at 38-40, 74-77. I find her unsupported conclusions unpersuasive. Her opinions also conflict with earlier testimony that she gave as a 30(b)(6) witness at the end of the discovery period, and, in rendering her opinion, she did not consider numerous AHCA documents regarding shortages of providers.[36] *See* Brown-Woofter on 10/25/2011 Rough Tr. at 88-97, 95-97, 100, 103-07, 109-22, 126-38; PX 205; PX 188; PX 186; PX 90; PX 101; PX 199.

N. Outreach and Medicaid Application Process

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

330. Between 2004 and 2006, Florida moved to a largely online system of applications, eliminating most of the office locations at which individuals can apply in person for Medicaid coverage. PX 238. Fifty-seven percent of DCF services centers were eliminated between 2004 and 2006. Nieves on 5/17/2010 Final Tr. at 2098:20 – 2099:1. These changes, accompanied by cuts in personnel,

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

were enacted not because they were viewed as improvements but rather due to budget cuts. Lewis on 10/20/2010 Final Tr. at 4602:25 – 4603:14.

331. In 2007, an analysis by AHCA of the revised application system reported: (a) that the online system will time out in 20 minutes leading to 350 lost sessions each day; (b) 25% of applicants are unable to complete their application on their first attempt; (c) "often, for numerous reasons, applicants are unaware that they have not submitted the required additional information and their case is closed;" and (d) that 17 to 20% of the applicant population—due to language barriers and other factors—cannot successfully complete one or all of the steps in the new ACCESS Medicaid eligibility process. PX 238; Nieves on 5/17/2010 Final Tr. at 2106:9 – 2111:20.

332. If assistance is required, it is difficult to obtain. The Tampa regional center reported 40% of incoming calls abandoned or receiving busy signals in 2007. Two other regional centers reported: 20% in Miami and 19% in Jacksonville. PX 238 at 3. At the time of the trial, Mr. Lewis, DCF bureau chief, testified that he believed that 40% of the incoming calls to the Tampa regional call center were *still* either abandoned or receiving busy signals. Lewis on 10/20/2010 Final Tr. at 4638:3 – 4634:8.

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

334. The Access Medicaid application has purportedly been simplified, but it remains a formidable challenge to complete. The application, reprinted as part of the application guide (DX 160), runs in excess of 50 pages of screens that Medicaid applicants must navigate. Nieves on 5/17/2010 Final Tr. at 2105:2 – 2106:4. Because it is a combined application in which families may apply for multiple cash and in-kind assistance programs, there are lengthy sections requiring

answers on assets and expenses not needed for the determination of a child's Medicaid eligibility. Complex terms, for example, are found in questions asking about "liquid assets" and "life estates." An applicant must gather a significant amount of records to complete the application. And, by virtue of being an online application, basic computer literacy is required

335. By contrast, the Florida KidCare application (DX 181) is two-pages for children seeking Medicaid or SCHIP assistance. The KidCare application, however, provides sufficient information for DCF to make a Medicaid eligibility determination. Lewis on 11/29/2011 Rough Tr. at 31. Although AHCA added an online link to the KidCare application during the course of the trial in this action, the KidCare application is an alternative to the primary ACCESS application which individuals must first find online—a feat that even Ms. Sreckovich, defendants' expert witness, had difficulty accomplishing unassisted by counsel. Sreckovich on 1/17/2012 Rough Tr. at 4-18. Applicants must then indicate that they want to apply solely for their children's Medicaid eligibility and no other potential programs. *Id.*

336. No reason was offered into evidence as to why the simple KidCare application could not serve as the default application for children seeking Medicaid. St. Petery on 2/2/2012 Rough Tr. at 86-87.

337. Even though DCF's online application is the primary vehicle by which applicants are encouraged to apply for Medicaid, DCF does not attempt to identify individuals who start the online application and do not complete it, collect demographic information on them, or determine why they fail to complete the application. Poirier 10/5/2011 Rough Tr. at 3-7, 6-7 33. DCF does not know how many people start but fail to finish the application. *Id.* at 12.

338. In addition to the complex application and the difficulties in obtaining help to complete the application, Florida has eliminated its primary outreach

program for Medicaid. Until 2003, Florida "had an award-winning outreach program" recognized by federal CMS as a model for other states. PX 700 at DOH 10000478. Before funding was terminated in 2003, approximately $4 million was spent on outreach programs annually, more than half of which came from the federal government. *Id.* The outreach program included: statewide multi-media campaigns in English, Spanish, and Creole on television, radio, bus cards, and billboards; free distribution of applications and promotional brochures, posters, and booklets; 17 regional outreach programs responsible for recruiting and training community partners; data driven market research, county level enrollment data reporting, and tracking; assistance for families with enrollment and coverage issues; and statewide training and technical assistance. *Id.* at DOH 10000478-479; St. Petery on 12/10/2009 Final Tr. at 526:3 – 531:9. Since 2003, direct outreach funding has been limited to a one-time non-recurring $1 million authorization in 2006. PX 700 at DOH 10000479. As AHCA acknowledged in its 2007-2008 budget request, this level of funding "will probably not provide the amount needed to make an impact on significantly decreasing the rate of uninsurance for children[,]" even if it were recurring. PX 711 at AHCA 01095027.

339. While a variety of outreach efforts continue to exist, AHCA does not assess the effectiveness of its written materials. Boone on 10/21/2008 Depo. Desig. at 58:21-60:2 And there has been no showing that these ad hoc efforts are an adequate substitute for the organized statewide program that existed before funding was terminated. There are at least four strong indications that they are not.

340. First, the difference between the outreach conducted before the budget cuts and that performed now is stark. Statewide multi-media campaigns in English, Spanish, and Creole including public service announcements (PSAs) on television and radio, as well as bus cards and billboards were eliminated. PX 700 at DOH 10000478-479. Anne Boone, who was AHCA's child health check-up

coordinator when she was deposed in 2008, was not aware of any PSA airing recently anywhere in the state on either radio or television. Boone on 10/21/2008 Depo. Desig. at 65:3-67:8. Rather, all she knew concerning whether any PSAs had been aired in the last several years on radio or television is that a single PSA about blood lead poisoning "might have been on a radio station." *Id.* That hypothetical PSA is the only one in existence in the voluminous record in this action. DX 492. Rather than airing on the radio or television, AHCA's PSAs are shown on television sets at booths at health fairs. Boone on 8/28/2008 Depo. Desig. at 163:14-164:1; Boone on 10/21/2008 Depo. Desig. at 309:21-310:6, 311:18-312:2. Similarly, Ms. Boone knew of only one instance in recent years in which there were child health bus billboards, and even then, the billboards only appeared on busses in one city. Boone on 10/21/2008 Depo. Desig. at 67: 9-20.

341. Second, the KidCare Coordinating Council, which has representatives drawn from a variety of governmental and private organizations interested in medical care for children, stated as follows:

> Unless families learn about Florida KidCare, how to apply and where to seek assistance if they need it, the program will not fully reach the population it is intended to serve. Florida KidCare enrollment significantly declined in 2004 … Enrollment started to increase again in 2007 as a result of increased emphasis on outreach. However, except for a non-recurring $1 million appropriation to Healthy Kids for community based outreach and marketing matching grants in Fiscal Year 2007-08, other activities were undertaken within existing resources and with non-recurring funds, making a large scale and ongoing initiative unsustainable without additional resources.

PX 682 at 25. The KidCare Coordinating Council recommended by a vote of 22 to zero that outreach funding for programs for unenrolled children be restored. PX 682 at 20. The Council has been making this recommendation for years. *See* PX

349 at DOH 00078171; PX 350 at 19-20; PX 682 at 2; PX 697 at16; PX 699 at 18; PX 700 at DOH 10000478.

342. Third, AHCA has also urged that outreach funding be restored in its LBRs. PX 711.

343. Fourth, the existence of over a quarter million children eligible for Medicaid but not enrolled as of 2008 is compelling evidence that additional outreach programs are required. Indeed, an AHCA staff analysis indicated that approximately 75% of children from families with incomes under 200% of the federal poverty level were ideal candidates for outreach efforts to increase enrollment in existing programs. PX 240.

344. One example of AHCA's inadequate commitment to outreach is its dental reminder letter. AHCA used to send letters reminding parents who had not taken their Medicaid child to a dentist for some time to do so. AHCA stopped doing this in 2000. Boone on 2/24/2012 Depo. Designation at 31:10-19, PX 441 at 6. AHCA discontinued sending the letters because so few dentists participated in the program that it was hard for parents to find a dentist close to where they lived. Parents became upset when they could not find a dentist willing to see their children. Boone on 8/28/2008 Depo. Desig. at 33:3-12. AHCA even told federal CMS that it had not actively marketed its dental program to recipients for four to five years because of the few numbers of dentists participating in Medicaid and because it was often difficult for those seeking treatment to find a provider nearby. Sharpe on 2/8/2011 Rough Tr. at 184.

345. Ms. Boone admitted that the letters did help increase utilization. Boone on 8/28/2008 Depo. Designation at 32: 14-19. But for years, AHCA did not send out dental reminder letters, despite the dental program's extremely low utilization rate, an intentional reduction of outreach efforts.

346. In February of 2008, federal CMS conducted an on-site visit in Florida as part of its decision to review states with dental utilization rates at or less than 30% on the CMS 416 report for the FY 2006. PX 440 at 3. In its report from that visit, federal CMS noted that Florida had sent reminder letters until 2000 and recommended that Florida again send dental reminder letters to "parents of beneficiaries who have not received periodic dental services." PX 441 at 6-7. AHCA stated in its response that Medicaid's new fiscal agent began on July 1, 2008, and in "the very near future" it "will work with the new fiscal agent" to send out dental reminder letters. *Id.* at 7.

347. Several years later, however, when Ms. Kidder testified on May 31, 2011, she acknowledged that AHCA had still not begun sending out dental reminder letters. Kidder on 5/31/2011 Rough Tr. at 107-108. She said the letters would likely go out soon. *Id.* Ms. Cerasoli, who had testified as AHCA's designated agency representative on dental issues at deposition, testified that the dental letters were not sent because the agency did not view this as a priority. Cerasoli on 8/11/2010 Final Tr. at 3980:12 – 3981:1.

348. When AHCA analyzed its claims data in May of 2011 to see how many children enrolled in Medicaid had not received any dental services, they found that 834,651 children had not received dental services in the last six months. PX 790. That figure did not include children enrolled in ADI, Reform HMOs, and non-reform HMOs offering dental services.

349. Given defendants' limited outreach, it is, perhaps, not surprising that A.D. did not know until she became a next friend in this action that her son was entitled to dental care through Medicaid. *See supra* at ¶ 30. And S.B. did not know that she was entitled to free transportation to doctor's appointments and laboratory visits. *See supra* at ¶ 11.

VII. CONCLUSIONS OF LAW

I conclude that Florida's Medicaid program has not compensated primary physicians or specialists at a competitive rate as compared with either that of Medicare or private insurance payors.

I further conclude that Florida's structure for setting physician reimbursement fails to account for statutorily mandated factors in the Medicaid Act, including the level of compensation needed to assure an adequate supply of physicians so as to discharge the mandate to provide EPSDT services or set rates at a level that will promote quality of care or equal access to care as required under 42 U.S.C. § 1396a(a)(30)(A). Except for certain codes held outside the normal budgetary process, Florida's conversion ratio and budget-neutrality mandates result in artificially set rates for many services without any consideration of physician incurred costs or what is needed for competitive rates that are sufficient to attract medical providers.

A system which mandates budget neutrality as the determining factor in rate-setting, without consideration of the factors required by federal law, does not satisfy the Equal Access requirement of § 1396a(a)(30)(A). Codes set by statute outside the normal budgetary process are also not evaluated to ensure that the rates are sufficient to attract primary and specialist physicians to treat Medicaid children.

There also is no process to adjust those rates for increases in the cost of living. While the medical cost of living index has increased over the past decade, there has been no commensurate increase in Medicaid reimbursement, and accordingly, the gap between Medicaid reimbursement and Medicare reimbursement has widened for most codes and will continue to do so.

Violations of continuous eligibility deprive children who are improperly terminated from Medicaid of their rights to EPSDT care and any needed follow-up

care under § 1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and their rights to medical care under the Reasonable Promptness and Equal Access provisions of Title XIX.

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

The failure of AHCA or DCF to promptly make the Medicaid eligibility of presumptively eligible newborns (*i.e.* "babies of") operatively deprives those babies of their rights to EPSDT care and any needed follow-up care under §1396a(a)(10) and §§ 1396a(a)(43)(B) and (C) and their rights to medical care under the Reasonable Promptness and Equal access provisions of Title XIX.

Defendants responsible for Florida's Medicaid program have failed to assure that plaintiff class received the preventative health care required under the EPSDT Requirements. I conclude, similar to other courts facing such evidence, *see Health Care for All, Inc. v. Romney,* No. Civ.A.00-10833RWZ, 2005 WL 1660677, *10-11 (D. Mass. July 14, 2005) (finding violation of EPSDT requirements as to dental care)*; Memisovski ex. rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *50-56 (N.D. Ill. Aug. 23, 2004) (finding violation of EPSDT provisions), that the EPSDT Requirements that children receive such care have not been met when, as shown above, approximately one-third of Florida children on Medicaid are not receiving the preventative medical care they are supposed to receive. This is true both for children on fee-for-service as well as in managed care, where screening rates are potentially lower. In addition, an unacceptable percentage of infants do not receive a single well-child visit in the first 18 months of their lives.

Because one-third of the enrolled children are not receiving any of their expected preventative care each year, I also conclude that they have not received care in accordance with the Reasonable Promptness requirements of the Medicaid Act. *See OKAAP v. Fogarty*, 366 F. Supp.2d 1050, 1109 (N.D. Okla. 2005) (finding violation of reasonable promptness provision as to medical care); *Health Care For All, Inc.*, 2005 WL 1660677, at *10-11 (finding violation of reasonable promptness provision as to dental care); *Clark v. Kizer*, 758 F. Supp. 572, 575-79 (E.D. Cal. 1990) (finding violation of reasonable promptness provision as to dental care), *aff'd in relevant part sub. nom. Clark v. Coyle*, 967 F.2d 585 (9th Cir. 1992).

I also conclude that there was a violation of Section 30(a), because Medicaid children lack equal access to primary care.

I also conclude that many pediatricians and family practitioners refuse to take any new Medicaid patients and other pediatricians sharply limit the number of new Medicaid patients they will accept.

I also conclude that the percentage of children in Florida who receive blood lead screenings is extremely low, notwithstanding the fact that part of Florida has an aging housing stock, which means children are more likely exposed to lead-based paint.

I agree with AHCA's statements in repeated LBRs that if AHCA increased the Medicaid reimbursement rates for well-child check-ups, more children would receive well-child check-ups. I conclude that the testimony of these pediatricians and specialists is credible. They are testifying based on their own personal experience and actions. Defendants did not call a single primary physician or specialist to counter this testimony. The testimony of plaintiffs' medical witnesses is consistent with the survey evidence and AHCA's admissions that there is a serious problem faced by Medicaid children in receiving prompt and equal access to medical specialists.

I conclude that children on Medicaid have not been provided the EPSDT guarantee of access to care for treatment of conditions identified based on the AHCA surveys showing serious shortages of specialist care for Medicaid, AHCA's admissions, the LBRs, and the testimony of a number of medical doctors practicing throughout the state. Children on Medicaid have to travel to other areas of the state and/or wait for several months to obtain care. While there are certain specialists and certain locations where issues of access—and reasonably prompt access—may not be a problem, the evidence presented leads me to find that the issue extends throughout the state and across many specialty types. Moreover, the evidence reflects that while a particular specialty problem in a given area may improve with the arrival of a new doctor, the situation may change or another problem may occur because of the dependency of the Medicaid population on a relatively small number of providers. Further, those providers often limit the number of patients they are willing to see. Accordingly, I conclude with respect to specialty care that during the time covered by this case, Florida has not met the obligations of the EPSDT Requirements in Section (a)(10) or the reasonable promptness requirements in Section (a)(8). *See OKAAP*, 366 F.Supp.2d at 1109 (finding violation of reasonable promptness provision as to medical care); *Memisovski*, 2004 WL 1878332, at *50-56 (finding violation of EPSDT provisions); *Clark v. Kizer*, 758 F. Supp. at 575-79 (finding violation of reasonable promptness provision as to dental care), *aff'd in relevant part sub. nom. Clark*, 967 F.2d 585.

I similarly conclude that children seeking specialist care have not received that care as required under Sections 43(B) and 43(C) of the Medicaid Act. *Memisovski*, 2004 WL 1878332, at *50-56 (finding violation of 42 U.S.C. 1396a(a)(43)(C) relating to the provision of EPSDT corrective services).

I also conclude based on extensive record evidence that children on Medicaid do not receive equal access to specialist care, compared to insured children in their geographical areas. *See, e.g.*, PX 583. *See also Memisovski*, 2004 WL 1878332, at *42-47 (finding violation of equal access provision as to medical care); *OKAAP*, 366 F.Supp.2d at 1107 (finding violation of equal access provision as to medical services); *Ark. Med. Soc'y, Inc. v. Reynolds*, 819 F. Supp. 816, 825-26 (E.D. Ark. 1993) (finding violation of equal access provision as to medical care); *Clark*, 758 F. Supp. at 580 (finding violation of equal access provision as to dental care). Rates are not set with any consideration to the level required to provide such equal access, consistent with the other requirements of Section (30)(A).

Based on the fact that 79% of the children enrolled in Medicaid are getting no dental services at all, I agree with Dr. Crall that Medicaid children in Florida are not receiving dental services with reasonable promptness. Crall on 1/26/2012 Rough Tr. at 96-97. *See Health Care for All, Inc.*, 2005 WL 1660677, at *10-11 (finding violation of EPSDT requirements and the reasonable promptness provision as to dental care); *Memisovski,* 2004 WL 1878332, at *50 (finding violation of EPSDT provisions); *Clark*, 758 F. Supp. at 580 (finding violation of reasonable promptness provision as to dental care).

I conclude that Florida is also not in compliance with the EPSDT requirements. *See Health Care for All, Inc.*, 2005 WL 1660677, at *14 (finding a violation of 42 U.S.C. § 1396A(A)(43) as to dental care); *Memisovski,* 2004 WL 1878332, at *50-56 (finding violation of EPSDT provisions).

I also agree with Dr. Crall's opinion that Florida's Medicaid dental rates are not sufficient enough to provide equal access in violation of 42 U.S.C. § 1396a(a)(30)(A) for Florida's Medicaid children in each of AHCA's 11 regional areas. I base my conclusion on the lack of dentist participating in Florida Medicaid

and on the 79% of children who receive no dental service. Crall on 1/26/2012 Rough Tr. at 98:6-20. *See Health Care For All, Inc.*, 2005 WL 1660677, at *10-11 (finding violation of equal access provision as to dental care); *Clark*, 758 F. Supp. at 580 (finding violation of equal access provision as to dental care).

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

There was also substantial support at trial that Medicaid reimbursement rates—to have a significant effect—need to be increased somewhere close to the level paid under the Medicare program. Dr. Flint testified to this opinion, and this was the increase in the Polk County example. Flint on 1/24/2012 Rough Tr. at 182-186. An increasing number of other states have set Medicaid reimbursement rates at or very near Medicare reimbursement rates *Id.* at 191-92. Moreover, Congress, in recent legislation, has required for a two-year period that primary care providers receive compensation at least at the Medicare rate. Sreckovich on 1/12/2012 Rough Tr. at 49. It is also logical that the Medicare reimbursement rates are a good indication of competitive market prices. Flint on 1/24/2012 Rough Tr. at 191-92. There was no evidence presented by defendants of any adequate different rate level. Given the record, I conclude that plaintiffs have shown that achieving adequate provider enrollment in Medicaid—and for those providers to meaningfully open their practices to Medicaid children—requires compensation to be set at least at the Medicare level.

Based on the applicable statutes and case law, I conclude that AHCA, as the agency that administers Florida Medicaid, is legally responsible to ensure that

children who obtain their care through a Medicaid HMO (or through a Provider Service Network) receive the care to which they are entitled under federal law.

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

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

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

Federal law requires states to effectively inform all EPSDT eligible individuals or their families about the availability of EPSDT services, how those services may be obtained, that those services may be obtained at no cost to the child, and that transportation is available. *See* 42 U.S.C. § 1396a(a)(43)(A); 42 C.F.R. § 441.56(a). Florida has delegated to DCF, among other agencies, certain

outreach and informational responsibilities. *See* Fla. Stat. § 409.9122(2)(c) (DCF must provide "clear and easily understandable information" about MediPass and Medicaid HMOs, the plans through which most children are supposed to receive EPSDT services in Florida). **I previously held that "DCF, as well as AHCA and DOH, have outreach responsibilities; they are required to 'ensure that each Medicaid recipient receives clear and easily understandable information' about MediPass or managed care options. This requirement arises from the Medicaid Act's outreach provision." 9/30/2009 Order on Class Certification, D.E. 671 at 7 (citations omitted). I reaffirm my holding here as to AHCA and DOH, but modify my ruling with respect to DCF. I recognize that § 409.9122(2)(c), Fla. Stat., has expired and DCF is no longer tasked with these outreach and informational responsibilities.**

Defendants contend that 42 U.S.C. § 1396a(a)(43) does not require them to conduct outreach to children who are not enrolled but are eligible for Medicaid. The plain language of the regulations implementing this section state that "[t]he agency must [p]rovide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program." *See* 42 C.F.R. § 441.56(a)(1); *Friends of Everglades v. S. Fla. Water Mgmt. Dist.*, 570 F.3d 1210, 1227-28 (11th Cir. 2009) (stating that an agency's promulgation of regulations interpreting ambiguous statutory language is entitled to deference as long as the interpretation is reasonable). "Medicaid's implementing regulations [in specific, § 441.56(a)] . . . obligate participating States to 'effectively' inform all eligible individuals." *See Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006). The plain language of the regulations, combined with the case law supporting this interpretation, compel the conclusion that § 1396a(a)(43) and 42 C.F.R. § 441.56(a)(1) mandate that the state conduct outreach to all eligible individuals.

Defendants have failed to "[p]rovide for a combination of written and oral methods designed to inform effectively *all EPSDT eligible individuals* (or their families) about the EPSDT program," and to conduct outreach in "clear and nontechnical language" that provides information about the benefits of preventative care, the services available under the EPSDT program, how those services may be obtained, that the services are available at no cost to children, and that transportation services are available. *See* 42 C.F.R.§§ 441.56(a)(1) & 441.56 (a)(2) (emphasis added). *See also* § 1396a(a)(43)(A).

I further conclude that the use of the Florida Access application in many of the circumstances in which it currently is utilized constitutes an unnecessary and impermissible barrier to the provision of the EPSDT services to children required under the EPSDT Requirements of the Medicaid Act.

VIII. CONCLUSION

These constitute my findings and conclusions following 90-plus days of trial.

DONE and ORDERED in chambers in Miami, Florida, this 31st day of March, 2015.

Adalberto Jordan
United States District Judge

Copy to: All counsel of record