No. 05-5100

IN THE
United States Court of Appeals for the Tenth Circuit

OKLAHOMA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS (OKAAP), et al.,

Plaintiffs-Appellants/
Cross-Appellees,

v.

MICHAEL FOGARTY, Chief Executive Officer of the Oklahoma Health Care Authority (OHCA), et al.,

Defendants-Appellees/
Cross-Appellants.

On Appeal from the United States District Court
for the Northern District of Oklahoma

The Honorable Claire Eagan
Chief District Judge

D.C. No. 01CV0187

BRIEF FOR AMICI CURIAE THE AMERICAN ACADEMY OF PEDIATRICS, THE AMERICAN MEDICAL ASSOCIATION, AND THE OKLAHOMA STATE MEDICAL ASSOCIATION SUPPORTING PLAINTIFFS-APPELLANTS AND REVERSAL IN NO. 05-5100

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RULE 26.1 CERTIFICATION

In compliance with Rule 26.1 of the Federal Rules of Appellate procedure, amicus the American Academy of Pediatrics states that it is a nonprofit corporation organized and operating under the laws of the State of Illinois. The American Academy of Pediatrics has no parent corporation, and no publicly held company owns 10% or more of its stock.

Amicus the American Medical Association is a nonprofit corporation organized and operating under the laws of the State of Illinois. The American Medical Association has no parent corporation, and no publicly held company owns 10% or more of its stock.

Amicus the Oklahoma State Medical Association is a nonprofit corporation organized and operating under the laws of the State of Oklahoma. It has no parent corporation, and no publicly held company owns 10% or more of its stock.

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INTEREST OF AMICI CURIAE

The American Academy of Pediatrics ("AAP"), the American Medical Association ("AMA"), and the Oklahoma State Medical Association ("OSMA") are all dedicated to ensuring access to quality care for all Americans.[1] The AAP is a nonprofit organization founded in 1930 of over 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of children. The AAP advocates for children and their right to medical care through the adoption of professional policies, educational programs, efforts to influence social and governmental policy, and, occasionally, litigation. The AAP has significant clinical and academic expertise regarding health care issues facing the over twenty million children served nationwide by Medicaid.[2]

The AAP is particularly interested in this case because of the stakes: ensuring that low-income children have access to adequate health care and to early

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1 Pursuant to Fed. R. App. P. 29(c)(3), amici state that the source of authority to file this brief is this Court's Order dated August 30, 2005, which granted amici leave to file this brief.

2 The AAP is a national organization that is wholly distinct from the Oklahoma Chapter, which is a party to this appeal. Chapters are individually incorporated and have their own bylaws, and local chapter members pay separate membership dues. The AAP does not direct or control the activities of local chapters, and the AAP's positions on this and other litigation are not directed or controlled by local chapters.

and periodic screening, diagnosis, and treatment ("EPSDT") services required under Title XIX of the Social Security Act (the "Medicaid Act"). AAP members, who regularly treat Medicaid-eligible children, know first-hand that failure to ensure such access endangers young lives. The AAP therefore seeks health care financing mechanisms that promote continuity and coordination of quality care for all children. In particular, the AAP has long advocated for a "medical home" for children. A medical home is an approach to the delivery of quality medical care that is, among other things, accessible, continuous, comprehensive, compassionate, culturally-effective, and family-centered, where such care is overseen by a pediatrician who continuously provides care over an extended period of time and can develop a relationship with the child and the child's family.[3]

The AMA, with approximately 250,000 members, is the nation's largest professional organization of physicians and medical students.[4] AMA members practice in all fields of medical specialization and in every state,

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[3] See AAP, Medical Home Initiatives for Children With Special Needs Project Advisory Committee, The Medical Home, 110 Pediatrics 184 (July 2002); AAP, Committee on Child Health Financing, Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years, 100 Pediatrics 1040 (Dec. 1997).

[4] The AMA submits this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies (the "Litigation Center"). The Litigation Center, a coalition of the AMA and 51 state medical societies (each state plus the District of Columbia), was established to present the views of the medical profession to the courts.

including Oklahoma. The AMA was founded in 1847 to promote the science and art of medicine and betterment of public health. The AMA seeks to become the most authoritative voice and influential advocate for patients and physicians.

The AMA believes that every United States citizen should have access to necessary medical care, regardless of ability to pay. The AMA supports the use of Medicaid to ensure access to health care for those without private insurance, and believes that Medicaid funding should be sufficient to enable recipients to secure access to an adequate number of physicians.

The OSMA is a not-for-profit medical association of approximately 4,900 Oklahoma physicians. Founded in 1906, its purpose is to advance the science and art of medicine for the betterment of Oklahoma physicians and the public they serve. The OSMA represents the interests of Oklahoma physicians as part of a national network of medical associations cooperating to represent physicians on local, state, and national issues.

Amici's goals cannot be met for all people unless state governments—as required by federal law—ensure that low-income individuals have the same access to quality comprehensive health care as their more fortunate peers, including the critical EPSDT services mandated by federal law. These goals are particularly important for children. Far more than adults, children rely on Medicaid for health care. Accordingly, amici have consistently sought meaningful

enforcement of the mandatory requirements of the Medicaid laws. In particular, amici are firmly convinced that continuity of care and access to preventive care are critical foundations of quality health care and that a state's failure to provide such services harms the short- and long-term health of children enrolled in Medicaid.

Unfortunately, due to the failure of Oklahoma and other states to comply with the mandates of federal law, Medicaid has been failing the children whose very lives often depend on it, as they are unable to receive timely medical care and lack the continuity of care vital to proper health. The question in plaintiffs' appeal in this case is whether affected parties have an effective mechanism to ensure state compliance with federal Medicaid mandates.[5] Notwithstanding overwhelming factual findings demonstrating that the Oklahoma Health Care Authority ("OHCA" or "Oklahoma") is violating critical provisions of the Medicaid Act by not providing Oklahoma's neediest children basic medical services to which they are legally entitled, the District Court found no liability, erroneously holding that OHCA need only "substantially"—rather than fully—comply with the law. Moreover, the District Court incorrectly held that physicians

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[5] Amici support affirmance of the portions of the District Court's judgment challenged in defendants' cross-appeal (No. 05-5107), and had sought leave to file a brief addressing both plaintiffs' appeal and defendants' cross-appeal. But because this Court's August 30, 2005 order granting leave required amici to file this brief before defendants filed their cross-appeal brief, this brief addresses only plaintiffs' appeal (No. 05-5100).

and their organizations lacked third-party standing to raise the rights of their minor patients. Unless affected parties—including pediatricians, other physicians, and their organizations—can ensure that federal law is fully obeyed, the costs of such non-compliance will fall disproportionately on one of the most defenseless segments of society: the millions of low-income children who rely on Medicaid for basic health care.

ARGUMENT

I. LOW-INCOME CHILDREN DEPEND ON THE MEDICAID ACT TO ENSURE THEY RECEIVE THE SAME QUALITY MEDICAL CARE AS THEIR MORE FORTUNATE PEERS.

Medicaid is a joint federal-state program providing medical assistance to low-income individuals and families. States receive federal funds in return for administering health insurance programs that meet mandatory requirements established by federal law. See West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 15 (3d Cir. 1989). Today, all fifty states and the District of Columbia participate in Medicaid, and it "is the largest source of funding for medical and health-related services for America's poorest people." Centers for Medicare and Medicaid Services ("CMS"), Medicaid: A Brief Summary (www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp).

The Nation's children disproportionately depend on Medicaid to meet their health care needs. Nationwide, nearly 54% of Medicaid beneficiaries are

children.[6] This represents a significant portion of all children in the United States. During fiscal year 2002, 51% of all infants and 45% of all children ages one through five were enrolled in Medicaid.[7] The absolute numbers are enormous: more than 25.9 million children depended on Medicaid for health care during fiscal year 2003, with 19.1 million enrolled for the entire year.[8] Likewise, 26.6 million children were expected to be enrolled in Medicaid during fiscal year 2004, with 19.6 million enrolled for the entire year. Id.

Medicaid is particularly vital to Oklahoma's children. Oklahoma's Medicaid program, called SoonerCare, serves more than 355,000 needy children in Oklahoma. March 22, 2005 Opinion ("Opinion") at 8 (FOF14).[9] Demonstrating the importance of this case, SoonerCare is the source of basic health care for a staggering percentage of Oklahoma's children, particularly the youngest. Over 70% of infants and nearly 69% of children ages one through five in Oklahoma

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6 See CMS, MSIS Statistical Reports for Federal Fiscal Year 2002, Table 5: FY 2002 Medicaid Eligibles by Age Group (up to age 20) (www.cms.hhs.gov/medicaid/msis/02_table05.pdf).

7 See AAP, Medicaid State Report—FY 2002, US Summary, at 3 (www.aap.org/research/medic02.htm).

8 See CMS, 2003 Data Compendium, Medicaid Enrollment and Beneficiaries Selected Fiscal Years (2003) (www.cms.hhs.gov/researchers/pubs/datacompendium/current/).

9 "FOF" refers to the District Court's findings of fact, and "COL" refers to the District Court's conclusions of law.

were enrolled in Medicaid during fiscal year 2002. See AAP, Medicaid State Reports—FY 2002, Oklahoma, at 3 (www.aap.org/research/medic02.htm). Almost half (49%) of Oklahoma's children up to age eighteen depend on Medicaid for their health care, and almost half of the births in the state (46%) were covered by Medicaid. Id. See also AAP, Oklahoma Medicaid Facts (July 2005) (www.aap.org/advocacy/washing/elections/med_factsheet_pub.htm).

Medicaid's central purpose is to ensure that low-income individuals are not denied the necessary medical services that others can readily access. Thus, federal law mandates that states provide certain health care services. Among those services are EPSDT services—which must be provided "to all eligible individuals" under the age of 21. See 42 U.S.C. § 1396a(a)(8) (requiring "medical assistance" be provided "to all eligible individuals"); id. § 1396a(a)(10) (requiring "medical assistance" be provided to "all individuals" covered by the plan); id. § 1396d(a)(4)(B) (defining "medical assistance" to include EPSDT services to eligible individuals under age 21). Mandatory EPSDT services include preventive medical screenings, immunizations, laboratory tests (including for blood lead level), vision services, dental services, hearing services, and all medically necessary health care services for "physical and mental illnesses and conditions discovered by the screening services." Id. § 1396d(r). Federal law also mandates that state Medicaid plans "assure that payments [to providers] 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) (commonly referred to as the "quality of care" and "equal access" requirement).

A basic question in plaintiffs' appeal is whether states must fully comply with these mandatory requirements to provide needed services to individual Medicaid recipients, or whether less-than-full compliance is enough. As explained below, Oklahoma and other states should not be able to avoid their legal obligations to vast numbers of Medicaid children in the face of factual findings demonstrating a systematic failure to provide mandatory services.

A. Children Enrolled In Medicaid Are Not Receiving The Mandatory EPSDT Services, Even Though Those Services Are A Critical Part of Quality Medical Care For Children.

1. States—including Oklahoma—have engaged in widespread violations of federal Medicaid mandates, including the EPSDT requirement and the quality of care and equal access requirement. In 2001, the General Accounting Office ("GAO") reported to Congress that only 28% of children enrolled in Medicaid managed care received all prescribed EPSDT screens, and that 60% received no screens at all. See GAO, Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services at 12-13 (July 2001)

(www.gao.gov/new.items/d01749.pdf). That same year, the federal official overseeing Medicaid recognized that more than half of Medicaid-eligible children receive no EPSDT screening in 25 states, with seven states providing no screening for more than two-thirds of Medicaid-eligible children. See Memorandum from Director, Center for Medicaid & State Operations, HHS, to Associate Regional Administrators for Medicaid & State Operations at 2 (Jan. 19, 2001) (www.healthlaw.org/search.cfm?fa=download&resourceID=60701&appView=folder&print).

The statistics regarding Oklahoma's non-compliance are particularly bleak. As the District Court found in this case, between 60 and 73 percent of eligible children in Oklahoma did not receive a single EPSDT service from 1995 to 2001. Opinion at 55 (FOF138).

2. The statistics regarding specific services further demonstrate the enormity of the problem. For example, states routinely fail to provide Medicaid-enrolled children with screening for lead poisoning—a mandatory EPSDT service. See 42 U.S.C. § 1396d(r)(1). In the federal government's view, "[i]t is critical that State Medicaid programs adhere to the Federal Medicaid policies for lead screening and provide the medically necessary follow-up services as part of [EPSDT] services." Letter from Director, Center for Medicaid & State Operations, HHS, to State Medicaid Directors at 1 (Oct. 22, 1999)

(www.cms.hhs.gov/states/letters/smdo2299.asp). But less than 20% of children served by Medicaid are ever screened for lead poisoning—even though children enrolled in federal health care programs are five times more likely to have lead poisoning than privately-insured children.[10] This failure to screen has left an estimated 436,000 children served by federal health care programs with elevated blood lead levels that remain undiagnosed—a condition that can cause reading and learning disabilities, hyperactivity, coma, convulsions, a reduction in IQ and attention span, and can ultimately cause a child's death. See GAO, Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children, supra, at 14, 29.

In Oklahoma, the failure to screen for lead poisoning is even worse. As the District Court found in this case, fewer than 1.5% of eligible one- and two-year olds were screened in 2000, and fewer than 3% in 2001. Opinion at 48 (FOF146). This means that over 57,000 Oklahoma children in 2000 and over 60,000 Oklahoma children in 2001 went unscreened for their blood lead level. Id. Despite the wide recognition that Medicaid-eligible children need this mandatory preventive care, they remain unlikely to receive it, especially in Oklahoma.

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10 See GAO, Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children at 23, 27 (Jan. 1999) (www.gao.gov/archive/1999/he99018.pdf); CDC, Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk (Feb. 2000) (www.cdc.gov/mmwr/preview/mmwrhtml/rr4914a1.htm).

3. Children insured by Medicaid also lack adequate access to dental care—another required EPSDT service. See 42 U.S.C. § 1396d(r)(3). Despite the fact that "[t]ooth decay is currently the single most common chronic childhood disease" and can lead to stress and depression, undermine self-image, and "interfere with vital functions such as breathing, eating[,] swallowing, and speaking," a recent year-long study found that fewer than one in five Medicaid-covered children had a single dentist appointment. See Letter from Director, Center for Medicaid and State Operations, HHS to State Medicaid Directors at 1 (Jan. 18, 2001) (www.cms.hhs.gov/states/letters/smd118a1.pdf). Similarly, the GAO reported that only 21% of Medicaid-eligible children ages two to five, and only 36% of such children ages six to eighteen, had been to a dentist within the previous year. See GAO, Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services, supra, at 12; see also American Public Human Service Association, Dental Care for Medicaid Enrolled Children at 2 (July 2000) (Medicaid-enrolled children in 42 of 44 surveyed states had trouble accessing dental care) (www.nasmd.org/pubs/DentalCare.PDF).

Once again, the numbers in Oklahoma are even worse. As the District Court found in this case, only 17% of children eligible for EPSDT dental services received any dental care in 2001. Opinion at 66 (FOF166). And this abysmal rate

actually represented an increase over the dental care provided during the three previous years, in which only 10-13% of children received any dental services. Id.

4. One reason Medicaid-enrolled children do not receive EPSDT services is the failure of states to ensure sufficient numbers of doctors who treat Medicaid patients. Across the United States, an average of only 54.6% of private office-based primary care pediatricians accept all Medicaid patients who request care. See Steve Berman, et al., Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients, 110 Pediatrics 239, 241 (Aug. 2002). Importantly for this case, Oklahoma had the second lowest rate of participation nationwide, at only 32.3%. Id. Even adjusting for practices that cannot accept new patients of any type, pediatric practices are significantly more likely to accept a new non-Medicaid patient than a new Medicaid patient. Id. Oklahoma ranks third worst under this measurement. Id. The lack of participating doctors leaves children covered by Medicaid facing at best longer wait times for appointments and at worst limited or no access to care. See Opinion at 49 (FOF123).

In its factual findings, the District Court recognized the enormity of the problem in Oklahoma. Only 34% of pediatricians in the state accept all new Medicaid patients, yet over twice that number accept privately-insured patients. Opinion at 19 (FOF45). When considering the participation by office-based

primary care pediatricians, the numbers are even more unacceptable: a mere 18% fully participate in Medicaid. Id. (FOF46). This lack of access to pediatricians denies children needed diagnostic and treatment services and follow-up care, resulting in serious conditions being undetected until it is too late for early intervention measures. Id. at 20-21 (FOF49-50).[11] Medicaid-enrolled children in Oklahoma also have extremely limited access to specialty providers, including (1) pediatric neurologists (wait times of up to a year), (2) ear, nose and throat doctors ("almost a crisis situation" in Oklahoma City and "very little access" in Tulsa), (3) orthopedists (wait times of months), (4) child psychiatrists ("inadequate" access), (5) electrophysiologists ("unavailable" to children with Medicaid but available to privately insured patients), and (6) pediatric emergency room doctors (only on staff at one hospital in entire state). See Opinion at 23, 25-28, 31, 34-35 (FOF56, 61-63, 67, 69, 74-76, 79, 86, 88). As the District Court correctly found, SoonerCare has patently unreasonable system-wide delays. Id. at 104 (COL32).

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11 Lack of access to physicians especially affects special needs children—including children with asthma, attention deficit disorder, or cerebral palsy—who require more medical services and specialty care than others. See, e.g., California HealthCare Foundation, The California Medical Home Project at 2 (Dec. 2003) (www.chcf.org/documents/chronicdisease/CAMedicalHomeFactSheet.pdf); Martha Gold, et al., Access to Physicians in California's Public Insurance Programs at 8, 12 (May 2004) (www.chcf.org/documents/policy/AccessTo PhysiciansInCAPublicProgramsIB.pdf).

The states and the Federal government, however, have done little, if anything, on their own to ensure compliance with the mandatory EPSDT requirements. For example, the GAO reports that the federal government does not monitor whether state Medicaid programs comply with federal lead screening policies, even though nearly half of the States' screening programs are less rigorous than the federal requirements. See GAO, Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children, supra, at 4. In addition, the GAO has found that most states do not set goals for, or even analyze, the availability of participating primary care physicians in Medicaid fee-for-service plans, even though such programs serve more than half of all children in Medicaid. See GAO, Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care at 33-34 (Jan. 2003) (www.gao.gov/new.items/d03222.pdf).

One reason (although not the only one) children and other Medicaid beneficiaries cannot obtain needed service is that reimbursement rates are so low that they do not even cover physicians' basic costs. Opinion at 45 (FOF113). As the District Court held in this case, "OCHA has frequently set rates below the levels which OCHA admits are adequate to assure there are enough providers to serve Medicaid enrolled children. The mandates of the federal Medicaid law

preclude such rate setting." Id. at 97 (COL17).[12] For example, an emergency room physician in Oklahoma receives $25 for seeing a child on Medicaid regardless of the time expended or the procedures performed. Id. at 13 (FOF29).

The problem is nationwide. In a survey of AAP pediatricians around the country, low reimbursement levels was the reason most commonly rated "very important" for limiting participation in Medicaid. See AAP, Pediatrician Participation in Medicaid/SCHIP, Survey of Fellows of the American Academy of Pediatrics, U.S. Report: Private Office-based Primary Care Pediatricians in Direct Patient Care at 2 (2000) (www.aap.org/statelegislation/med-schip/pcp/US.pdf).[13] Oklahoma pediatricians agree, with 93% stating that low reimbursement is a very important reason for limiting Medicaid participation and 69.5% stating that

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[12] Florida provides an example of the link between reimbursement rates and the provision of EPSDT services. When Florida recently doubled its EPSDT reimbursement rate, its ESPDT screening rates for Medicaid-eligible children also doubled—from 32% to 64%. See GAO, Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services, supra, at 18.

[13] Other studies have come to the same conclusion. See Opinion at 42, 43 (FOF105, 106, 109); The Lewin Group, Analysis of Medicaid Reimbursement in Oregon at 3, 6 (Feb. 26, 2003); Ohio Coalition of Primary Care Physicians and the Ohio State Medical Association, 2002 Ohio Physician Medicaid Survey, Key Findings (Jan. 2003); David L. Skaggs, et al., Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California, 107 Pediatrics 1405, 1407 (June 2001); Berman, supra, at 243; Joel W. Cohen & Peter J. Cunningham, Medicaid Physician Fee Levels and Children's Access to Care, 14 Health Affairs 255 (Spring 1995).

reimbursement does not even cover their overhead expenses. Opinion at 42 (FOF105).

Oklahoma and other states are plainly failing to comply with the federal EPSDT mandate. As next shown, this failure has seriously compromised the health of low-income children and others who depend on Medicaid to meet their basic health care needs.

B. Non-Compliance With Federal Medicaid Mandates Has Compromised The Health Of Children Served By Medicaid.

The lack of EPSDT services and equal access to quality care can be catastrophic for the health of Medicaid children in Oklahoma and elsewhere. In general, "poor kids are sicker than other kids." Colleen A. Foley, Comment, The Doctor Will See You Now: Medicaid Managed Care and Indigent Children, 21 Seton Hall Legis. J. 93, 108 (1997). As the District Court found, "low-income children are more likely than other children to struggle with low birth weight, lead poisoning, rheumatic fever, and asthma, as well as vision, dental, speech, and behavioral problems." Opinion at 10 (FOF20). The stresses of "low wages, substandard housing, violence, and inadequate nutrition also contribute to higher rates of physical and mental illness for poorer children." Id. The problem is especially pronounced in Oklahoma, which is the only state whose health status (including that of poor children) has worsened since 1990. Id. at 9 (FOF18).

Failure to provide services and the failure to provide them on equal terms to the general population harm the health of children and other Medicaid beneficiaries for two basic reasons. First, the lack of physicians willing to accept Medicaid leads to unacceptable waiting times for outpatient care.[14] In one nationwide study, only 48% of surgeons were willing to treat a child on Medicaid, while 100% were willing to treat a privately insured patient. Opinion at 41 (FOF104). Notably, none of the three Oklahoma surgeons in the study would treat the child, but all three agreed to treat the privately-insured child. Id. In a similar study in California by the same researchers, randomly selected orthopedic surgeons in Los Angeles were contacted about a hypothetical child with a broken arm. Only 2% would schedule an appointment within a week for a Medicaid-insured child, whereas 100% would schedule an appointment within a week for a privately-insured child. See Skaggs, supra, at 1405. Of the 98% who refused to see the Medicaid-insured child, 87% could not even recommend another orthopedic office that would accept Medicaid. Id.

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14 The GAO has found that "[n]ationally, low Medicaid physician fees and physician participation have been long-standing areas of concern." See GAO, Medicaid and SCHIP, States' Enrollment and Payment Policies Can Affect Children's Access to Care at 29 (Sept. 2001) (www.gao.gov/cgi-bin/getrpt?GAO-01-883). Because payment rates are one factor in whether a physician participates in Medicaid, lower Medicaid payments relative to other payers result in fewer participating physicians. Id. at 33.

The situation in Oklahoma is no different. As one pediatrician testified, he spent six-weeks attempting—without success—to find an orthopedist to treat a four-year-old girl with a fractured toe. Opinion at 30 (FOF74). Given the importance of seeing injured children quickly, it is obvious that the lack of access for Medicaid-eligible children negatively impacts their overall health. Indeed, "if a fracture is not properly aligned in the first few weeks, a permanent deformity may result." Skaggs, supra, at 1405. Moreover, delay in care inherently means a prolongation of pain regardless of the ultimate medical outcome.

Second, the failure of Oklahoma and other states to ensure that physicians are available to provide the EPSDT services mandated by federal law has prevented Medicaid-enrolled children from receiving the continuity of care that is essential for maintaining proper health. Effective primary pediatric care requires a regular physician who can follow the child, thereby providing continuous, coordinated, and comprehensive care. Research demonstrates that having a continuous relationship with a health care provider improves the quality of care. See Opinion at 82 (FOF203); Leighton Ku & Donna Cohen Ross, The Commonwealth Fund, Staying Covered: The Importance of Retaining Health Insurance For Low Income Families at 7 (Dec. 2002); Dimitri A. Christakis, et al., Continuity of Care Is Associated with High-Quality Care by Parental Report, 109 Pediatrics 54 (Apr. 2002). Continuity of pediatric care provides health advantages

in childhood and beyond in part because having a regular source of care is "the most important factor associated with receiving preventive care services." See Barbara Starfield & Leiyu Shi, The Medical Home, Access to Care, and Insurance: A Review of Evidence, 113 Pediatrics 1493, 1495 (May 2004).

Preventive care, such as periodic well-child visits, greatly increases the health of Medicaid-insured children and decreases avoidable hospitalizations for them.[15] Coordination of care and continuity of care are especially critical for children with special needs and disabilities, who require early intervention as well as treatment plans that must be regularly reviewed and revised. See AAP, Committee on Children With Disabilities, Role of the Pediatrician in Family-Centered Early Intervention Services, 107 Pediatrics 1155 (May 2001) (www.aappolicy.aappublications.org/cgi/content/full/pediatrics;107/5/1155).

The EPSDT services mandated by federal law are thus of the utmost importance to children enrolled in Medicaid, as these children tend to have increased and exacerbated health problems. Like many states, however, Oklahoma has demonstrated that it is not willing to comply with the requirement on its own.

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15 See Rosemarie B. Hakim & Barry V. Bye, Effectiveness of Compliance With Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries, 108 Pediatrics 90, 94 (July 2001); see also Dimitri A. Christakis, et al., Association of Lower Continuity of Care with Greater Risk of Emergency Department Use and Hospitalization in Children, 107 Pediatrics 524-529 (Mar. 2001); Lindsey Grossman, et al., Decreasing Nonurgent Emergency Department Utilization By Medicaid Children, 102 Pediatrics 20 (July 1998).

Accordingly, as shown below, Medicaid beneficiaries and their providers must—as Congress intended—have an adequate remedy to require full compliance with federal law.

II. THE DISTRICT COURT ERRED IN APPLYING A "SUBSTANTIAL COMPLIANCE" FUNDING STANDARD TO ACKNOWLEDGED VIOLATIONS OF INDIVIDUAL RIGHTS.

Numerous courts have held, as the District Court did here (Opinion at 106-108 (COL38-40)), that 42 U.S.C. § 1396a(a)(8) and § 1396a(a)(10) confer individually-enforceable rights under Section 1983—including the EPSDT provisions.[16] Other provisions of the Medicaid Act have similarly been held to create individually-enforceable rights.[17] The central question in plaintiffs' appeal is whether a State must actually comply with these mandatory legal requirements or whether, as the District Court held (Opinion at 121), a State's documented failure to provide individuals with required services can be excused if the court

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16 See S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 603 (5th Cir. 2004); Sabree v. Richman, 367 F.3d 180, 190 (3d Cir. 2004); Bryson v. Shumway, 308 F.3d 79, 89 (1st Cir. 2002); Michelle P. ex rel. Deisenroth v. Holsinger, 356 F. Supp. 2d 763, 767 (E.D. Ky. 2005); Memisovski ex rel. Memisovski v. Maram, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004); Mendez v. Brown, 311 F. Supp. 2d 134, 140 (D. Mass. 2004); Clark v. Richman, 339 F. Supp. 2d 631 (M.D. Pa. 2004); Kenny A. ex rel. Winn v. Perdue, 218 F.R.D. 277, 293-294 (N.D. Ga. 2003); Collins ex rel. Collins v. Hamilton, 231 F. Supp. 2d 840, 846-847 (S.D. Ind. 2002), aff'd, 349 F.3d 371 (7th Cir. 2003).

17 See, e.g., Wilder v. Virginia Hosp. Ass'n. 496 U.S. 498, 522-523 (1990); Rabin v. Wilson-Coker, 362 F.3d 190, 201-202 (2d Cir. 2004); Gean v. Hattaway, 330 F.3d 758, 772-773 (6th Cir. 2003); Kerr v. Holsinger, 2004 WL 882203, at *4-*5 (E.D. Ky. Mar. 25, 2004).

finds that the State has "substantially" complied with its legal duties by providing some beneficiaries with some services.

That the rights are individual rights answers the question. The District Court detailed through hundreds of findings of fact the manner in which OHCA continuously and consistently has failed to provide mandatory EPSDT services to its neediest children. The law provides that every state Medicaid plan "must" ensure medical assistance—including EPSDT services—is "furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (emphases added); id. § 1396d(a)(4)(B). Thus, in determining liability, the proper question is whether Oklahoma has "established a Medicaid program designed to provide all EPSDT services to all Medicaid-enrolled children on a timely basis." Memisovski, 2004 WL 1878332, at *50 (emphasis added); see generally Armen H. Merjian, Substantial Compliance Permits Substantial Suffering: Debunking the Myth of a Principled "Split" in the Circuits Over Mandatory Timeliness Requirements in Federal Benefits Law, 11 B.U. Pub. Int. L.J. 191 (2002) (explaining why full compliance is the proper standard for federal benefits statutes).

If a State is not implementing a Medicaid plan designed to ensure that all Medicaid children receive required EPSDT services—and the District Court's findings amply demonstrate that Oklahoma is not—it is not following the law, and it is no answer to say that the plan would provide some services to some

individuals. For example, if a State's plan categorically excluded services for individuals in 10% of its counties, that violation could not be excused on the basis that the remaining 90% were served. So too here, where the District Court's own factual findings demonstrated Oklahoma's failure to provide mandatory services. Indeed, even if the standard were "substantial" compliance—and it is not—that standard could not be met when 97% of Medicaid-eligible in Oklahoma receive no blood lead screening and 83% receive no dental care. See Opinion at 48, 66 (FOF 146, 166).

The District Court imported a "substantial compliance" standard from a different statutory context—the funding context—that is used by a different reviewing body—the federal government—when evaluating the aggregate success of a state in meeting its obligations under the Medicaid Act. See 42 U.S.C. § 1396c (further payments of federal funds will not be made to a state when "there is a failure to comply substantially" with the Act). The standard by which the federal government chooses whether to continue funding a state program is not designed to protect or enforce individual rights, like those held by Medicaid recipients. It simply sets the minimal level of compliance before the federal government must cut off federal funding entirely, imposing a " 'virtual death sentence' " on a state's Medicaid program. See Health Care for All, Inc. v.

Romney, 2005 WL 1660677, at *8 (D. Mass. July 14, 2005) (citing Withrow v. Concannon, 942 F.2d 1385, 1387 (9th Cir. 1991)).

As the Health Care for All court explained:

> The lower standard of substantial compliance, as opposed to full or perfect compliance, serves to balance the dire consequences of failure to comply in the context of funding. However, nothing merits or implies the use of a low standard with respect to a state Medicaid program's fulfillment of its statutory and regulatory obligations to serve beneficiaries.

Id. See also Reynolds v. Giuliani, 2005 WL 342106, at *17 (S.D.N.Y. Feb. 14, 2005) (full compliance, not substantial compliance, is proper standard for remedying violations of 42 U.S.C. § 1396a(a)(8)); cf. Robertson v. Jackson, 972 F.2d 529, 535 (4th Cir. 1992) (applying full compliance standard to a state's violations of Food Stamp Act).

The dangers of using a substantial compliance standard are illustrated by the District Court's decision. This is not a case about sporadic non-compliance or an inadvertent error. Rather, OHCA continuously, consistently, and knowingly fails to provide mandatory EPSDT services and equal access to quality care to its neediest children. The District Court's "substantial compliance" holding confused the standards for liability with the appropriate remedy. Liability exists here because OHCA has not complied with its mandatory legal obligation to establish a plan designed to provide EPSDT services to all eligible children. In fashioning an

equitable remedy for that violation, the District Court would have discretion to determine the form of injunctive relief that would best ensure future compliance. No remedy, of course, is ever perfect. But that fact will not prevent a finding of liability where, as here, there are overwhelming factual findings demonstrating that a statutory duty is not being followed.

Once the proper full compliance standard is properly applied, it is readily apparent that the District Court's remedy—which addressed different violations of the Medicaid Act—does not address OHCA's serious breaches of its responsibilities to provide EPSDT services to all eligible children. The increase in reimbursement rates ordered by the District Court focuses on correcting the state's violation of the "equal access" and "quality of care" provisions in 42 U.S.C. § 1396a(a)(30)(A). It is of critical importance that Medicaid rates be sufficient to ensure equal access, but that alone is insufficient to remedy OHCA's violations of the EPSDT provisions. Those provisions require that each State's plan ensure that the mandatory services are actually provided, not merely that physicians are paid.

Medicaid is an individual entitlement program, and the EPSDT provisions impose a specific, mandatory, and binding duty on each State to establish a plan providing every eligible low-income child with access to diagnostic, screening, and treatment services. If affected parties cannot ensure that the states carry out these mandatory obligations, Congress's important promise to

needy Americans will be an empty one. This Court should therefore conclude that "the standard to be applied in this case will be full compliance." Health Care for All, 2005 WL 1660677, at *8.

III. PROVIDER ORGANIZATIONS HAVE STANDING TO ENFORCE THE RIGHTS OF THEIR MEMBERS' PATIENTS.

The District Court dismissed OKAAP, an organization whose members include physicians serving Oklahoma Medicaid patients, for lack of standing. Opinion at 93 (COL9). This was an error. Contrary to the District Court's statement, OKAAP's standing is not determined by whether providers (as distinguished from beneficiaries) have an enforceable right under the equal access and quality care provisions (42 U.S.C. § 1396a(a)(30)(A))—because OKAAP never sought to assert its physician members' rights directly. Rather, throughout this case, OKAAP has sought to assert its members' right to advocate for their patients. OKAAP does have standing on this ground.

Physicians and their organizations have standing to enforce the rights of the Medicaid patients they serve. Physicians have third-party standing to assert their patients' rights, and physician organizations have associational standing to litigate on behalf of their members. In such circumstances, third-party standing and associational standing are appropriately applied together to allow provider

organization plaintiffs to assert the rights of Medicaid patients.[18] Indeed, this Court has already held that nursing home operators have standing to challenge Medicaid rules on behalf of recipients. See Colorado Health Care Ass'n v. Colorado Dep't of Soc. Servs., 842 F.2d 1158, 1164 (10th Cir. 1988). It follows a fortiori that physicians and their organizations have third-party standing to raise the rights of recipients.

1. Under third-party standing principles, physicians have standing to sue on behalf of their Medicaid-insured patients because physicians have a concrete interest in the outcome, they share a close relationship with their patients, and patients face obstacles in bringing suit on their own. See Powers v. Ohio, 499 U.S. 400, 411 (1991) (outlining three requirements); Wauchope v. U.S. Dep't. of State, 985 F.2d 1407, 1411 (9th Cir. 1993) (same). Importantly, as appellants have noted, the obstacle facing Medicaid recipients need not be "insurmountable" or

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18 See Pennsylvania Psychiatric Soc'y v. Green Springs Health Servs., Inc., 280 F.3d 278, 287-289 (3d Cir. 2002) (associational standing of medical association could be combined with its members' third-party standing so that association has standing to pursue patients' claims); Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 528 (8th Cir. 1993) (provider organizations have standing to challenge Medicaid laws because "[f]irst, Medicaid recipients and providers individually have standing to contest the Medicaid laws" and "[s]econd, the [provider] organizations, through this lawsuit, are obviously seeking to protect interests that are directly relevant to the organizations' purposes"); see also Fraternal Order of Police v. United States, 152 F.3d 998, 1002 (D.C. Cir. 1998), rehearing, 173 F.3d 898, 903 (D.C. Cir. 1999) (analysis of standing "unchanged from our prior opinion"); Ohio Ass'n. of Indep. Sch. v. Goff, 92 F.3d 419, 421-422 (6th Cir. 1996).

make it "impossible" for them to sue, but must simply present "some hindrance." Powers, 499 U.S. at 411; Singleton v. Wulff, 428 U.S. 106, 116-117 (1976).

The pediatrician members of OKAAP meet these three requirements. Their interest in the outcome and the close relationship they share with their patients are beyond dispute. See, e.g., Singleton, 428 U.S. at 114-115 (doctors had standing to challenge Medicaid statute on behalf of patients because rights of patients were inextricably bound up with doctors' activities); Caplin & Drysdale, Chartered v. United States, 491 U.S. 617, 624 n.3 (1989) (noting that "[t]he attorney-client relationship . . . , like the doctor-patient relationship . . . , is one of special consequence"). Indeed, the pediatrics profession views advocating for children—particularly needy children—as a basic professional duty, and a pediatrics residency "prepare[s] residents for the role of advocate for the health of children within the community." See Accreditation Council for Graduate Medical Education, Program Requirements for Residency Education in Pediatrics at 12 (www.acgme.org/acWebsite/Images/pdf.gif); id. at 13 (residency curriculum must include focus on underserved populations); AAP, Committee on Community Health Services, The Pediatrician's Role in Community Pediatrics, 115 Pediatrics 1092 (Apr. 2005) (describing pediatrician's role as an advocate for their patients' health and well-being) (www.pediatrics.org/cgi/content/full/115/4/1092). And

Oklahoma law explicitly recognizes physicians should advocate for children in the context of reporting child abuse. See Okla. Stat. tit. 10 § 7103.

Moreover, the third requirement is met because of the hindrances to Medicaid recipients bringing suit solely on their own. At a basic level, Medicaid recipients move frequently, change eligibility status over short periods of time, and often face language barriers. See GAO, Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services at 14. In addition, much of the Medicaid program is administered directly between OHCA and providers and involves decisions of which recipients are completely unaware. For example, the District Court found OHCA in violation of the Medicaid Act for failure to "consult[] with child health care organizations in establishing its periodicity schedule." Opinion at 61 (FOF155). Medicaid-insured individuals are not a party to this required consultation and do not know when and if it occurs. Moreover, they lack other relevant information necessary to know if they have rights that are being violated—such as what EPSDT requirements are, how great the variance is between provider participation in Medicaid and private insurance, and how much longer the delays in receiving care are for Medicaid-insured individuals than for privately-insured individuals. Lastly, a Medicaid recipient's need for medical care is often temporary, whereas physicians have long-term interests in securing the rights of their many patients. See Singleton, 428 U.S. at 117. These numerous

impediments obstruct the ability of poor children (or their parents) to assert and vindicate their rights.

2. Moreover, physician organizations such as OKAAP have associational standing to sue on behalf of their members because their members would have standing on their own, the interests the organizations seek to protect are germane to their purpose, and neither the claim asserted nor the relief requested requires the participation of individual members. See Hunt v. Washington State Apple Adver. Comm'n, 432 U.S. 333, 343 (1977); Roe No. 2 v. Ogden, 253 F.3d 1225, 1230 (10th Cir. 2001) (organization had standing to assert rights of its law school student members regarding bar admission rule); Harris v. Board of Supervisors, Los Angeles County, 366 F.3d 754, 761-764 (9th Cir. 2004) (organization had standing to assert Medicaid rights of indigent members).

There can be no dispute that OKAAP seeks here to protect interests germane to its purpose. In addition, neither the claim asserted nor the relief requested require the participation of individual OKAAP members; rather, this case concerns Oklahoma's failure to implement and administer a Medicaid program that meets the federal requirements. NCAA v. Califano, 622 F.2d 1382, 1392 (10th Cir. 1980) (associational standing proper when "the case presents issues of law common to all members," "[n]o damages are sought for the individual members," and the association "asks for declaratory and injunctive

relief"). And OKAAP's associational standing is not affected by the fact that its members have third-party rather than direct standing. In New York State Club Association, Inc. v. City of New York, 487 U.S. 1, 9 (1988), the Court rejected a limited view of associational standing that would have required members to have standing only to sue on behalf of themselves, not on behalf of third parties. As the Court held, "[u]nder Hunt, an association has standing to sue on behalf of its members when those members would have standing to bring the same suit. It does not matter what specific analysis is necessary to determine that the members could bring the same suit." Id. Thus, as long as the associations' members would have standing to bring suit on behalf of a third party, associational standing was proper. Id.; see also Council of Ins. Agents & Brokers v. Gallagher, 287 F. Supp. 2d 1302, 1308 (N.D. Fla. 2003) (under New York State Club, associational and third-party standing "may be stacked").

So too here. OKAAP members have third-party standing to assert claims for their Medicaid patients, and OKAAP has associational standing to assert the rights of its members. The District Court's decision to dismiss OKAAP for lack of standing should therefore be reversed.

CONCLUSION

For the foregoing reasons, the portions of the District Court's judgment challenged in No. 05-1500 should be reversed.

Respectfully submitted,

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September 12, 2005

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ADDENDUM

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Briefs and Other Related Documents

United States District Court,D. Massachusetts.
HEALTH CARE FOR ALL, INC., et al.
v.
Governor Mitt ROMNEY, et al.
No. Civ.A. 00-10833RWZ.

July 14, 2005.

MEMORANDUM OF DECISION

ZOBEL, J.
***1** Plaintiff Virgin Torres complains that she cannot find an oral surgeon for her daughter. Plaintiff Patricia Meaney says that she cannot locate a dentist of adequate quality for her sons. Plaintiff Sharleen Campbell's child saw a dentist only after Ms. Campbell called approximately fifty other providers. These experiences illustrate the frustration and failure that plaintiffs in the instant case claimed to confront in seeking Medicaid-covered dental care in Massachusetts. Medicaid is a nationwide medical assistance program operated on a state-by-state basis pursuant to individual state plans. States that participate in Medicaid may receive cooperative federal funding if their state plans comply with certain federal criteria. These requirements include provision of dental care and services to Medicaid enrollees under the age of 21. States may elect to provide dental care and services also to adults, and the Medicaid program of the Commonwealth of Massachusetts (commonly known as "MassHealth") does so only for a discrete class of adult beneficiaries who meet regulatory guidelines for severe chronic disabilities or certain clinical conditions and are therefore known as "special circumstances" enrollees.

According to plaintiff Health Care For All, Inc. ("HCFA"), the Commonwealth and MassHealth have fallen far short of meeting statutory and assumed obligations to serve the dental needs of children and adult MassHealth enrollees. HCFA is a nonprofit, tax-exempt organization that represents the interests of Massachusetts residents who seek quality, affordable health care. Together with numerous MassHealth enrollees, HCFA filed suit against several Commonwealth and MassHealth executives in order to procure improved dental care and services. Two subclasses comprise the plaintiff enrollees-those under the age of 21 who are fully eligible for dental and early and periodic screening, diagnostic and treatment ("EPSDT") services, and those who are adults with special circumstances that qualify them for MassHealth coverage. State defendants in this suit include Mitt Romney, Governor of Massachusetts; Ronald A. Preston, Secretary of Health and Human Services; Eric Kriss, Secretary of Administration and Finance; Beth Waldman, Director of the Office of Medicaid; and Steve Kadish, Assistant Secretary for Health.

Plaintiffs originally alleged seven statutory violations by defendants. They have since voluntarily dismissed Counts I and IV, and this Court allowed defendants' motion to dismiss Count V. Two of the four remaining allegations, Counts II and III, respectively assert unsatisfactory provision of dental care by defendants for lack of "reasonable promptness" and comparatively inequitable "amount, duration, [and] scope" of care, in violation of 42 U.S.C. § § 1396a(a)(8) and 1396a(a)(10)(B). The other two, Counts VI and VII, concern the provision of EPSDT services and the requirement to inform eligible individuals under the age of 21 of the availability of such services, as required by 42 U.S.C. § § 1396a(a)(43) , 1396a(a)(10)(A) , 1396d(a)(4)(B) and 1396d(r). Intended specifically to address the health needs of children on Medicaid, EPSDT services include preventive, diagnostic and treatment services that all state Medicaid programs must provide to enrollees under the age of 21. In defending against summary judgment earlier in the proceedings, plaintiffs successfully argued that the statutory underpinnings of these allegations constitute enforceable rights, the deprivation of which may be remedied through a civil action under 42 U.S.C. § 1983.

***2** The parties presented evidence on these claims at a bench trial followed by closing arguments. The issues at trial centered on whether defendants, in fact, deprived MassHealth enrollees of their rights to obtain medical assistance with reasonable promptness (Count II), to receive such assistance with comparable equity in amount, duration and scope (Count III), to receive notices about EPSDT screening and preventive services (Count VI) and to access such services with periodic regularity (Count VII). Although plaintiffs sought certification as a class, this motion was withdrawn, as defendants stipulated that any "remedial relief ordered or agreed to pursuant to a judgment in favor of the named plaintiffs shall benefit all similarly eligible MassHealth members." Stipulation of Parties Agreed to in Open Court on Day One of Trial. Defendants stipulated further that the testimony by four plaintiff enrollees-Elizabeth Curtis, Sharleen Campbell,

Sharon Liberty and William Liberty-was relevant to all named plaintiffs whose own experiences were outlined in the Third Amended Complaint and to other similarly eligible but unnamed MassHealth beneficiaries. *See id.*

I. Facts

1. Plaintiff Enrollees: Hardships in Accessing Dental Care

Plaintiffs Elizabeth Curtis, Sharleen Campbell, Sharon Liberty and William Liberty described their family's and their own experiences in trying to obtain dental care as MassHealth enrollees. Each testifying plaintiff confronted hardships in identifying MassHealth participating dentists, obtaining appointments for dental care and receiving quality services. Ms. Curtis and Ms. Campbell's testimony related to the plaintiff subclass of enrollees under the age of 21, while Mr. and Mrs. Liberty spoke as members of the plaintiff subclass of adult enrollees with special circumstances.

Ms. Curtis needed to find Medicaid-covered dental care for herself, her disabled husband and three of her six children. Although the most convenient provider would have been the Ellen Jones Community Dental Center on Cape Cod, she could not schedule any appointments there in advance of the year-long wait on the list for new patients. Thus, Ms. Curtis consulted the participating provider list supplied by MassHealth. Because only one of the five listed providers in fact accepted MassHealth for children, she drove her children forty minutes to an hour to Centerville Dental for their appointments. In the meantime, she and her husband lacked dental care except for urgent services received at the Falmouth Hospital Emergency Room and covered by MassHealth. When Falmouth Hospital informed Ms. Curtis of a local dental clinic, Tatakut Dental Clinic ("Tatakut"), that would accept MassHealth coverage for her entire family, she moved the family to this new provider. At Tatakut, however, she observed what she believed to be poor quality care, and the clinic eventually closed after a fire. Centerville Dental was no longer accepting MassHealth patients, so the Curtis family paid out-of-pocket to receive dental services from a solo practitioner. By this time, one of Ms. Curtis's sons had over thirteen cavities. Tatakut then re-opened under new ownership but showed little improvement in quality. The children complained of mouth discomfort during and after cavity fillings, and some of the fillings fell out within a month.

***3** Ms. Campbell experienced similar difficulty in locating a participating dentist. Her daughter suffered an infected molar and could not attend school, eat or sleep due to the pain until they found a dentist who accepted MassHealth and extracted the tooth. Ms. Campbell then searched for two months to find an oral surgeon who accepted MassHealth and would perform extractions for her son whose permanent teeth were not developing properly. A friend informed her of a dental clinic, Cranberry Dental, that would treat the entire family, and they obtained services at this clinic for about a year until Ms. Campbell received ill-fitting dentures. They saw another dentist, but only briefly because his office appeared cluttered, dingy and unclean. The Campbell family subsequently located Unident Dental Care and have been receiving MassHealth-covered services there.

Sharon and William Liberty are wheelchair-bound enrollees who both received services from the Harvard Faculty Practice until it ceased accepting MassHealth. They then received dental care at the Tufts Dental Facility for the Handicapped ("Tufts Dental"). Both found the quality of care delivered by Tufts Dental to be unacceptable, because the practitioners often refused to lift them from their wheelchairs into a dental chair. Instead, the dentists tried to treat Mr. and Mrs. Liberty while they remained seated in their wheelchairs and received examinations with only a light and a mirror. Mr. Liberty has searched for other dentists who accepted MassHealth and could treat him in a more appropriate physical setting but, so far, has not found any.

Defendants raised several points during cross examination of these witnesses. First, although plaintiffs encountered challenges in obtaining appropriate dental care that would be covered by MassHealth, none of the plaintiffs took full advantage of procedures available to notify MassHealth of such challenges and seek assistance. Although MassHealth offered transportation services, Ms. Curtis never inquired as to the availability of such services. While MassHealth offered a complaint line, neither Ms. Campbell nor Mr. Liberty ever filed a complaint regarding the quality or type of services covered by MassHealth. Moreover, the plaintiffs acknowledged that in most cases, they eventually obtained needed services that, with limited exceptions, were paid for by MassHealth.

2. Reports and Data: Research Regarding Enrollee Access to MassHealth Dental Services and Their Health Outcomes

While plaintiffs may not have pursued all avenues for obtaining care, additional evidence corroborated their reports of impeded access. In response to national statistics showing that not enough children on Medicaid received preventive care services, the Massachusetts legislature commissioned the Report of the Special Legislative Commission on Oral Health (the "Commission"), entitled *Oral Health Crisis in Massachusetts* and published in February of 2000 (the "Legislative Commission Report"). The Access Committee that supervised the project was chaired by Robert Compton, D.M.D., an expert in dental insurance program operations and Chief Dental Officer of Delta Dental Plan of Massachusetts ("Delta Dental"), the largest private insurer of dental services in the Commonwealth. The Legislature ordered the Commission to report on the status of access to dental services by Commonwealth residents, particularly by high-risk and low-income populations. Statistics presented in the Legislative Commission Report that address MassHealth enrollees portrayed a dire situation for their dental care. Of the over 4,500 practicing dentists in the Commonwealth, 86% at the time of the Legislative Commission Report did not accept MassHealth patients, and this percentage was growing as more dentists left the program, "citing inadequate reimbursement rates." Legislative Commission Report, p. 5. As explained by the Legislative Commission Report, "[t]he primary barrier to improving utilization of dental services by MassHealth members is the critical and growing shortage of participating dentists." *Id.* at 6. In exploring the genesis of this shortage, the Commission found that

> ***4** [o]ne of the most significant factors is the longstanding inadequacy of the MassHealth fee schedule. Present reimbursement rates are so dramatically below current market levels that dentists who choose to treat MassHealth patients receive fees that cover only about 75% of their direct costs of providing the service.

Legislative Commission Report, p. 7.

Both parties cited another survey of dental health in the Commonwealth published by the Massachusetts Oral Health Collaborative (the "Collaborative"), a group of academics, public officials, state representatives and delegates from dental professional societies, public interest groups and health insurers. The Collaborative conducted in-person oral health screenings of several thousand third-grade students in the Commonwealth and developed key findings set forth in the 2004 *Massachusetts Oral Health Report* (the "Oral Health Report"). According to data from 1999 and 2002, "[w]hile 73% of children ha[d] a dental visit on average, only a third of children with MassHealth ha[d] a dental visit." *Oral Health Report,* p. 4. During the same time periods, "[w]hile 79% of Massachusetts' residents ha[d] a dental cleaning visit on average, less than a third of children with MassHealth ha[d] a dental cleaning visit." *Id.* At the same time, however, the Oral Health Report presented statistics that over 73% of MassHealth children had a checkup in the prior year, and over 71% of MassHealth children listed a dentist.

These apparently competing statistics illustrate a fundamental and pervasive problem with the figures presented by both parties throughout the trial. Too often, the parties failed to establish an apples-to-apples comparison between their statistics-for instance, presenting figures based on the total MassHealth population instead of focusing on the two subclasses at issue in this case-thereby preventing the opportunity for a meaningful understanding of the relationship between these numbers. This irreconcilability severely undermined the utility of both parties' statistics.

3. Participating Dental Providers: Insufficient Reimbursement

Several dentists and administrators in various positions of responsibility in the Massachusetts dental community and government agencies further substantiated plaintiffs' testimony and the Legislative Commission Report statistics regarding barriers to access and identified inadequate reimbursement as a source of these barriers. For example, according to Stephen Schusterman, D.M.D., the former Dentist-in-Chief at the Children's Hospital Dental Clinic ("CHDC") in Boston, MassHealth children constitute 65 to 70% percent of CHDC's average patient caseload and many CHDC patients travel distances from Worcester, Springfield and other parts of the state for treatment of cavities and similarly mundane dental problems. New patients often wait one to two months for an initial appointment. He explained that, MassHealth pays CHDC significantly less than CHDC's usual and customary fee, and CHDC operates at a loss. Mary Foley, Director for the Commonwealth's Office of Oral Health, discussed state funding for programs that support children's dental health, including the Essential School Health Services Program and school-based health centers ("SBHC"). She testified that the grant money

provided by this program to school systems for developing such health centers has decreased by one-third since 2002, and only one of the over 50 centers offers dental services.

***5** Another witness, Mark Doherty, D.M.D., served as Director of Oral Health Services at several community health centers ("CHCs"), including ones in Dorchester and Taunton, that cared for the MassHealth population as safety net providers. He testified that state funding cuts for MassHealth devastated these CHCs' budgets, as MassHealth enrollees and uninsured individuals composed about 90% of their dental patient base. As noted by the Legislative Commission Report, "most safety-net providers also serve many MassHealth members and are struggling under the same inadequate reimbursement rates as are dentists in private practice." Legislative Commission Report, p. 8. The wait for both new and follow-up patients at the Dorchester and Taunton CHCs is about 50 days, although emergency care is usually available on a same-day basis for patients who are willing and able to wait. CHCs rarely refer to private dentists, Dr. Doherty said, because very few accept either MassHealth or uninsured patients. Similar testimony was provided by Timothy Martinez, D.M.D, a dentist who served as Dental Director for several community health clinics, including the Ellen Jones Community Dental Center on Cape Cod and the Mid-Upper Cape Community Health Center. According to Dr. Martinez, MassHealth enrollees comprise over 90% of the patient bases at these centers, and the wait for a new appointment is six months to a year. Dr. Martinez also maintained two private practices but did not accept MassHealth patients, because the payment for services was insufficient. The burden of low reimbursement is further compounded by state law that prohibits dentists who agree to accept MassHealth coverage from limiting the number of MassHealth patients they see, by characterizing any such limitation as discriminatory. As explained by Dr. Martinez, however, the unintended consequence of this law is that a private dentist who chooses to participate in MassHealth risks financial instability if too many MassHealth patients join the practice, since MassHealth reimbursements would be a completely inadequate source of primary income. Thus, a dentist who is willing to accept a limited number of such patients accepts none.

4. Delta Dental: Perspectives from Private Insurance

Plaintiffs also presented testimony by Dr. Compton who led Delta Dental, the largest private insurer of dental services in the Commonwealth with approximately 1.8 million members and a participating provider list that included 97% of the approximately five thousand dentists currently in practice. Of these approximately 4,850 Delta Dental dentists, Dr. Compton said only about 675 accept MassHealth coverage, and there are approximately 500,000 children on MassHealth. He explained that the federal agency responsible for administering the Medicare and Medicaid programs, the Centers for Medicare and Medicaid Services, required every Medicaid program to summarize utilization by enrollees who receive EPSDT services, including dental services. The reports prepared and submitted by MassHealth indicated that only slightly more than 30% of MassHealth children received at least one dental visit each year for the years 2001, 2002, and 2003 and, as clarified by Dr. Compton, these numbers did not reflect the degree or full range of services that a child may actually need and did not receive. FN1 In contrast, 80 to 85% of children covered by Delta Dental across all plans accessed care, and as an expert, Dr. Compton opined that an appropriate benchmark for access to dental services by all children would be 70 to 75%, with initial appointments available within four to six weeks. With respect to palliative care, or care delivered in order to relieve pain, Dr. Compton said that he reviewed both MassHealth and Delta Dental utilization reports to find that children covered by MassHealth receive about ten times more palliative care than those covered by Delta Dental, likely because the lack of preventive care for MassHealth enrollees allowed dental disease to progress to severe stages.

> FN1. Defendant challenged the accuracy of these figures on the basis that not all enrollees remained eligible for MassHealth for an entire year. A child who enrolled for three months and had no dental visit during that time would not necessarily reflect a problem with access to dental care. Thus, for purposes of evaluating access to care, the percentages may be artificially low. However, for the years 2001, 2002 and 2003, the period of eligibility for all EPSDT enrollees was around 0.80, or between nine and ten months, and thus allows a reasonable annual approximation.

***6** He later testified that Delta Dental sought to add dentists to its network when the waiting time for a dental cleaning appointment exceeded four weeks and opined that the industry generally considered

four to six weeks to be an appropriate waiting time for such appointments. To add and retain dentists, Dr. Compton explained that Delta Dental marketed aggressively and employed licensed dentists to interact with participating providers, two approaches to developing a provider network that MassHealth has not adopted. Also different from MassHealth, Delta Dental simplified billing practices by implementing the standard billing form designed by the American Dental Association instead of a proprietary form as used by MassHealth.

5. MassHealth Regulators: Reimbursement and Policy

In addressing more specifically the derivation of reimbursement rates for dental services under MassHealth, defendants offered testimony by Phyllis Peters, Deputy Assistant Secretary for the Office of Acute Services in the Executive Office of Health and Human Services ("EOHHS"). Ms. Peters explained that the Division of Health Care Finance and Policy ("DHCFP") held direct responsibility for establishing and re-evaluating rates on a biannual basis, and MassHealth participated in such discussions including those regarding dental rates. The most recent rate review in 2002 resulted in increased dental rates for MassHealth children but elimination of dental services for MassHealth adults. Defense witness Lucinda Brandt, Pricing Policy Manager of EOHHS, explained that MassHealth dental rates are based on Delta Dental charge data because it was available and was specific to Massachusetts. According to Ms. Brandt, MassHealth usually set reimbursement at 80% of the Delta Dental median, as MassHealth believed that amount to be in an acceptable range for participating dentists. However, even MassHealth's efforts to use Delta Dental data as a benchmark were not entirely successful, as Ms. Brandt did not realize that Delta Dental updated its rates every six months, not annually, with the result that MassHealth rates failed to reflect current Delta Dental fees. For example, the most recent Delta Dental rates presented at trial were based on Delta Dental's fee data from April of 2003 fees. Ms. Brandt testified that obtaining updated fee data now might further delay the MassHealth reimbursement review process.

As mentioned by plaintiffs' witness Zoila Feldman, Executive Director of the Great Brook Valley Health Center in Worcester, an enhanced reimbursement fee also became available to MassHealth CHCs that implemented a plan to improve access to dental care, for example by subcontracting with private dentists, increasing hours of operation, or adding specialty services. Both Ms. Feldman and plaintiffs' witness Dr. Doherty discussed the availability and benefit of infrastructure and loan forgiveness grants to community health centers for expanding services and recruiting more dentists with broader skills. Defense witness David Noel, D.M.D., Chief Dental Program Consultant for the State of California, further testified to the beneficial impact of infrastructure grants and loan forgiveness programs. Ms. Peters confirmed that in spite of these efforts MassHealth still received more complaints by enrollees about dental care than about any other service, on the order of thousands of complaints per month, and she recalled no significant decrease in these complaints over time. *See also*, Legislative Commission Report, p. 6. Dr. Noel emphasized the relevance of employing licensed dentists to interact with, retain and recruit MassHealth providers. Neither Maximus, Inc. nor Unisys Corporation, the third-party entities that administer the beneficiary and provider enrollment and billing portions of MassHealth, employed any licensed dentists on staff to advise or directly handle provider or beneficiary concerns.

***7** Some of the evidence presented by defendant attributed the differences in dental health as observed between MassHealth enrollees and individuals with private insurance to pre-existing cultural and educational differences. For example, Dr. Noel opined that lack of educational awareness may lead to a poor diet that, in turn, leads to higher incidence of tooth decay. Both he and Dr. Compton also noted that MassHealth enrollees often compose a disproportionately large percentage of patient "no-shows" where a scheduled patient fails to appear for his appointment. Defendant's underlying point posed a "chicken and egg" scenario by challenging whether insufficient dental care caused MassHealth children's bad health outcomes or, instead, whether the outcomes resulted from poor education and absence of cultural importance placed on proper dental care. Additionally, Dr. Noel explained that dentists themselves frequently harbored a bias in favor of patients with private insurance, as these patients typically represent increased revenue for the practice. He testified that while some providers easily integrated MassHealth patients into their practices, generally it took years to establish a change in perspective across the majority of dentists.

Defendants also highlighted the fact that by the time of trial, all eligible plaintiffs had successfully obtained access to dental services covered by MassHealth. Although plaintiffs experienced appointment delays, individual providers controlled

their own scheduling policies and received no instruction from MassHealth with respect to waiting lists or the allocation of services to MassHealth enrollees or as between MassHealth and non-MassHealth patients. Defendants noted that all patients in general experienced waits for appointments regardless of insurance status, and participating providers always delivered priority care to all patients with emergencies. Moreover, while plaintiffs focused on the percentage of enrolled children who obtained dental care as hovering around 30% for several years, defendants cited an over 12% net increase in the number of such children who received dental care from FY2001 to FY2004.

II. Standard of Review

One of defendants' ongoing positions with respect to this litigation regards the role of the Centers for Medicare and Medicaid Services as the proper evaluator of defendants' conduct. Defendants assert that any shortcoming on their part should be assessed and remedied not by plaintiffs or the judicial system but by the Centers for Medicare and Medicaid Services, as the federal agency charged with administration and oversight of the Medicaid program. To this end, defendants argue that any review of its conduct in connection with the instant case should address whether "there is a failure to comply substantially with any such provision [of the statutory requirements for state Medicaid plans set forth in 42 U.S.C. § 1396a]." 42 U.S.C. § 1396c. In other words, defendants believe their conduct should be held to the standard of substantial compliance, not full or perfect compliance as urged by plaintiffs. Defendants maintain that plaintiffs have failed to show any such deficiencies and, thus, have failed to establish any sufficient factual bases for the claims at issue.

***8** Plaintiffs contend that the substantial compliance standard measures an entity's performance to determine whether it deserves continued federal funding. A finding of insubstantial compliance means "that further payments will not be made to the State ... until the Secretary [of Health and Human Services] is satisfied that there will no longer be any such failure to comply." 42 U.S.C. § 1396c. The lower standard of substantial compliance, as opposed to full or perfect compliance, serves to balance the dire consequences of failure to comply in the context of funding. However, nothing merits or implies the use of a low standard with respect to a state Medicaid program's fulfillment of its statutory and regulatory obligations to serve beneficiaries. Nothing mitigates the traditional expectation that a regulated entity fully comply with its governing statutes and regulations, even if "absolutely perfect compliance is unattainable." *Withrow v. Concannon*, 942 F.2d 1385, 1388 (9th Cir.1991)(finding that while "[i]mpossibility of perfect compliance may be a defense to contempt ... it does not preclude ... requiring compliance with the regulations when a pattern of non-compliance has been shown to have existed."). The *Withrow* plaintiffs sought enforcement of time constraints for state officials' "failure to issue timely decisions" in hearings under the Aid to Families With Dependent Children, Food Stamp and Medicaid programs. *See* *Withrow*, 942 F.2d at 1386. The *Withrow* defendants advocated for the substantial compliance standard, but for the above-mentioned reasons, the Ninth Circuit required compliance " 'as strict as is humanly possible." ' *Withrow*, 942 F.2d at 1388.

While absolutely perfect compliance by defendants in the instant case may not be feasible, this fact does not excuse them from striving to comply as much as possible. The Centers for Medicare and **Medicaid** Services applies the **substantial compliance** standard to balance the "virtual death sentence" of withheld funding, not because perfect compliance is impossible. *Withrow*, 942 F.2d at 1387. Defendants have not offered a compelling analogy to justify application of the substantial compliance standard in the instant case where federal funding is not at risk, much less a thoughtful rationale for why the conventional standard of full compliance is not an appropriate expectation. Accordingly, the standard to be applied in this case will be full compliance.

III. Count II: "Reasonable Promptness"

Plaintiffs' complaint seeks to establish a relationship between MassHealth reimbursement for dental care and access to such care by MassHealth enrollees. In Count II, plaintiffs accuse defendants of failing to provide medical assistance with "reasonable promptness" as required by statute:

> [a] 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
>
> ***9** with reasonable promptness to all eligible individuals; ..."

42 U.S.C. § 1396a(a)(8). Related federal regulation deems "delay caused by the agency's administrative procedures" to be unacceptable. 42 C.F.R. § 435.930. Plaintiffs argue that MassHealth impeded enrollees'

access to and receipt of services by providing such low reimbursement for dental care that dentists in the Commonwealth could not afford to participate as MassHealth providers. As a result, only a few dentists offered appointments to enrollees, and the waiting period for dental care services grew. Before applying this law to the facts at issue, defendants challenge this claim by questioning the appropriate scope of the statutory obligation, while plaintiffs tender a contrary interpretation of the statutory language.

1. Scope of Statutory Obligation

According to defendants, the term "medical assistance" refers to payment for dental services and not the provision of treatment, as the statute defines this term to mean "payment of part or all of the cost of ... care and services" covered by Medicaid. 42 U.S.C. 1396d(a). Defendants urge that "reasonable promptness" means "a prompt determination of eligibility and a prompt provision of funds to eligible individuals to enable them to obtain the medical services that they need." *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir.2003)(explaining that "the statutory reference to 'assistance' appears to have reference to *financial* assistance rather than to actual medical *services") (* emphasis in original). Otherwise, "a requirement of prompt *treatment* would amount to a direct regulation of medical services," and Medicaid "is not a scheme for state-provided medical assistance, as through state-owned hospitals." *Bruggeman*, 324 F.3d at 910 (emphasis in original). Plaintiffs, on the other hand, press the opposing view that a state Medicaid program should be held "ultimately responsible for ensuring the actual delivery of dental services to eligible persons." Pls'. Reply to Defs'. Proposed Findings of Fact and Conclusions of Law, p. 17. Characterizing this principle as the "gravamen of [their] Complaint," plaintiffs seek an expansive interpretation of "medical assistance" beyond payment to include the eventual furnishing of services. *Id.*

Both parties' positions present problems. Defendants' myopic reading of the statutory language misses the forest for the trees. Timely payment for services does little to benefit enrollees who cannot find a provider willing to accept such payment. Because payment for services necessarily presumes delivery of services, state Medicaid programs may indirectly impede medical assistance through practices and protocols that delay the delivery of services. In *Bryson v. Shumway*, for example, the First Circuit recognized that a state Medicaid program may have interfered with the reasonable promptness of medical assistance by executing certain of its responsibilities in a sluggish manner. *See* 308 F.3d 79, 89 (1st Cir.2002). The "medical assistance" at issue involved the state's administration of a wait list for certain services and whether New Hampshire Medicaid was "diligently filling the empty slots with reasonable promptness." *Bryson*, 308 F.3d at 89. Although not presented with enough facts to rule on the merits of the issue, the First Circuit opined that the untimely allocation of empty treatment slots to enrollees on a wait list for certain services may subject New Hampshire Medicaid to liability for "not being reasonably prompt in its provision of medical assistance." *Bryson*, 308 F.3d at 89. In other words, the First Circuit recognized that actions and protocols of New Hampshire Medicaid that undermined the timeliness of medical assistance must be subject to review under 42 U.S.C. § 1396a(a)(8), if the reasonable promptness provision was to be enforceable in a meaningful way.

***10** As a solution, plaintiffs propose that defendants be held "ultimately responsible" for delivery of services, but they offer no clarification of exactly what conduct would be covered by this umbrella of responsibility. For example, to the extent that state Medicaid programs govern participating providers through contractual and regulatory controls, plaintiffs' proposal may be read to hold defendants accountable for barriers to prompt medical assistance that individual providers independently erect. However, the theory of liability acknowledged by the First Circuit in *Bryson* concerned state Medicaid programs' actions and protocols and did not expand the timely payment obligation to cover actions by participating providers such as dentists. Moreover, plaintiffs have not offered a persuasive substantive legal basis for anchoring this potentially far-reaching obligation to the reasonable promptness provision.

Between the defendants and plaintiffs polar views lies an interpretation of the "reasonable promptness" provision that both upholds the underlying purpose of requiring punctual medical assistance and tailors the reach of this statute to those undoubtedly intended to be governed by it. A state may not circumvent a statutory duty for prompt payment by under-funding a mandatory Medicaid service to the degree that no health care practitioners can afford to provide the service. Setting reimbursement levels so low that private dentists cannot afford to treat Medicaid enrollees effectively frustrates the reasonable promptness provision by foreclosing the opportunity for enrollees to receive medical assistance at all, much less in a timely manner. To that end, the

promptness standard set forth in 42 U.S.C. § 1396a(a)(8) may be reasonably understood to constrain actions and protocols by a state and its Medicaid administrative and rate-setting agencies that otherwise subvert the statute's intent.

2. Analysis

A. Plaintiff Subclass of Enrollees Under 21

Plaintiffs' evidence shows that enrollees encountered extraordinary difficulty in obtaining timely dental services. As plaintiff enrollees testified, the challenge began with identifying a dentist who accepted Medicaid payment. Because the provider list from MassHealth did not accurately represent current participating providers, enrollees often relied instead on word-of-mouth referrals or direct cold calls to private offices. In times when no available providers could be located, plaintiff enrollees said they either paid out-of-pocket for services that should have been covered by MassHealth or simply went without treatment. The fact that MassHealth received thousands of calls each month from enrollees regarding problems of access to providers further corroborated this obstacle.

Upon finding a participating provider, plaintiff enrollees next confronted the hurdle of scheduling an appointment. As confirmed by the testimony of several CHC administrators, the wait for new patient appointments at CHCs were as short as one and a half months and, at some clinics, as long as one year, although children with emergencies usually qualified for same-day appointments. Conditions short of an emergency, therefore, went unattended for at least an additional six or eight weeks, often several months to a year, after scheduling an appointment.

***11** It is clear that the difficulties encountered by enrollees who sought dental appointments resulted from a shortage of dentists participating in MassHealth. Defendants query whether the MassHealth population could be adequately served by the current number of participating dentists if enrollees took full advantage of MassHealth services such as free transportation to visits, but they never offered concrete data to support this proposal. Defendants do not emphatically challenge plaintiffs' assertion that insufficient reimbursement accounted for the shortage in participating providers, instead admitting at trial that MassHealth recognized that valid issues existed but asserting that defendants were taking internal measures to remedy these problems. CHC administrators and practicing dentists as well as data presented in the Legislative Commission Report all confirmed the inadequacy of MassHealth payments as the primary reason that private dentists refused to open their practices to enrollees. Although plaintiffs did not vigorously dispute defendants' competing culturally-based explanations for low utilization and high rates of disease, defendants do not explain why a program that intends to serve such populations should not be expected to develop measures designed to mitigate the negative impact of such potential influences. For these reasons, plaintiffs' evidence persuasively demonstrates that MassHealth established reimbursement levels so low that private dentists could not afford to treat enrollees who, thus, either received dental care only after much delay or not at all. Accordingly, as to the plaintiff subclass of enrollees under the age of 21, defendants have failed to comply fully with their statutory obligation set forth in Count II.

B. Plaintiff Subclass of Enrollees With Special Circumstances

Direct testimony by Mr. and Mrs. Liberty constituted the only evidence offered specifically with respect to difficulties encountered by adult enrollees with special circumstances. Their testimony regarded the quality, not the promptness, of dental services. Nothing suggested that special circumstances enrollees encountered problems in obtaining appointments with participating providers at Tufts Dental, or that Tufts Dental practitioners believed the reimbursement for treating these enrollees to be insufficient. Rather, these enrollees objected to the manner in which they received treatment. Plaintiffs therefore have not shown that defendants violated the promptness provision at 42 U.S.C. § 1396a(a)(8) with respect to this subclass of plaintiff enrollees.

IV. Count III: Comparability Provision

In Count III, plaintiffs fault defendants for not providing equivalent medical assistance to all Medicaid enrollees, since:

> [a] State plan for medical assistance must ... provide ... that the medical assistance made available to any individual described in subparagraph (A)-(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A); ...

***12** 42 U.S.C. § 1396a(a)(10)(B). Plaintiffs argue that this provision prohibits geographic variations in access to covered services, including dental care, and that defendants violated it through, in part, inadequate funding. *See Sobky v. Smoley*, 855 F.Supp. 1123, 1140-42 (E.D.Cal.1994).

1. Plaintiff Subclass of Enrollees Under 21

In support of this claim, plaintiffs offered evidence at trial that many areas of the Commonwealth have no CHCs or other safety-net dental clinic, thereby requiring MassHealth patients to travel distances, often 50 miles or more, to obtain dental care. For example, Dr. Doherty testified that dentists at the Dorchester CHC often see Worcester patients (approximately a 50 mile trip) while Cape Cod patients obtain care at the Taunton CHC (approximately a 70 mile trip). The number of children treated at Children's Hospital Boston who live beyond greater Boston has increased in recent years, according to plaintiffs' witness Dr. Shusterman. Additionally, when Cape Code safety net CHCs cannot accommodate new patients, the dentists refer them to Boston-area providers and dental schools, 60 to 120 miles away.

Defendants counter by clarifying the intent of the statute in question as ensuring that access by and services to "categorically needy" beneficiaries was available "first and in amounts not less than" access by and services to other categories of Medicaid eligibles such as the "medically needy," for whom coverage is optional. *See, e.g., Mass. Ass'n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir.1983). This provision, claim defendants, does not require "uniform proximity" to services or "identical convenience of service everywhere in the state." *See, e.g., Bruggeman*, 324 F.3d at 911. Defendants also note that this provision is not intended to ensure comparable utilization of dental services between the Medicaid population and the non-Medicaid population.

While plaintiffs offered some information about travel times for enrollees and the location of CHCs and other safety net providers, their assertion that dental services are inequitably distributed is overshadowed by their primary argument that access is generally poor for all enrollees. While plaintiffs have shown that some enrollees live in parts of the state where participating dentists are woefully lacking (e.g., Cape Cod), they have shown that plaintiffs living in areas of higher concentrations of dentists may also suffer long waits and impaired access (e.g., Boston). In other words, plaintiffs never established that MassHealth provides sufficient treatment to some enrollees and insufficient treatment to others and, thus, have not shown any actual discrepancy in access among enrollees.

Furthermore, as explained by defendants, the comparability provision applies specifically to protect categorically needy enrollees from inadequate service as compared to other such enrollees or to medically needy enrollees. *See* 42 U.S.C. § 1396a(a)(10)(B), *and King by King v. Sullivan*, 776 F.Supp. 645, 653-654 (D.R.I.1991). Plaintiffs never addressed the relationship, if any, between the alleged geographic differences in access and whether MassHealth enrollees were categorically or medically needy. Additionally, "nothing in the statute prohibits a state from offering different services to persons in different categories of medical need or with different degrees of medical necessity," and plaintiffs never addressed, much less proved, whether the alleged differences may be explained by varying degrees of medical necessity in the MassHealth population. *King by King*, 776 F.Supp. at 654. Accordingly, plaintiffs have not shown that defendants violated the comparability provision set forth at 42 U.S.C. § 1396a(a)(10)(B).

2. Plaintiff Subclass of Enrollees With Special Circumstances

***13** Again, direct testimony by Mr. and Mrs. Liberty constituted the only evidence offered specifically with respect to difficulties encountered by adult enrollees with special circumstances. Their testimony regarded the quality, not the comparable amount, duration and scope, of dental services. Nothing suggested that access to covered services by special circumstances enrollees varied according to geography or that such variance created problems. Plaintiffs did not address the distinction between categorically and medically needy individuals in the context of special circumstances enrollees, either. Plaintiffs therefore have not shown that defendants violated the comparability provision at 42 U.S.C. § 1396a(a)(10)(B) with respect to this subclass.

V. Count VI: Inform about and Arrange for EPSDT Dental Services

Federal Medicaid laws require state programs to provide information about and to provide or arrange for the delivery of certain services to enrollees under the age of 21. Specifically:

> [a] State plan for medical assistance must-... provide for-(A) informing all persons in the State who are under the age of 21 ... of the availability of EPSDT services ... and the need for age-appropriate immunizations against vaccine-preventable diseases, (B) providing or arranging for the provision of such screening services in all cases where they are requested, (C) arranging for (directly or through referral to appropriate [providers]) corrective treatment [as needed and indicated per the screening services], and (D) reporting to the Secretary [certain utilization data].

42 U.S.C. § 1396a(a)(43). Plaintiffs contend that defendants have failed to effectively inform plaintiffs of the EPSDT program; to ensure adequate provision, or arrangement for the provision, of EPSDT dental screens and services; and to recruit and retain enough dental providers to meet plaintiffs' EPSDT needs.

To this end, plaintiff enrollees testified to the inadequacy and inaccuracy of written material provided by defendants. For example, the MassHealth member handbook provided to enrollees mentions dental benefits only generally as a covered service for certain enrollees and does not clarify the availability of EPSDT services. Plaintiffs did not dispute that MassHealth mailed notices to enrollees every six months to recommend services such as dental checkups, cleanings and other covered treatments. On the other hand, written literature and telephone customer service information provided by MassHealth about available dental providers was often incorrect and outdated. Notices that accurately inform an enrollee about the need for screening but then inaccurately explain the means to obtain such screening do not satisfy defendants' obligation to notify. Defendants contend that their duties to arrange or provide for EPSDT dental services are triggered by plaintiffs' request for such services, so any apparent shirking of these duties actually reflected a lack of enrollee requests for such services. However, defendants' explanation does not eliminate the real possibility that any shortfall in requests for services derived from misinformation in the notices about effective means for scheduling appointments and not from the absence of need for such services.

***14** Reports filed by the Commonwealth with the Centers for Medicare and Medicaid Services indicated that just over 30% of MassHealth children received a dental visit. Defendants argue that the percentage of visits provided may accurately reflect the demand for such services, that essentially only 30% percent of MassHealth children actually sought dental services. They suggest that socioeconomic and cultural norms, and not a lack of providers, compromised access, as such norms may have downplayed the importance of dental health and effectively undermined MassHealth's information campaign. As noted earlier, though, it remains unclear why a program designed to serve such populations should not be expected to develop measures to mitigate the negative impact of such potential influences. When 80% of the children covered by Delta Dental are obtaining dental visits, demand for services alone seems unlikely to account for this gulf between the haves and the have nots.

The fact that defendants' notices contained incorrect and outdated guidance on obtaining services, that plaintiff enrollees' testified to and confirmed the inability to find participating providers of covered services based on information provided in the notices, that thousands of calls daily flooded MassHealth's consumer hotline seeking supplementary advice on locating providers, and that the actual percentages of children enrolled in MassHealth who received dental services as reported to the Centers for Medicare and Medicaid Services is shockingly low all support the finding that defendants have failed to comply fully with the obligation to provide such notices and subsequently arrange for and provide EPSDT services as required under 42 U.S.C. § 1396a(a)(43). Although plaintiffs suggest that this violation by defendants resulted in part from inadequate reimbursement to providers, plaintiffs have not offered compelling evidence on this point, and the finding does not rely upon or endorse any such theory.

VI. Count VII: Provide EPSDT dental services at reasonable intervals

Additional statutory obligations govern defendants' provision of EPSDT services. Plaintiffs complain that MassHealth does not meet the requirement that:

> [a] State plan for medical assistance must-provide-for making medical assistance available, including at least the care and services listed in ... section 1396d(a) of this title ...," which include "early and periodic screening, diagnostic, and treatment services ... for individuals who are eligible under the plan and are under the age of 21 ...," such services defined to include "... Dental services-(A) which are provided-(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary to determine the existence of a suspected illness or condition; and (B) which shall at a minimum include relief of pain

and infections, restoration of teeth, and maintenance of dental health.

***15** § § 1396a(a)(10)(A) , 1396d(a)(4)(B) and 1396d(r). Plaintiffs argue that violation of these provisions ensued from insufficient reimbursement to participating dental providers.

MassHealth's EPSDT periodicity schedule requires the screening provider to "encourage members to seek regular dental care from a dental provider, beginning at age three years, or earlier, if indicated, including examinations once every six months, preventive services, and treatment, as necessary." App. W to all Provider Manuals, *EPSDT Services: Medical Protocol and Periodicity Schedule,* Transmittal Letter ALL-113, Page W-3 (Apr. 1, 2003). Plaintiffs only minimally challenge the substance of this protocol through their expert, Dr. Compton, who testified that the American Dental Association and the American Association of Pedatric Dentists recommend that a child's initial dental screening occur at age 1, not at age 3. Based on this spare argument, defendants correctly contend that plaintiffs failed to demonstrate that the protocol did not comply generally with EPSDT requirements.

Plaintiffs' dominant complaint is that defendants failed to implement this protocol. To the extent that the protocol governs defendants' role in ensuring appropriateness in the actual intervals of care provided, once an enrollee becomes a patient, neither party presented extensive evidence on the actual or average length of time between appointments experienced by enrollees who became patients of a practice. To the extent, however, that defendants' conduct impeded enrollees' ability to obtain an initial appointment and thus even fall within the scope of the protocol, the factual underpinnings of plaintiffs' argument strongly resemble those presented in Count II regarding the "reasonable promptness" provision. A child who cannot find a participating provider certainly cannot obtain dental care at the prescribed intervals.

Accordingly, plaintiffs have shown that defendants failed to implement their EPSDT periodicity schedule, because enrollees were unable to locate participating providers and thus avail themselves of the periodic treatment required by the schedule. This omission constitutes another way in which defendants breached the "reasonable promptness" provision and thereby also implicates inadequate reimbursement to providers as part of the offending conduct.

VII. Conclusion

Plaintiffs have demonstrated that defendants violated sections of the Medicaid Act that require prompt provision of services, adequate notice and treatment at reasonable intervals and that these violations resulted, in part, from insufficient reimbursement. Defendants agreed at the outset of the trial to be bound as to the entire "class" of MassHealth enrollees under the age of 21 who qualify for dental services. The Court has not found any violations by defendants with respect to adult enrollees with special circumstances. The parties shall attempt to develop a joint remedial program and judgment and report to the Court thereon by August 31, 2005. The court will schedule a hearing thereafter to determine the appropriate course of action.

D.Mass.,2005.
Health Care For All, Inc. v. Romney
Slip Copy, 2005 WL 1660677, Med & Med GD (CCH) P 301,663

Briefs and Other Related Documents (Back to top)

• 1:00cv10833 (Docket) (Apr. 28, 2000)

END OF DOCUMENT

Not Reported in F.Supp.2d, 2004 WL 882203 (E.D.Ky.), Med & Med GD (CCH) P 301,481

United States District Court,E.D. Kentucky.
Vada Jewell KERR, et al., Plaintiffs,
v.
James W. HOLSINGER, et al., Defendants.
No. Civ.A.03-68-H.

March 25, 2004.

Anne Marie Regan , Office of Kentucky Legal Services Programs , Inc., Louisville, KY, Edward C. King , Eugene Coffey , National Senior Citizens Law Center , Washington, DC, Herbert Semmel , Eric Carlson , National Senior Citizens Law Center, Los Angeles, CA, for Plaintiffs.
Ann Truitt Hunsaker, Frankfort, KY, for Defendants.

MEMORANDUM OPINION AND ORDER

HOOD, J.
***1** This action is before the Court on several motions. Defendants have filed a motion to dismiss or for summary judgment [Record No. 7]. Plaintiffs have responded [Record No.25], requesting oral argument on the motion, and Defendants have replied [Record No. 31]. FN1 Plaintiffs have filed a motion for preliminary injunction [Record No. 36]. Defendants have responded [Record No. 42], and Plaintiffs have replied [Record No. 44]. Defendants have also filed a notice of change in administrative regulation [Record No. 39]. Plaintiffs have filed a response [Record No. 41], and Defendants have replied [Record No. 45]. These matters are now ripe for decision.

> FN1. Plaintiffs have requested oral arguments in their response to Defendants' motion to dismiss or for summary judgment [Record No. 25]. Having reviewed the pleadings, the Court does not believe that oral arguments would be helpful or are necessary in resolving the matters contained therein and shall deny Plaintiffs' motion.

I. FACTUAL BACKGROUND

Plaintiffs are residents of Kentucky and Medicaid recipients who have had their necessary level of care determined by the Department for Medicaid Services (hereinafter, "Department") through a medical review completed under contract by a Peer Review Organization (hereinafter, "PRO"). Defendants are the administrators of the Cabinet for Health Services ("Cabinet") and the Department. FN2 The Department is a single state agency designated pursuant to 42 U.S.C. § 1396a(a)(5) and KRS Chapters 194A and 205 for the administration of the Kentucky Medical Assistance Program (hereinafter, "Medicaid") in the Commonwealth of Kentucky. FN3 The Department is located within the Cabinet pursuant to KRS 194A.030(3).

> FN2. Defendants administer the Medicaid level of care provisions through a state law contract with a PRO, a contract subject to a competitive bid process. The contract is administered in accordance with the provisions of KRS § 205.6315. Reviews are conducted periodically to make certain that a Medicaid recipient is receiving only those services that are medically necessary as the term is defined by 907 KAR 3:130.
> When PRO determines that the level of care does not meet the criteria for services, it sends a notice to the Medicaid recipient. Recipients, like Plaintiffs in this matter, are then afforded an opportunity to a hearing. Plaintiffs in this matter have requested hearings. The cases are then forwarded to the Administrative Hearings Branch of the Cabinet. Hearing Officers, attorneys licensed in Kentucky, are appointed pursuant to KRS Chapter 13B and are specifically trained to deal with the complex nature of the programs administered by the Cabinet, although the Court understands that they do not have the authority to evaluate the lawfulness of the regulations.

> FN3. All provisions of the Medicaid program are to be operated pursuant to 42 U.S.C. § 1396(a), an approved Medicaid State Plan and State Plan Amendment, or a waiver to the Medicaid State Plan. Approval is made by the United States Department of Health and Human Services (hereinafter, "HHS") and the Center for Medicare and Medicaid Services (hereinafter, "CMS"). At all times relevant to this matter, the Department's State Plan and all State Plan Amendments have been approved by CMS although the state has withdrawn its request for approval of the 2003 regulations as an amendment of the State Plan upon advice from the CMS that no approval was required.

The parties have described how a record number of Kentuckians have become participants in the

Medicaid program just as huge budget shortfalls have hit the state and while medical and pharmacy costs have increased. Plaintiffs allege that the Commonwealth responded to the budget crunch by adopting an "emergency regulation" that redefined eligibility for Medicaid long-term care and rendered ineligible persons previously certified as eligible for nursing facility (hereinafter, "NF") and other long-term care. The emergency regulations described in the complaint, 907 KAR 1:022E , were replaced by virtually identical permanent regulations, 907 KAR 1:022 on October 30, 2003 (hereinafter, collectively, "2003 regulations"). FN4 As a result, there have been determinations that some Medicaid recipients residing in nursing homes and others receiving Home and Community Based Services (hereinafter, "HCBS"), all previously acknowledged by the state as needing these services, were no longer eligible for long-term care under Kentucky's Medicaid program.

> FN4. A new emergency regulation, also 907 KAR 1:022E, was promulgated on January 30, 2003 (hereinafter, "2004 regulation"), changing, yet again, the standards by which the necessity of NF and HCBS service benefits will be determined.

On April 4, 2003, Plaintiffs were receiving services under the Kentucky Medicaid program based on determinations that they were entitled to receive long-term care. Some resided in nursing homes, and others participated in the HCBS waiver program. With the adoption of the 2003 regulations and the alteration of the level-of-care criteria for mandatory federal Medicaid nursing facility services, it was projected that the Commonwealth would save some $45 million. When Plaintiffs' needs were reconsidered under the 2003 regulations and information obtained by the PRO from Plaintiffs' physicians, care givers, and health care practitioners, none of the plaintiffs remained eligible for NF services even though they had previously been recognized as having medical need of those services. The PRO recommended and the Department accepted the PRO's recommendation that Plaintiffs did not meet the standards for the level of care in a NF or HCBS as set out in Kentucky administrative regulations. FN5 There has been no finding or suggestion that Plaintiffs' conditions have changed or that they are less in need of long-term care services than they were before April 4, 2003.

> FN5. If a Medicaid recipient has need of a level of care that meets the NF standards, they are entitled to care in a licensed and regulated NF or can participate in Kentucky's approved HCBS waiver program. Medicaid recipients participating in the HCBS waiver program receive a variety of services (adult day care, homemaker services, home health care, etc.) in their home or the home of another individual.

***2** Plaintiffs allege that they are being deprived of mandatory services by the implementation of the new regulations. They complain that the administrative redefinition of the need for NF services and HCBS is not based upon new medical knowledge "providing a more enlightened understanding of who actually needs nursing facility services, or indeed upon any medical or health-related considerations at all ..." and that Defendants have not even suggested that the amendments are in the best interest of Kentucky Medicaid recipients or that the new regulations are consistent with the objectives of the Medicaid Act or in accord with federal Medicaid law. [Response at 1.]

Plaintiffs seek relief from the Cabinet's determination of the level of care under the 2003 regulations by alleging that the level of care standard is contrary to the provisions of federal law and that subject to preemption under the Supremacy Clause of the United States Constitution. Plaintiffs also allege that the level of care standard in the 2003 regulations is unreasonable. Further, Plaintiffs claim that the notices sent to them are insufficient under the Medicaid Act and the Due Process Clause of the Fourteenth Amendment. Finally, Plaintiffs allege a violation of state law because, allegedly, Defendants are not assuring that PRO complies with state law, that hearings are conducted properly, or that services are continued pending completion of the appeal process.

II. APPLICABLE STANDARDS OF REVIEW

Defendant has moved this Court to dismiss Plaintiff's claims pursuant to Fed.R.Civ.P. 12(b)(1) , arguing that the Court does not have subject matter jurisdiction in this case, and pursuant to Fed.R.Civ.P. 12(b)(6), arguing that Plaintiff has failed to state a claim upon which relief may be granted. When considering a 12(b)(1) motion, the Court may consider matters outside of the record, without converting the motion to a motion for summary judgment, as the Court must determine whether or not the Court is even allowed to reach the merits of the case. *Rogers v. Stratton Ind., Inc.*, 798 F.2d 913, 915-917 (6th Cir.1986). Plaintiff bears the burden of demonstrating that subject matter jurisdiction exists. *Hedgepath v. Kentucky*, 215 F.3d 608, 611 (6th Cir.2000). With regard to the 12(b)(6) motion, this

Court must accept all factual allegations in Plaintiff's complaint as true. *Broyde v. Gotham Tower, Inc.*, 13 F.3d 994, 996 (6th Cir.1994). The complaint may be dismissed only if it is clear that no relief could be granted on any set of facts that could be proven consistent with the allegations, and this Court's review amounts to a determination of whether it is possible for the plaintiff to prove any set of facts in support of its claims that would entitle it to relief. *Sistrunk v. City of Strongsville*, 99 F.3d 194, 197 (6th Cir.1996) ; *Miller v. Currie*, 50 F.3d 373, 377 (6th Cir.1995). This Court must ignore all outside evidence submitted by the parties in ruling on the motion to dismiss pursuant to 12(b)(6).

***3** Defendants have asked, in the alternative, for summary judgment in this matter. Under Fed.R.Civ.P. 56(c), summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no issue as to any material fact, and that the moving party is entitled to judgment as a matter of law." The moving party may discharge its burden by showing "that there is an absence of evidence to support the nonmoving party's case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 325, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). The nonmoving party, which in this case is the plaintiff, "cannot rest on [her] pleadings," and must show the Court that "there is a genuine issue for trial." *Hall v. Tollett* 128 F.3d 418, 422 (6th Cir.1997). In considering a motion for summary judgment the court must construe the facts in the light most favorable to the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986).

Finally, Plaintiffs have made a motion for preliminary injunction in this matter. In order to succeed, they must show that (1) there is a substantially likelihood that they will succeed on the merits of this litigation, (2) that there is a serious risk of irreparable harm if the injunction is not issued, (3) that the balance of hardships favors Plaintiffs, and (4) that an injunction would be in accordance with the public interest. *United States v. Detroit Int'l Bridge Co.*, 7 F.3d 497, 503 (6th Cir.1993). Of these factors, no one is determinative to the appropriateness of the relief sought, rather there is a balancing of the factors. *Roth v. Bank of the Commonwealth*, 583 F.2d 527, 536 (6th Cir.1978).

III. DISCUSSION

A. STANDING AND PRIVATE RIGHT OF ACTION

Parties invoking a court's jurisdiction must establish their standing in a case or controversy under Article III of the United States Constitution, a matter turning on the parties' personal stake in the dispute. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992) ; *Duke Power Co. v. Carolina Environmental Study Group, Inc.*, 438 U.S. 59, 72, 98 S.Ct. 2620, 57 L.Ed.2d 595 (1978). In order to meet the "irreducible constitutional minimum" of Article III standing, Plaintiffs must demonstrate three elements: (1) an injury in fact, (2) a causal connection between the injury and the conduct of which they complain, and (3) redressability of the injury by the relief sought. In the instant matter, Defendants argue that Plaintiffs have not been injured because there is no individual right that may be enforced under 42 U.S.C. § 1983 with regard to the Medicaid Act because that legislation was enacted pursuant to Congress' spending power and that Plaintiffs, thus, do not have standing to bring those claims.

42 U.S.C. § 1983 prohibits the deprivation of a person's "rights, privileges, or immunities" secured by the laws or the constitution of the United States under color of state law. 42 U.S.C. § 1983. It is true that, "[i]n legislation enacted pursuant to the spending power [such as the Medicaid Act], the typical remedy for State noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 28, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981). Nonetheless, in some circumstances, federal Medicaid provisions can create a right privately enforceable against state officers through § 1983. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 511-12, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990) (holding that the Boren Amendment to the Medicaid Act created a right enforceable under § 1983); *Westside Mothers v. Haveman*, 289 F.3d 852, 862-863 (6th Cir.2002) (applying test set out in *Wilder* to determine of private right of action existed under 42 U.S.C. § 1983 for noncompliance with screening and treatment provisions of Medicaid Act).

***4** Provisions of the Medicaid Act create an enforceable right under § 1983 if, after a particularized inquiry, the court concludes that:

> (1) the statutory section was intended to benefit the putative plaintiff, (2) it sets a binding obligation on a government unit, rather than merely expressing a congressional preference, and (3) the interests the plaintiff asserts are not so " 'vague and amorphous'

that [their] enforcement would strain judicial competence ." *Blessing v. Freestone*, 520 U.S. 329, 341, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997)] (quoting *Wright v. Roanoke Redevel. and Housing Auth.*, 479 U.S. 418, 437, 107 S.Ct. 766, 93 L.Ed.2d 781.... (1987)).

Westside Mothers, 289 F.3d at 862-863. "If these conditions are met, [the Court] presume[s] the statute creates an enforceable right unless Congress has explicitly or implicitly foreclosed this." *Id.* at 863 (citing *Blessing*, 520 U.S. at 341; *Wood v. Tompkins*, 33 F.3d 600, 605 (6th Cir.1994)). As Congress has not foreclosed the possibility of private enforcement of rights under 42 U.S.C. § § 1396a(a)(1)(A)(i) , 1396d(a)(3) and (4) , and 1396a(a)(17), the Court will presume that the Medicaid statute creates an enforceable right unless Plaintiffs fail to meet the conditions set out above.

Under the terms of the Act, Kentucky must:

> ... provide (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to (i) all individuals [who meet the age and financial requirements of a categorical population.

42 U.S.C. § 1396a(a)(10)(A). 42 U.S.C. § 1396d(a)(4)(A) specifies "nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older" as among the required care or services. 42 U.S.C. § 1396d(a)(4)(A). This is to say that NF services are a mandatory service under Medicaid. *See Westside Mothers*, 289 F.3d at 856 ("The Medicaid Act and related regulations set out a detailed list of services every state program must provide.") Further, the "nursing facility services" of § 1396d(a)(4)(A) are specifically defined as services required for "an individual who needs or needed on a daily basis nursing care (provided directly or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis." 42 U.S.C. § 1397d(f). The same may be said of those long-term care services available under the HCBS waiver program, an alternative to the services otherwise to be provided under auspices of NF services, to those who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility which would be reimbursed under Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI) and § 1396n(c)(1) ; 42 C.F.R. § 430.25.

Thus, this Court is persuaded that the NF services and the long-term care services available under the HCBS waiver program are clearly intended to benefit Plaintiffs, all within the class of persons eligible for NF services and HCBS. In fact, there is a binding obligation on the Commonwealth to provide these services as they "are couched in mandatory rather than precatory language, stating that Medicaid services "*shall* be furnished" to eligible persons and that the NF services "*must* be provided." 42 U.S.C. § § 1396a(a)(8) and 1396a(a)(10)(A) (emphasis added). These provisions are not so vague or amorphous as to defeat judicial enforcement because the statute carefully details the services to be provided. *See* 42 U.S.C. § § 1396d(a)(4)(A) and 1396r(a). Thus, Plaintiffs have a private right of action to enforce these provisions.

***5** Similarly, the Court is persuaded that Plaintiffs have a private right of action for alleged violations of 42 U.S.C. § 1396a(a)(17), requiring that a "state plan for medical assistance must ... include reasonable standards ... for determining eligibility for and the extent of medical assistance under the plan ... which are consistent with the objectives of [the Act.]" Specifically, this portion of the Act is "by its terms ... intended to provide standards upon which individual applicants can rely in the determination of their benefit eligibility by state officials. It is intended to benefit the plaintiffs, and it is a binding obligation on the state agency." *Markva v. Haveman*, 168 F.Supp.2d 695, 711 (E.D.Mich.2001), *aff'd*, 317 F.3d 547 (6th Cir.2002). The requirement that these standards be consistent with the objectives of the Act is not so vague and amorphous as to defeat this Court's review of the situation. Plaintiffs may bring an action to remedy this perceived wrong.

Finally, Plaintiffs also have the right to pursue claims for violations of the requirement for a "fair hearing before the State agency." 42 U.S.C. § § 1396a(a)(3). This is a binding obligation on the state to provide a fair hearing and is clearly "intended to benefit [a] putative plaintiff." *Gean v. Hattaway*, 330 F.3d 758, 772 -773 (6th Cir.2003) (*quoting Wilder*, 496 U.S. at 509). It is not "congressional preference" for certain conduct nor an interest "too vague and amorphous" to be enforced by a competent judiciary, particularly in light of the judiciary's regular review of matters to determine whether an individual has been afforded appropriate procedural due process by a state entity, a claim also raised by Plaintiffs under the Fourteenth Amendment to the United States Constitution. *Id.* Thus, it is proper for those affected by that obligation to bring a suit for its breach under § 1983.

No doubt, each Plaintiff has a personal stake in the outcome of this controversy and can claim an injury

due to Defendants' decision to terminate certain Medicaid benefits through their application of the 2003 regulations and their alleged failure to provide Plaintiffs with adequate procedural due process. Specifically, they have lost NF and HCBS services under the Medicaid program, a concrete and particularized injury, and they seek to vindicate interests falling within the "zone of interests" protected and regulated by the Medicaid Act, as described above. Defendants allegedly caused their injury by adopting and implementing the regulations, and that the relief sought, an injunction preventing the use of the regulations to bar the provision of the services they seek, would redress or prevent their alleged loss of mandated services under the Medicaid Act. This is sufficient for standing in this matter, and Plaintiffs may pursue their claims. Defendants' motion to dismiss this action for lack of standing shall be denied.

B. RIPENESS

***6** Defendants have also suggested that this claim is not yet ripe for adjudication as Plaintiffs have failed to exhaust their administrative remedies with the state administrative agency. However, "exhaustion is not a prerequisite to an action under § 1983," especially where plaintiffs raise federal constitutional issues and Congress has not carved out an exception requiring exhaustion as is the case in this matter. *Patsy v. Board of Regents*, 457 U.S. 496, 501 and 507, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982). While Plaintiffs may seek a hearing before state ALJ's on the application of the new criteria to their case, the state hearing officers will not address the federal questions raised here. Accordingly, this matter is ripe for adjudication, and Plaintiffs' claims shall not be dismissed on these grounds.

C. DUE PROCESS

The Act requires states to provide a fair hearing when a Medicaid agency takes action to suspend, terminate, or reduce eligibility or covered services. 42 U.S.C. § 1396a(a)(3) ; 42 C.F.R. § 431.200, *et seq.;* § 431.210. In fact, it is explicitly required that Kentucky's Medicaid hearing system meet the constitutional due process standards set forth in *Goldberg v. Kelly*. 42 C.F.R. § 431.205(d) ; 907 KAR 1:563 ; *Goldberg v. Kelly*, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970). At the time of application or any action affecting their claims, a state agency must inform applicants or recipients in writing of their right to a hearing, the method by which they may obtain a hearing, and that they may be represented by legal counsel, a relative, a friend, or other spokesperson. 42 C.F.R. § 431.206. A notice of adverse action must contain a statement of what action is intended, the reasons for the intended action, the specific regulation supporting or changing the law that requires the action, an explanation of the right to request hearing, and an explanation of the circumstances under which Medicaid is continued if a hearing is requested. 42 C.F.R. § 431.210.

The initial notices to Plaintiffs explaining that they were no longer eligible for NF or HCBS services under the 2003 criteria failed to give any reasons for the denial, stating only that:

> Healthcare Review Corporation, having reviewed your medical case with your physician or having made an effort to contact your physician, has determined that the case as presented, deos not meet payor criteria for: continued stay in a facility.

[Complaint, Exh. A-J.] Notices for five of the plaintiffs added " ... documentation was insufficient to support level of care for conitnued stay in a nursing facility." Notices for the other five read "documentation does not support medical necessity/approrpiateness for further stay in a nursing facility level of care as outlined in 907 KAR 1:022."

The Court agrees that these notices lack specificity as to why Plaintiffs no longer met the level of care criteria, as required by 42 C.F.R. § 431.210(b) and 907 KAR 1:563 § 2(3)(b); *see Moffitt v. Austin*, 600 F.Supp. 295, 297-98 (W.D.Ky.1984) (notices prvoiding that "further stay at the intermediate care facility not necessary" and "after due consideration of the medical data ... the adverse decision should be upheld" are inadequate to allow individuals to prepare defense and violate due process regulations). Further, none of the original notices accurately cited a specific regulation supporting the decisions. One cited 907 KAR 1:022 , not the then newly enacted emergency regulation 907 KAR 1:022E, and none cited a particular section or subsection of the long, complicated regulations. In fact, five of the notices failed to cite any level of care regulation, whether in force or not, at all. The notices were insufficient "to protect claimants from proposed agency action resting on a misapplication of the rules [or] policies [to] the facts of particular cases" and may well have denied them the process due under the Act. *Goldberg v. Kelly*, 397 U.S. at 268, *cited in Oritz v. Eichler*, 794 F.2d 889, 893 (3rd Cir.1986).

***7** Adverse notices must explain circumstances under which Medicaid will be continued if a hearing is requested. 42 C.F.R. § 431.210(e) ; 907 KAR 1:563 § 5. The original adverse notices sent to Plaintiffs in this matter explained that:

> If the request for an administrative hearing is postmarked or received within ten (10) calendar days of the adverse advance notice date of the denial specified on the notice for denial of level of care, Medicaid vendor payments shall continue until the date the hearing decision is rendered.

[Complaint, Exh. A-J.] While the Court is not convinced that this portion of the adverse notice is confusing, the Court is more concerned that, of the two dates on the notice, no date is specified as the adverse advance notice date. Again, the notices are insufficient.

Finally, certain Plaintiffs complain that self-contradicting and sometimes separate but inconsistent notices created confusion in the recipients about whether they are entitled to a hearing and how to communicate a wish to be heard. Such notices have been held to "unreasonably discourage the exercise of a recipient's established right." *Ward v. Thomas*, 895 F.Supp. 401, 404 (D.Conn.1995). For example, Plaintiff Hannah received her initial adverse notice on April 11, 2003, advising that she no longer met payor criteria for continued stay in a facility. On April 21, 2003, she received two notices, one advising that she no longer qualified for Medicaid and another advising that she still qualified for Medicaid. This type of confusing, contradictory notice is insufficient and denies Plaintiffs' appropriate notice.

Notwithstanding Defendants lengthy explanation of the law on this subject, they have not demonstrated any lack of material issue of fact that would decide this matter in their favor. Accordingly, their motion to dismiss or, in the alternative, to dismiss Plaintiff's claims for due process violations shall be denied. Turning to Plaintiffs' motion for a preliminary injunction on these grounds, the Court finds that they have demonstrated a likelihood of success on the merits.

D. NF AND HCBS BENEFITS

Plaintiffs have also claimed, pursuant to 42 U.S.C. § 1983 , that they have been illegally denied necessary long-term care services to which they are entitled under the Medicaid Act, 42 U.S.C. § 1396a(a)(10) and § 1396d(a)(4)(A), by virtue of the promulgation and application of the 2003 Regulations. Plaintiffs next allege that Defendants have violated the Medicaid Act, 42 U.S.C. § § 1396 , 1396a(a)(17) , 1396d(f) , and 1396n(c)(1), by failing to use reasonable standards to determine Plaintiffs' medical need for long-term care services and by terminating payments for Plaintiffs' long-term care services by and through the 2003 Regulations. Specifically, they argue that the regulations do not permit elderly and disabled persons with genuine medical needs access to the level of care required by the Medicaid Act.

As discussed above, NF services are a mandatory service under Medicaid, which is to say that they are services which any state participating in the Medicaid program must provide. *See* *Westside Mothers*, 289 F.3d at 856 ("The Medicaid Act and related regulations set out a detailed list of services every state program must provide."). 42 U.S.C. § 1396a(a)(10)(A) requires that a state "must ... provide ... for ... medical assistance ... at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a)" for all individuals meeting the eligibility requirements. § 1396d(a)(4)(A) specifies "nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older" as among the required care or services. 42 U.S.C. § 1396d(a)(4)(A). The "nursing facility services" of § 1396d(a)(4)(A) are defined as services required for "an individual who needs or needed on a daily basis nursing care (provided directly or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis." 42 U.S.C. § 1397d(f).

***8** Accordingly, Plaintiffs argue that individuals within the population identified in § 1396a(a)(10), needing nursing care on a daily basis which can, as a practical matter, be delivered only in a nursing facility on an inpatient basis, must be provided with coverage for nursing care facilities. They argue that the state Medicaid program must also provide, similarly, for long-term care services under the HCBS waiver program, available to those who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility which would be reimbursed under Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI) and § 1396n(c)(1) ; 42 C.F.R. § 430.25. The Court agrees.

The Court is, thus, left to consider whether or not Defendants, by virtue of the 2003 Regulations, allegedly enacted to reduce state expenses by restricting the medical eligibility criteria of its Medicaid program, act to deny the long-term care services required of the Commonwealth by the Act in violation of the terms of the Medicaid Act. Effectively, the Court must determine whether or not the state may expand or contract their eligibility standards, thus denying services to eligible individuals, solely to conform to constraints on the

state budget.

There is great appeal to the idea that a state may limit services in order to avoid shortfalls in the face of a budget crisis, and certainly states may exercise discretion in choosing the "proper mix" of Medicaid coverage. FN6 *Alexander v. Choate*, 469 U.S. 287, 303, 105 S.Ct. 712, 83 L.Ed.2d 661 (1985). Nonetheless, states must also assure that they are providing care and services in the recipients' "best interests." 42 U.S.C. § 1396a(a)(19); *see Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977) ; *Weaver v. Reagan*, 886 F.2d 194 (8th Cir.1989). Thus, it is clear that:

> FN6. In fact, 42 U.S.C. § 1396a(a)(30)(A) requires that state Medicaid agencies provide methods and procedures relating to utilization and payment for care and services given by Mediciad providers, including but not limited to NF, to safeguard against unnecessary utilization of care and services and to assure that the care and services are provided in with quality, efficiency, and economy. State law also requires that Defendants review reimbursement systems for appropriateness and cost-effectiveness. Defendants argue that it was by pursuant to these laws and through the medical review process that it was discovered in 2003 that its contracting agent peer review organization had incorrectly applied the standard for medical necessity for nursing facility services. Thus, Defendants claim to have worked with the PRO to correct the misapplication of the standard and, pursuant to KRS Chapter 13A, lawfully promulgated the 2003 regulations to clarify the standard to be used in determining need for nursing facility or long-term HCBS waiver care. Certainly, the Court appreciates the need to clarify and refine standards in order that they may be applied properly, but the Court does not appreciate how the apparent sea change in eligibility standards in Kentucky could be understood as a mere clarification or refinement to correct a misapplication of standards by a PSO.

[T]he discretion of the state is not unbridled: "[A state] may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition." 42 C.F.R. § § 440.230(c). "[A]ppropriate limits [may be placed] on a service based on such criteria as medical necessity or utilization control procedures." *Id.* at § § 440.230(d). Moreover, the state's plan for determining eligibility for medical assistance must be " 'reasonable' and 'consistent with the objectives' of the Act." *Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977) (quoting 42 U.S.C. § § 1396a(a)(17)). This provision has been interpreted to require that a state Medicaid plan provide treatment that is deemed "medically necessary" in order to comport with the objectives of the Act. *See id.* at 444-45, ("serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage"); *Pinneke v. Preisser*, 623 F.2d 546, 548 n. 2 (8th Cir.1980).*Weaver*, 886 F.2d at 197-98 (8th Cir.1989)

Plaintiffs are correct that there is no precedent for the proposition that an a state can alter eligibility for a mandatory Medicaid service simply because the state does not wish to pay the price required to provide the service to all eligible recipients. *Alexander*, 469 U.S. at 303; *Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 522 (9th Cir.1993) (invalidating state Medicaid reimbursement scheme "set solely on the basis of budgetary considerations, and without regard to the requirements of the federal Medicaid statute"); *Ala. Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5th cir.1980) ("Inadequate appropriations do not excuse noncompliance."); *Thomas v. Johnston*, 557 F.Supp. 879, 914 (W.D.Mich.1990) ("If a state could evade the requirements of the Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will. That obviously is not the case."); *see also Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir.1994) (rejecting budget cutting as grounds for waiver of federal AFDC requirements). Rather, as Congress recognized that those eligible for Medicaid "are the most needy in the country ... [,] it is appropriate for medical care costs to be met, first for these people." *Scweiker v.. Hogan*, 457 U.S. 569, 590, 102 S.Ct. 2597, 73 L.Ed.2d 227 (1982) (quoting H.R.Rep. No. 213 89th Conf. 1st Sess., 66 (1965)).

***9** The Medicaid Act requires states to establish "reasonable standards ... for determining eligibility for and the extent of medical assistance under the [Medicaid] plan which ... are consistent with the objectives of [the Medicaid Act ...,]" in this case to provide services for an "individual who needs or needed on a daily basis nursing care ....or other rehabilitation services which as a practical matter can only be provided in a nursing facility or on an inpatient basis" or long-term care services available under the HCBS waiver program as an alternative to the services otherwise to be provided under auspices

of NF services. FN7 42 U.S.C. § § 1396a(a)(17) , 1396a(a)(10)(A)(ii)(VI) , 1396d(f) , and 1396n(c)(1) ; 42 C.F.R. § 430.25. Plaintiffs allege that the only goal of the new regulation was to reduce the state's expenditures for health care in Kentucky's Medicaid program by excluding recipients that the state had already recognized as having medical need of nursing facility services.

> FN7. The parties do not dispute that the plaintiffs in this matter have medical need for long-term care, whether in nursing facilities or HCBS. In fact, the named Plaintiffs have used Medicaid benefits for these purposes in the past.

Medicaid regulations adopted for the wrong reasons, i.e., without a Medicaid-related or a health-related purpose, are contrary to the purposes of the Act because they are inherently arbitrary, unreasonable, and invalid. *See* *Stephens v. Childers*, 1994 WL 761466, *5 (E.D.Ky.1994) ("State agencies must consider, on the basis of a reasonably principled analysis, the substantive requirements of 42 U.S.C. § 1396a."); *see also* *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1499 (9th Cir.1997) ; *Weaver*, 886 F.2d at 200 ("Missouri Medicaid's approach to its coverage of the drug AZT is unreasonable and inconsistent with the objectives of the Medicaid Act."). Thus, reducing mandatory benefits to qualified recipients by manipulating eligibility standards in order to make up for budget deficits is unreasonable and inconsistent with Medicaid objectives because it exposes recipients to "whimsical and arbitrary" decisions which the Act seeks to avoid. Focusing solely on budgetary concerns simply does not rise to the level of a reasonable standard for determining eligibility for long-term care services and is inconsistent with Medicaid objectives. If the Court accepts Plaintiff's allegations as true, Kentucky has inappropriately chosen to use cost-savings as the sole touchstone in its determination, focusing on how much money it wants to save rather than upon the medical needs of Medicaid recipients or the Medicaid statutory requirements. Defendants' motion to dismiss or, in the alternative, for summary judgment shall be denied. As with their due process claims, the Court is of the opinion that Plaintiffs have demonstrated a likelihood of success on the merits of their claims for violations of 42 U.S.C. § § 1396a(a)(1)(A)(i) , 1396d(a)(3) and (4) , and 1396a(a)(17) , pursuant to 42 U.S.C. § 1983.

E. PRELIMINARY INJUNCTION

1. REMAINING FACTORS

Finally, the Court turns to the three remaining requirements for a preliminary injunction. No doubt, there is a serious risk of irreparable harm if the injunction is not issued. One of the original named plaintiffs in this matter, Kerr, has died since the filing of this suit. She and the other named plaintiffs all require long-term care and all suffer from multiple serious medical conditions. The physical and mental deterioration that can from lack of appropriate care upon the loss of health care services are obvious. *See* *Morris v. North Hawaii Community Hospital*, 37 F.Supp.2d 1181, 1188 (D.Haw.1999) (preliminary injunction appropriate where "lack of home health care [because of termination of Medicaid home services] poses a serious risk to plaintiff's physical and psychological well-being ...").

***10** Additionally, the balance of hardships favors Plaintiffs for the harm that the Defendants will suffer if an injunction is entered against them, in the form of financial costs, is clearly less than the harm that the Plaintiffs will suffer if their request is denied and they are denied medical treatment, perhaps facing more serious illness or death as a result. *See* *Schalk v. Teledyne*, 751 F.Supp. 1261, 1268 (W.D.Mich.1991). Plaintiffs are all aged or disabled, requiring either institutional care or are homebound. By way of example, Plaintiff Barnett has been institutionalized for four and a half years, Plaintiff Nauer has been disabled since the age of two and receiving HCBS services for four years, Plaintiff Garmon has had three heart attacks and suffers from post-polio syndrome. No doubt, the Commonwealth's spending concerns are outweighed by the Plaintiffs' need for appropriate health care access, and Defendants' speculation that such an injunction will result in cuts in services to other individuals is simply not enough to overcome the relatively greater hardship on Plaintiffs in this matter.

Finally, the Court finds that an injunction would be in accordance with the public interest, for no doubt the benefit that would accrue to the public interest in granting the injunction versus the benefit to the public interest that would accrue from a denial militates in favor of the award of the injunction. *United Food and Commercial Workers Union, Local 1099 v. Southwest Ohio Reg'l Transit Auth.*, 163 F.3d 341, 363 (6th Cir.1998). No doubt the public's interest lies in the "preservation of a healthy population." *Schalk*, 751 F.Supp. at 1268. Accordingly, all factors being satisfied and balanced, this Court shall grant Plaintiffs' motion for preliminary injunction.

2. BOND

The Court notes, as well, that as the Plaintiffs in this matter are all low-income individuals in need of medical services. Exercising that discretion afforded it, this Court shall not require the posting of a bond upon the grant of the preliminary injunction. *Simon Property Group, Inc. v. Taubman Centers, Inc.*, 261 F.Supp.2d 919, 944 (E.D.Mich.2003) (citing *USACO Coal Co. v. Carbomin Energy, Inc.*, 689 F.2d 94, 100 (6th Cir.1982)); *Sluiter v. Blue Cross and Blue Shield of Michigan*, 979 F.Supp. 1131 (E.D.Mich.1997).

3. TERMS AND SCOPE OF PRELIMINARY INJUNCTION

While a new regulation has supplanted those of which Plaintiffs complain, the new regulation alone cannot undo the damage allegedly done by the 2003 regulations. Certainly, Plaintiffs describe the standard for eligibility for NF and HCBS services under the new 2004 Emergency Administrative Regulation as "less severe" than that in the challenged 2003 Regulations. Their concern with the new regulation is, in the context of this case, not with the standard but with the proposed actions by Defendants on behalf of Plaintiffs and others like them in order to remedy the harm allegedly caused by actions taken under the 2003 Regulations.

***11** Defendants are voluntarily attempting to notify those individuals who were terminated from or denied coverage by application of the 2003 regulations. For those individuals with pending appeals, Defendants will instead order that their cases be remanded for the hearing officers for an amended agency review based on the 2004 Regulation. Plaintiffs contend that this is insufficient and argue that, because any termination of long-term care coverage based on an application of the challenged regulations is arguably illegal, those who had previously attained eligibility-a group that includes all named Plaintiffs-should have their NF or HCBS immediately reinstated while their reapplication for benefits or any pending appeals are considered under the newest regulations. FN8 The Court agrees.

> FN8. According to Defendants, individuals who did not previously have Medicaid coverage and were denied coverage on the basis of the 2003 Regulations will receive notices informing them of the new emergency regulation and their right to reapply. While Plaintiffs agree that this is arguably within the range of relief sought, they propose, instead, that this reassessment for eligibility should be done within thirty days without requiring these individuals to reapply. The Court notes that reassessment is no doubt due in short order, but any ruling on this portion of the preliminary injunction would address those individuals that are part of the putative class and not named Plaintiffs. Accordingly, any decision on this portion of the motion for summary judgment must await an order certifying the class.

IV. CONCLUSION

For the reasons stated above, the Court has determined that this Plaintiffs have standing to pursue their claims. Dismissal or summary judgment in favor of Defendants would be inappropriate at this time. A preliminary injunction, however, is in order.

Accordingly, IT IS ORDERED:

(1) that Plaintiffs' motion for oral arguments on Defendants' motion to dismiss or, in the alternative, for summary judgment [Record No. 25] be, and the same hereby is, DENIED;

(2) that Defendants' motion to dismiss or, in the alternative, for summary judgment [Record No. 2] be, and the same hereby is, DENIED;

(3) that Plaintiff's motion for preliminary injunction be, and the same hereby is, GRANTED IN PART;

(4) that Defendants are enjoined from failing to fully reinstate within fifteen days of entry of this order, Medicaid benefits for nursing facility or HCBS services to Plaintiffs whose benefits for said services were terminated based on Defendants' determination that the recipient did not meet the eligibility criteria set forth in either 907 KAR 1:022E or 907 KAR 1:022, as in effect from April 4, 2003, to January 30, 2004; and

(5) that Defendants are enjoined from providing notices of action that do not comply the requirements of 42 C.F.R. § § 431.206 , 431.210 , and 431.211.

E.D.Ky.,2004
Kerr v. Holsinger
Not Reported in F.Supp.2d, 2004 WL 882203 (E.D.Ky.), Med & Med GD (CCH) P 301,481
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Not Reported in F.Supp.2d, 2004 WL 1878332, Med & Med GD (CCH) P 301,515

United States District Court,N.D. Illinois, Eastern Division.
Kerim & Advije MEMISOVSKI, by their mother Theresa Memisovski; Loretta Sturdivant; Michael Sampson by his mother Michelle Sampson; and Joseph and Adam Hassan by their mother Michelle Hassan; all on behalf of themselves and all others similarly situated, Plaintiffs,
v.
Barry S. MARAM, Director of the Illinois Department of Public Aid and Carol L. Adams, Secretary of the Illinois Department of Human Services, Defendants.

No. 92 C 1982.

Aug. 23, 2004.

Frederick H. Cohen , David Joel Chizewer , Matthew H. Metcalf , Hillary Levitt Dunn , Goldberg, Kohn, Bell, Black, Rosenbloom & Moritz, Ltd., Chicago, IL, for Plaintiffs.
Karen Elaine Konieczny , John E. Huston , Asst. Atty. Gens, Illinois Attorney General's Office , Warren Lupel , Weinberg Richmond LLP, Chicago, IL, for Defendants.

MEMORANDUM OPINION AND ORDER

LEFKOW, J.

***1** This case is a class action brought on behalf of minor children in Cook County, Illinois who are or will be eligible for the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act. The plaintiffs allege, pursuant to 42 U.S.C. § 1983 , that defendants are in violation of the federal Medicaid Act, 42 U.S.C. § § 1396 *et seq.*, by failing to ensure (1) that all plaintiffs have pediatric care and services to the extent that such care and services are available to the general population and (2) that plaintiffs are provided early and periodic screening, diagnostic, and treatment ("EPSDT") services. For the reasons set forth below, and based on the evidence received at trial, the court finds that the defendants have been and are in violation of the requirements of the federal Medicaid Act.

I. Introduction

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). State participation in Medicaid is voluntary, but if a state chooses to participate in the program, it must comply with the Medicaid Act and its implementing regulations promulgated by the Secretary of Health and Human Services. *Id.* at 502. To qualify for federal assistance, a state is required to submit to the Secretary an approved "plan for medical assistance," which must contain "a comprehensive statement describing the nature and scope of the State's Medicaid program." *Id.* (citing 42 U.S.C. § 1396a(a) and 42 C.F.R. § 430.10).

On March 23, 1992, plaintiffs filed this action alleging that defendants were in violation of the federal Medicaid Act. The case was assigned to the Honorable James B. Zagel. On October 8, 1992, Judge Zagel certified the following class: "All children (persons under the age of 18) in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act." FN1 The case was stayed for many years thereafter and, on July 2, 1999, reassigned to the Honorable William J. Hibbler. From Judge Hibbler, and pursuant to this court's executive order, the case was reassigned to the undersigned on September 5, 2000.

> FN1. Judge Zagel also certified a separate class of women in Cook County on Medicaid who "have been, are, or will be pregnant." The claims on behalf of this class of pregnant women were voluntarily dismissed on May 29, 2003.

On November 29, 2000, defendants filed a motion to dismiss what was then the plaintiffs' Third Amended Complaint. The defendants argued both that the Eleventh Amendment barred plaintiffs' requested relief and that plaintiffs could not seek redress for any violations of the Medicaid Act under § 1983. That motion was denied by memorandum opinion and order dated October 17, 2001. *See Memisovski v. Patla*, No. 92 C 1982, 2001 WL 1249615 (N.D.Ill. Oct.17, 2001). Defendants' Eleventh Amendment argument was rejected because this action seeks only prospective injunctive relief for violations of the federal Medicaid Act and does not seek compensatory damages. *Id.* at *4-5. Concerning defendants' argument that the plaintiffs could not seek redress for any violations under 42 U.S.C. § 1983 , the court cited and applied the three-factor test established by the Supreme Court in *Blessing v.*

Freestone, 520 U.S. 329, 340, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997). Citing cases which had allowed causes of action under § 1983 for violation of the same statutory sections at issue in this case, the court rejected defendants' argument, noting that "[d]efendants have provided no reason why this court should reject the analysis set forth in these cases, which hold that violations of the statutory provisions requiring EPSDT services are redressable through § 1983." FN2

> FN2. The court also noted that defendants had failed even to mention the three-factor test at all in their moving papers. *Id.* at *5.

***2** After denial of defendants' motion to dismiss, the parties conducted extensive discovery for nearly three years. This case was tried to the court during eleven days from May 3, 2004 to May 25, 2004. Based on the evidence received, including the parties' statement of uncontested facts, the exhibits received in evidence and the testimony of the witnesses, the court has weighed the evidence and the credibility of the witnesses and has made findings of fact and conclusions of law, which are discussed in parts III and IV below. First, however, the court considers, in part II below, defendants' argument for judgment on the pleadings.

> II. Judgment on the Pleadings FN3
>
> FN3. A motion for judgment on the pleadings is properly granted when there are no material issues of fact and the moving party is entitled to judgment as a matter of law. *Alexander v. City of Chicago*, 994 F.2d 333, 335-36 (7th Cir.1993).

First in their pre-trial submissions, and again in their post-trial brief, defendants argue that the issue of whether a statute confers enforceable rights under § 1983 has changed since this court's memorandum opinion and order on October 17, 2001. Specifically, defendants contend that the Supreme Court's opinion in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002) , has changed the legal landscape sufficiently for this court to reconsider whether plaintiffs continue to have rights enforceable under § 1983. Because, however, this court's previous ruling that enforceable rights exist under § 1983 is the law of the case, it will not be reconsidered "unless [the court has] a strong conviction that the earlier ruling was wrong and the party that benefitted from the earlier ruling would not be unduly harmed." *White v. Godinez*, 301 F.3d 796, 804 (7th Cir.2002).

The first specific statutory section of the federal Medicaid Act that plaintiffs assert provides them enforceable rights is located at 42 U.S.C. § 1396a(a)(30)(A), which states in relevant part as follows:

> A State medical plan for assistance must-
> * * *
> (30)(A) 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; ...

The other statutory sections at issue relate to the EPSDT services which are scattered among several portions of the Medicaid Act, including 42 U.S.C. § 1396a(a)(10) and (43) , § 1396d(a)(xiii)(4)(B) and (r) (hereinafter collectively referred to as the "EPSDT provisions"). The issue defendants raise after trial is whether, under *Gonzaga*, § 1396a(a)(30)(A) and the EPSDT provisions provide enforceable rights under 42 U.S.C. § 1983 FN4 to individuals.

> FN4. 42 U.S.C. § 1983 provides:
> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

There is no question that § 1983 provides a federal remedy for violations not only of the United States Constitution but also for federal statutes as well. *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 65

L.Ed.2d 555 (1980). To have a cause of action under § 1983 for violation of a federal statute, a plaintiff must first establish that the statute in question gives the plaintiff enforceable rights. *Gonzaga University*, 536 U.S. at 283 (statute must contain "unambiguously conferred right to support a cause of action brought under § 1983.").

***3** Because the federal Medicaid Act is a spending statute, *see Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir.2003), Congress must "speak with a clear voice" and manifest its "unambiguous" intent to confer individual rights before federal funding provisions will be read to provide a basis for private enforcement. *Gonzaga University*, 536 U.S. at 1268 (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 & n. 21, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981)). "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *31 Foster Children v. Bush*, 329 F.3d 1255, 1268 (11th Cir.2003) (citing *Pennhurst*, 451 U.S. at 28)); *see also Bruggeman*, 324 F.3d at 911 (noting that different portion of Title XIX of the Social Security Act "cannot be interpreted to create a private right of action, given the Supreme Court's hostility, most recently and emphatically expressed in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002), to implying such rights in spending statutes.").

In *Blessing*, the Supreme Court set forth three factors to determine whether a federal statute can be read to confer a right enforceable under § 1983:(1) Congress must have intended that the provisions in question benefit the plaintiff; (2) 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; and (3) the statute must unambiguously impose a binding obligation on the States imposed in mandatory, rather than precatory, terms. 520 U.S. at 340-41. Following *Blessing*, in *Gonzaga* the Court clarified that, under the first factor above, a plaintiff may bring suit under § 1983 as an intended beneficiary of a statute only if the statute itself unambiguously demonstrates congressional intent to confer an individual or personal right on that plaintiff. *See* 536 U.S. at 283 (rejecting notion that cause of action may be inferred "so long as the plaintiff falls within the general zone of interest that the statute is intended to protect" and noting that it is "*rights*, not the broader or vaguer 'benefits' or 'interests,' that may be enforced under the authority of [§ 1983]."") (emphasis in original).

In *Gonzaga*, the Court dealt with provisions of the Family Educational Rights and Privacy Act of 1974 ("FERPA"), which prohibits the federal funding of educational institutions that have a policy or practice of releasing education records to unauthorized persons. The specific portion of the FERPA addressed by the Court provided:

> No funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of education records (or personally identifiable information contained therein ...) of students without the written consent of their parents to any individual agency, or organization.

***4** 20 U.S.C. § 1232g(b)(1). In concluding that this statutory provision was not enforceable under § 1983, the Court noted that the FERPA's nondisclosure provisions "entirely lack the sort of 'rights creating' language critical to showing the requisite congressional intent to create new rights." 536 U.S. at 287.

As a basis for comparison, the Court examined the FERPA's language in light of other statutes where a private right was found, such as Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d ("*No person* in the United States *shall* ... be subject to discrimination under any program or activity receiving Federal financial assistance ....") (emphasis added) and Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a) ("*No person* in the United States *shall*, on the basis of sex ....") (emphasis added). The Court explained that those statutes are phrased "with an unmistakable focus on the benefitted class." *Gonzaga University*, 536 U.S. at 284 (quoting *Cannon v. University of Chicago*, 441 U.S. 677, 691, 99 S.Ct. 1946, 60 L.Ed.2d 560 (1979)). By contrast, the Court characterized the FERPA's language above ("[n]o funds shall be made available" to any "educational agency or institution" which has a prohibited "policy or practice") as "two steps removed from the interest of individual students and parents and clearly does not confer the sort of 'individual entitlement' that is enforceable under § 1983." *Id; see also Alexander v. Sandoval*, 532 U.S. 275, 294, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001) ("Statutes that focus on the person regulated rather than the individuals protected create 'no implication of an intent to confer rights on a particular class of persons." ') (quoting *California v. Sierra Club*, 451 U.S. 287, 294, 101 S.Ct. 1775, 68 L.Ed.2d 101 (1981)).

Moreover, the court further noted that the FERPA's

nondisclosure provisions "speak only in terms of institutional policy and practice, not individual instances of disclosure." *Gonzaga University*, 536 U.S. at 288 (quoting 20 U.S.C. § 1232g(b)(1)-(2), prohibiting funding of "any educational agency or institution which has a *policy or practice* of permitting the release of education records.") (alteration in original). The FERPA had an "aggregate" focus under which recipient institutions could avoid termination of funding so long as they "comply substantially" with the Act's requirements. *Id.* at 228; *cf. Blessing*, 520 U.S. at 335 (Title IV-D of Social Security Act failed to support a § 1983 suit because it required only "substantial compliance" with federal regulations).

Finally, the Court noted that its conclusion that the FERPA's nondisclosure provisions failed to confer enforceable rights was "buttressed by the mechanism that Congress chose to provide for enforcing those provisions," including that the FERPA allowed the Secretary of Education to "deal with violations" of the Act and design review boards for investigating and adjudicating any violations. *Id.* at 289. The Court noted that these administrative review procedures distinguished the FERPA from other statutory sections previously found to confer rights enforceable under § 1983 and supported the Court's conclusion that there was no congressional intent to create individually enforceable private rights under the FERPA. *Id.*

***5** Bearing in mind the factors to be considered in determining whether a statute confers rights enforceable under § 1983 and considering the Supreme Court's analysis in *Gonzaga*, this court will analyze whether rights are enforceable under the sections of the federal Medicaid Act relevant to this action. The court notes, however, that because *Gonzaga* modified the three-part *Blessing* analysis only in regard to the first factor, and since *Blessing* was decided prior to this court's decision that rights are enforceable under the statutory sections at issue (and, indeed, the court cited and applied *Blessing* in its October 17, 2001 memorandum opinion and order), here the only issue that needs to be revisited is the first factor. Thus, the issue under consideration is after *Gonzaga*, do 42 U.S.C. § 1396a(a)(30)(A) and the EPSDT provisions unambiguously confer rights on plaintiffs supporting a cause of action brought under § 1983. As will be explained below, the answer is yes.

A. 42 U.S.C. § 1396a(a)(30)(A)

The statutory section, 42 U.S.C. § 1396a(a)(30)(A), referred to as the "equal access" provision, requires a state plan to enlist sufficient providers so that care is available "at least to the extent that such care and services are available to the general population in the geographic area;...." Prior to *Gonzaga*, the Seventh Circuit specifically allowed *providers* of medical care to have a private right of action, pursuant to § 1983 , to enforce § 1396a(a)(30)(A). *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir.1996). The fact that the Seventh Circuit only dealt with providers of medical care, and not recipients as is the case here, is a distinction of no import. The case on which the Seventh Circuit relied, *Arkansas Medical Soc'y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir.1993), specifically allowed suit for both providers and recipients. *Id.* at 526 ("The equal access provision is indisputably intended to benefit the recipients by allowing equivalent access to health care services."); *see also Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir.1996) (allowing suit by both providers and recipients under § 1983 to enforce § 1396a(a)(30)(A)). Indeed, cases disagreeing with the conclusion that medical providers were afforded rights to enforce § 1396a(a)(30)(A) noted that it was recipients, and not providers, who should be afforded such rights. *E.g., Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 544 (3d Cir.2002) (en banc) (rejecting providers' right to sue under § 1396a(a)(30)(A) and noting that "recipients have sued to enforce Section 30(A), and the other courts of appeals have uniformly held that recipients may assert such claims under § 1983."); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 927 (5th Cir.2000) ("We agree with our sister circuits which have held that recipients are the intended beneficiaries of section 30(A).").

***6** This court has found only two decisions after *Gonzaga* considering whether recipients have a right of action under § 1983 to sue for violation of § 1396a(a)(30)(A). Compare *Sanchez v. Johnson*, 301 F.Supp.2d 1060 (N.D.Cal.2004) (reconsidering issue after *Gonzaga* and rejecting that § 1396a(a)(30)(A) provides rights enforceable under § 1983 to recipients) with *Clayworth v. Bonta*, 295 F.Supp.2d 1110 (E.D.Cal.2003) (holding that in § 1396a(a)(30)(A) "Congress created rights to quality care and equal access that may be enforced by Medicaid recipients under § 1983."). FN5

FN5. Most courts after *Gonzaga* have stated that providers do not have enforceable rights under § 1396a(a)(30)(A). *See, e.g., Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 58-59 (1st Cir.2004); *In re*

NYAHSA Litig.,-F.Supp.2d-, 2004 WL 1126348, at *9 (N.D.N.Y. May 20, 2004) ; *Burlington United Methodist Family Servs. Inc. v. Atkins*, 227 F.Supp.2d 593, 595-96 (S.D.W.V.2002). *But see, AARM v. Minnesota Comm'r of Human Servs.*, No. 03-2438, 2003 WL 22037719, at *7-8 (D.Minn. Aug.29, 2003).

The defendants argue that § 1396a(a)(30)(A) does not unambiguously demonstrate congressional intent to confer individual or personal rights on plaintiffs because (1) plaintiffs are not the intended beneficiaries of the statute insofar as the statute pertains only to what a State's Title XIX plan should contain to satisfy federal law; (2) the statute is not phrased in terms of the persons benefitted; and (3) the statute has only an aggregate focus and does not deal with individual rights.

Most of defendants' arguments, however, fail based on another portion of the federal Medicaid Act, 42 U.S.C. § 1320a-2. That statutory section provides:

> In an action brought to enforce a provision of this chapter, such provision is not deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. This Section is not intended to limit or expand the grounds for determining the availability of private action to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992) , but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that section 671(a)(15) of this title is not enforceable in a private right of action.

This section was passed in 1994 after the Supreme Court's decision in *Suter v. Artist M*, 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992). The Court in *Suter* held that § 671(a)(15) of the Adoption Act was unenforceable by a private person in part because that section merely required states to have a plan that contained a specific provision requiring states to make certain reasonable efforts. *Id.* at 358-59. As the plain language of § 1320a-2 illustrates, it was enacted to overrule *Suter* in part. FN6 *See Messier v. Southbury Training Sch.*, 916 F.Supp. 133, 144 (D.Conn.1996) ("[T]he fairest reading of Section 1320a-2 is that Congress was concerned only that a court should not eviscerate an otherwise enforceable right merely because it appears in a statute mandating that participating states include a particular provision in their state plans.").

FN6. Language identical to that of § 1320a-2 is contained in another statutory section, 42 U.S.C. § 1320a-10. This court is unaware of why this is so and, as one court has theorized, it may in fact be a mistake. *See Clayworth*, 295 F.Supp.2d at 1120 ("These statutes are identically worded, and the fact that there are two such statutes is probably a mistake.").

Based on § 1320a-2 , § 1396a(a)(30)(A) will not be deemed unenforceable simply because it only elaborates on what a state plan must include. Other courts have reached similar conclusions applying this and other portions of the federal Medicaid Act. *See Clayworth*, 295 F.Supp.2d at 1121 (in private action to enforce § 1396a(a)(30)(A) , relying on § 1320a-2 to conclude that "the court will not consider that an individual entitlement is absent simply because the wording of the statute is directed to the required contents of a state plan as opposed to the rights of a beneficiary or provider under a plan."); *see also, Rabin v. Wilson-Coker*, 362 F.3d 190, 201 (2d Cir.2004) (in an action brought under a separate portion of the Medicaid Act, noting that § 1320a-2 "precludes defendant from relying on the plan requirement language of Section 1386r-6" to support claim that no enforceable rights were present in that statute).

***7** Several other considerations persuade the court that § 1396a(a)(30)(A) confers rights on plaintiffs enforceable pursuant to § 1983. Initially, the requirement of equal access is not phrased in indirect terms "such as requiring a general policy or requiring substantial compliance." *Clayworth*, 295 F.Supp.2d at 1123. As the *Clayworth* court observed, if the statutory section were phrased indirectly or in more general terms (such as in *Gonzaga* and *Blessing*), "that might suggest that no single beneficiary is entitled to quality care or equal access." *Id.* at 1123. Instead, the requirements of equal access are phrased in mandatory and not precatory language. *See Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir.2004) (citing *Blessing*, 520 U.S. at 341). States "must" have a plan that affords equal access and there can be no dispute that the access provisions directly benefit recipients, as several circuit courts have found. *Pennslyvania Pharmacists*, 283 F.3d at 537; *Evergreen Presbyterian Ministries*, 235 F.3d at 928-29. In addition, dissimilar to the statute in *Gonzaga*, the court has not been presented with anything suggesting that administrative procedures exist through which recipients can seek equal access to

health care. Through § 1396a(a)(30)(A), a mandatory obligation was imposed on states and no administrative mechanism was formulated so as to ensure compliance with this obligation. This further weighs in favor of a private right of action to enforce this statutory section under § 1983. FN7

> FN7. There is also legislative history supporting a private right of action for recipients to enforce § 1396a(a)(30)(A) under § 1983. In 1997, Congress repealed the Boren Amendment, which required states to pay providers rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the 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 law." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 503, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). In repealing the Boren Amendment, legislative history evinces Congress' intent only to end provider suits. *See* H.R.Rep. No. 105-149, at 590 (1997) ("It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive."). Conversely, in passing an amendment to § 1396a(a)(30)(A) in 1981, Congress noted that "in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action." H.R.Rep. No. 97-158, at 301 (1981). As several courts have noted, this implies that Congress intended some class of plaintiffs, most likely recipients, to be able to enforce the provisions of § 1396a(a)(30)(A) by private suit under § 1983. *E.g.*, *Pennslyvania Pharmacists*, 283 F.3d at 540-41; *Clayworth*, 295 F.Supp.2d at 1123.

The court acknowledges that the language of § 1396a(a)(30)(A) is not similar to the typical rights creating language in, for example, Title VI. However, as one court has noted, it is "difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant Title XIX language-'A State plan must provide'-from the 'No person shall' language of Titles VI and IX." *Sabree*, 367 F.3d at 190. Indeed, as another court has observed, since the structure of § 1396a(a) lists the general requirements that a state plan must meet, that structure "largely prevented Congress from using the sort of 'no person shall' language cited by the *Gonzaga* Court." *Clayworth*, 295 F.Supp.2d at 1122. That would, perhaps, be why Congress enacted § 1320a-2 , to ensure that direction to include certain provisions in a state plan does not preclude a private action enforceable under § 1983.

Finally, the court finds further support for the conclusion that § 1396a(a)(30)(A) provides enforceable rights to plaintiffs in cases where the Supreme Court has already found such enforceable rights. In *Wilder*, the Court considered whether the now repealed Boren Amendment conferred enforceable rights on medical providers. The specific portion of the Boren Amendment provided that

> a State plan for medical assistance must-
> * * *
> 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 ... *which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the 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 law, 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.

***8** *Wilder*, 496 U.S. at 2514 (citing 42 U.S.C. § 1396a(a)(13)(A) (1982 ed. Supp. V)) (emphasis in original.)

The *Wilder* Court concluded that this statutory provision did confer enforceable rights on medical providers because (1) it was cast in mandatory rather than precatory terms and (2) the receipt of federal funds was expressly conditioned on compliance with the Amendment. *Id.* at 513. In *Gonzaga*, the Court made clear that it was not overruling *Wilder*, and explained that case by stating that the Boren Amendment "explicitly conferred specific monetary entitlements upon the plaintiffs." 536 U.S. at 280 (discussing *Wilder* and noting that "Congress left no doubt of its intent for private enforcement, we said, because the provision required States to pay an 'objective' monetary entitlement to individual health care providers, with no sufficient administrative means of enforcing the requirements against States that failed to comply.").

In light of *Wilder*, which other courts have noted is still good law, *see* *Sabree*, 367 F.3d at 192, § 1396a(a)(30)(A) must provide a private right of action enforceable under § 1983. The structure and language of the two statutes are nearly identical, and each focuses on mandatory obligations a state plan must meet. *See* *Sabree*, 367 F.3d at 192 ("Our confidence in this conclusion rests securely on the fact that the Court has refrained from overruling *Wright [v. Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 107 S.Ct. 766, 93 L.Ed.2d 781 (1987)] FN8 and *Wilder*, which upheld the exercise of individual rights under statutes that contain similar (or, in the case of *Wilder*, identical) provisions to 42 U.S.C. § 1396."). If a private right of action was allowed in *Wilder*, there is no principled basis to say that a private right of action is unavailable in this case. FN9

> FN8. *Wright* dealt with a rent ceiling provision imposed under the Brooke Amendment to the Housing Act of 1937. The Court concluded that a private right of action under § 1983 was available because the provision unambiguously conferred "a mandatory [benefit] focusing on the individual family and its income." 479 U.S. at 430. The statute at issue provided "[a] family shall pay as rent for a dwelling unit assisted under this chapter ... the highest of the following amounts...." 42 U.S.C. § 1437a.
>
> FN9. In *Sanchez v. Johnson*, the court stated that under § 1396a(a)(30)(A) there is no "specific monetary entitlement conferred upon Medicaid recipients...." 301 F.Supp.2d at 1064. Thus, the court concluded that "there is no rights-creating language in § 30(A) bestowing an enforceable right upon Plaintiffs." *Id.* There is no doubt that there is no objective "monetary entitlement" in § 1396a(a)(30)(A), but this court finds that distinction irrelevant. What § 1396a(a)(30)(A) does provide is an objective entitlement to access, that being equal access to quality medical care.

Thus, for all of the above reasons, the court concludes that § 1396a(a)(30)(A) does confer individual rights on plaintiffs which are enforceable pursuant to 42 U.S.C. § 1983.

B. EPSDT Provisions

As noted above, the EPSDT provisions are located in several different portions of the federal Medicaid Act. Under 42 U.S.C. § 1396a(a)(10), a state Medicaid plan "must" provide for "making *medical assistance* available, including at least the care and services listed in ... section 1396(a) of this title." (Emphasis added.) Section 1396d(a) defines the term "medical assistance" to include "early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21...." 42 U.S.C. § 1396d(a)(xiii)(4)(B). The EPSDT services are defined in § 1396d(r)(1)-(4) and include, among other things, screening, vision, dental and hearing services. Moreover, under § 1396a(a)(43), a state Medicaid plan "must" also provide for

> (A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance ... of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,
>
> ***9** (B) providing or arranging for the provision of such screening services in all cases where they are requested,
>
> (C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and
>
> (D) reporting to the Secretary ... the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:
>
> (i) the number of children provided child health screening services,
>
> (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child screening services),
>
> (iii) the number of children receiving dental services, and
>
> (iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title.

Prior to *Gonzaga*, the Seventh Circuit had allowed suit under § 1983 to enforce certain EPSDT provisions. *See* *Miller by Miller v.. Whitburn*, 10 F.3d 1315, 1319-20 (7th Cir.1993) ; *Bond v. Stanton*, 655 F.2d 766 (7th Cir.1981); *see also*, *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 293 F.3d 472, 479 (8th Cir.2002) ; *Westside Mothers v. Haveman*, 289 F.3d 852, 862-63 (6th Cir.2002). One other circuit court has disagreed at least in part. *See* *Frazar v. Gilbert*, 300 F.3d 530, 545 (5th Cir.2002)

rev'd on other grounds sub nom Frew v. Hawkins, 540 U.S. 431, 124 S.Ct. 899, 157 L.Ed.2d 855 (2004) (although noting that relief under § 1983 for a violation of EPSDT provisions "may be available," holding "that plaintiffs cannot sue under § 1983 to require a plan to meet statewide or systemwide participation or performance measures, because, under *Blessing*, state compliance with such standards is not an individualized right actionable under § 1983."). In the October 17, 2001 memorandum opinion and order, this court cited several other cases which had allowed suit under § 1983 to enforce the EPSDT provisions. *See Danjour B. v. New York*, No. 00 CIV 2044(JGK) , 2001 WL 830674, at *8 (S.D.N.Y. July 23, 2001) ; *Salazar v. District of Columbia*, 954 F.Supp. 278, 324 n. 92 (D.D.C.1996) ; *Wellington v. District of Columbia*, 851 F.Supp. 1, 6 (D.D.C.1994) ; *New York Coalition to End Lead Poisoning v. Giulliani*, 187 Misc.2d 425, 720 N.Y.S.2d 298, 301 (N.Y.Sup.Ct.2000).

After *Gonzaga*, the court has found only a few cases addressing this issue, and most have stated that the EPSDT provisions are enforceable by private right of action under § 1983. *See* Kenny A. ex rel. Winn v. Perdue, 218 F.R.D. 277, 293-94 (N.D.Ga.2003) ; *Collins v. Hamilton*, 231 F.Supp.2d 840, 846-47 (S.D.Ind.2002); FN10 *S.D. v. Hood*, No. Civ. A 02-2164, 2002 WL 31741240, at *4-6 (E.D.La. Dec.5, 2002).

> FN10. The Seventh Circuit affirmed the *Collins* decision at 349 F.3d 371 (7th Cir.2003). There is no discussion as to whether the EPSDT provisions afford enforceable rights under § 1983. This court is unable to conclude that the Seventh Circuit's silence on the subject can be construed as precedent.

Defendants argue that, after *Gonzaga*, these EPSDT provisions cannot afford rights enforceable under § 1983 for many of the same reasons they claimed above. First, defendants state that these provisions only concern the requirements of a state's Medicaid plan and, moreover, only describe the elements that must be included in a Title XIX state plan. This argument fails based on the court's discussion of § 1320a-2. That statutory section would apply with equal force to the EPSDT provisions and, accordingly, that the EPSDT provisions speak only in terms of what a plan must include and do not focus on the person benefitted does not render these EPSDT provisions unenforceable by private action.

***10** Defendants also argue that the EPSDT provisions do not confer any specific monetary or other entitlement on the plaintiffs. True, there is no monetary entitlement at issue in these provisions, but that is irrelevant. The court disagrees with defendants' characterization that no entitlements are otherwise presented in these provisions. First, the EPSDT provisions themselves defined in § 1396d(r) are considered "medical assistance" and, therefore, "must be provided" in a state's plan. Moreover, § 1396a(a)(43) provides several specific entitlements that plaintiffs "must" be provided, including (1) that they are informed of the availability of periodic screening, diagnostic, and treatment services and the need for age-appropriate immunizations against vaccine preventable diseases, (2) that they are provided arrangement of screening services in all cases where they have been requested, and (3) that they are provided arrangement for corrective treatment when disclosed by a child health screen. Notice once again the language in all of these EPSDT provisions is mandatory and not precatory. Moreover, similar to above, the court has not been presented with any administrative mechanisms to enforce these specific EPSDT entitlements afforded on plaintiffs. Rights are provided under these provisions, and no avenue is presented to vindicate these rights. Finally, similar to the argument above, the language contained in the EPSDT provisions is nearly identical to that of *Wilder* and no reason exists to distinguish this case so long as *Wilder* remains good law.

Defendants, in response, suggest that this court should rely on the Fifth Circuit's decision in *Frazar*. The court in *Frazar* interpreted the EPSDT provisions and, while seemingly acknowledging that individuals could in some circumstances vindicate rights provided under the EPSDT requirements, *see* 300 F.3d at 544, noted that no actionable individual rights were afforded by a state's "failure to meet ... a participation goal or other systemwide performance standard" under the EPSDT requirements. *Id* . at 545. The *Frazar* court noted that the district court lacked "the power to impose systemwide standards under § 1983, since such standards do not give rise to individual rights." This conclusion conflicts with the holdings of cases cited by this court in its October 17, 2001 memorandum opinion and order. *See, e.g.*, *Dajour B* ., 2001 WL 830674, at *9-10; *see also*, *Pediatric Specialty Care, Inc.*, 293 F.3d at 479 (holding that EPSDT provisions imposed a binding obligation on states "to create a state plan that includes the provision of EPSDT services" and that this requirement was not "so ambiguous or amorphous that its enforcement strains judicial competence."). Insofar as *Frazar* was decided before *Gonzaga*, and as a result *Gonzaga* did not influence

the *Frazar* decision, the court simply sees no reason to find *Frazar* more persuasive than the cases previously relied on. Furthermore, *Frazar* would also appear in conflict with precedent binding on this court which has allowed actions seeking modification of state Medicaid plans that do not sufficiently implement EPSDT provisions. *Bond*, 655 F.2d at 768-69. Defendants' argument on this ground, therefore, must be rejected.

***11** Thus, for the reasons stated above, the court concludes that the EPSDT provisions also confer individual rights on plaintiffs which may be enforced pursuant to 42 U.S.C. § 1983.

III. Findings of Fact

A. Background

1. The plaintiff class consists of all children (persons under the age of 18) in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act.

2. A state participating in the Medicaid program is required to satisfy the Secretary of the United States Department of Health and Human Services that it complies with the requirements of federal law. The United States Department of Health and Human Services reimburses a participating state by matching the state's expenditures on the covered services provided through the program. The agreement between the United States Department of Health and Human Services and the participating state is evidenced in the State Plan for Title XIX. (Ellinger Trial Tr. at 776:11-777:17, 778:1-24.)

3. Illinois participates in the Medicaid program and has filed a Title XIX State Plan with the Secretary of the United States Department of Health and Human Services. (Def.Ex. 86.)

4. There are approximately 800,000 children on Medicaid in Illinois, and approximately 600,000 of those children are in Cook County. (Joint Ex. 1 at 280683.)

5. The Illinois Department of Public Aid ("IDPA") is the single state agency responsible for the administration of the Medicaid program in Illinois. (Admitted, Defendants' Response to Plaintiffs' Proposed Findings of Fact and Conclusions of Law ("DRFFCL"); Ellinger Trial Tr. at 804:11-805:6; Powers Dep. Tr. at 9:17-10:5.)

6. Defendant Barry S. Maram is sued in his official capacity as the Director of IDPA. (Admitted, DRFFCL.)

7. IDPA has delegated to the Illinois Department of Human Services ("IDHS") the responsibility for carrying out some personal interactions with children and their families under the Medicaid program. IDHS administers local offices throughout the state where applicants can apply for Medicaid, and IDHS local office staff are the primary personal contact with Medicaid applicants and recipients. IDHS local offices determine whether applicants are eligible for the Medicaid program. (Lopez Dep. Tr. at 13:18-14:15; 15:13-21.)

7. Defendant Carol L. Adams is sued in her official capacity as the Secretary of IDHS. (Admitted, DRFFCL.)

B. Equal Access

8. IDPA sets the qualifications for medical providers to participate in the Medicaid program and sets reimbursement rates for providers of pediatric services. (Defendants' Response to Plaintiffs' Proposed Statement of Contested and Uncontested Facts ("DRPUF") ¶ 19; A. Kane 6/06/02 Dep. Tr. at 27:17-29:15.)

9. Medicaid reimbursement rates are determined primarily by the amount of funds allocated to IDPA by the Illinois Bureau of the Budget (the "available pie"). IDPA does not consider or study the effect of rate increases or decreases on provider participation nor does it compare Medicaid rates to Medicare or private insurance rates. (Powers Dep. Tr. at 69:21-78:13; Werner Dep. Tr. at 111:1-11, 133:21-142:21, 143:2-20, 144:10-146:20 161:20-162:20, 196:9-13; Luttrell Dep. Tr. at 50:2-9; Kane 6/06/02 Dep. Tr. at 69:1-19, 162:7-17, 162:23-163:2, 163:7-22, 164:4-7, 231:3-20, 232:6-11, 232:18-233:18, 244:3-9.)

***12** 10. IDPA decreased rates by 3% in 2002 solely because of a budget downturn. (Powers Dep. Tr. at 182:14-16, 182:18-185:5; Kane 6/06/02 Dep. Tr. at 225:4-13, 225:21-22.)

11. If IDPA were to be allocated more funds from the Bureau of the Budget, IDPA represents that it would increase provider reimbursement rates. (Kane 6/06/02 Dep. Tr. at 69:1-19.)

12. The costs of medical practice are generally 20% more expensive in Cook County than in downstate

Illinois, yet the Medicaid reimbursement rates in Cook County are the same as the rates elsewhere in the state. (Flint Trial Tr. at 699:1-25, 749:23-750:4.)

13. IDPA creates a schedule of reimbursement rates for each service that physicians regularly provide to plaintiffs. (Powers Dep. Tr. at 69:21-78:13; Def. Ex. 102.) IDPA creates that schedule without taking into account any of the factors that could result in a willingness by doctors to provide an appropriate level of care to the plaintiffs. (Werner Dep. Tr. at 111:1-11, 133:21-142:21, 144:10-146:20, 161:20-162:20, 196:9-13; Kane 6/06/02 Dep. Tr. at 125:2-5, 125:12-15, 125:17-126:21, 127:25-128:4, 128:8-10, 128:12-22, 173:13-174:6, 174:10-175:4, 175:14-176:9, 190:8-11, 191:2-3, 191:5-19, 200:3-7, 200:19-20, 204:19-205:4, 231:3-20, 232:6-11, 232:18-233:18, 244:3-9, 244:14-21; Powers Dep. Tr. at 69:21-78:19; Luttrell Dep. Tr. at 50:2-9.)

14. Dr. Samuel Flint ("Dr.Flint"), plaintiffs' expert, compared Illinois' Medicaid reimbursement rates for pediatric physician services in Cook County to (a) Medicare rates for the same region and (b) private insurance reimbursement rates for the same region. Dr. Flint concluded that Medicaid reimbursement rates are, on average, approximately half of the Medicare reimbursement rates for the same service, delivered in the same location, by the same provider. (Flint Trial Tr. at 707:3-25; Pl.Ex. 105 at Bates No. MO3 000739.)

15. Dr. Flint has been a consultant in the fields of health policy, health economics and child health care. He received his Ph.D. from the University of Chicago. (Admitted, DRFFCL, DRPUF ¶ 485; Flint Trial Tr. at 676:20-682:11.)

16. Medicare rates for services, including services provided to children, are compiled by a federal agency, the Centers for Medicare and Medicaid Services ("CMS"), in collaboration with the American Medical Association, based on the cost of providing the service. These rates are then modified to take into account regional differences in costs. Medicare rates are set to allow a physician to recover overhead costs and a modest profit. (Flint Trial Tr. at 695:9-699:25; Krug Trial Tr. at 299:18-305:23.) Health care economic analysts and other government agencies generally use Medicare reimbursement rates as a benchmark in considering the adequacy of Medicaid reimbursement rates. (*Id.;* Flint Trial Tr. at 713:17-25; Pl.Ex. 105 at Bates No. MO3 000735-MO3 000736.)

17. The most commonly billed service in the Illinois Medicaid program is the "Established Patient Office Visit; Moderate Complexity." The maximum Medicaid reimbursement rate received for this service in 2002 was $29.85 (this includes an add-on rate which was paid to only 37% of the providers who billed for this service). The Medicare reimbursement rate for this same service was $54.16. Thus, Medicaid paid, at most, only 55% of the rate that Medicare paid for the same service. The rate Illinois paid to 63% of billing physicians was even lower because those physicians did not receive the "add-on." (Pl.Ex. 105 at Bates No. MO3 000738-MO3 000739.)

***13** 18. Medicaid reimbursement rates are also, on average, significantly lower than private insurance reimbursement rates for the same pediatric service in Cook County. FN11 (Flint Trial Tr. at 708:1-710:25; Pl.Ex. 105 at MO3 000739.)

> FN11. Defendants object to Dr. Flint's methodology in using only two Cook County pediatric populations with a combined caseload of 14,000 patients as representative of the prevailing Cook County private insurance market rates. Although Dr. Flint himself conceded that such an analysis was "unscientific by accepted rigorous research standards," he stated that it was the best available evidence under the circumstances, and his conclusion is supported by extensive evidence in the record. Several doctors testified that in their experience, Medicaid reimbursement rates are significantly lower than private reimbursement rates for the same pediatric services in Cook County. (Lelyveld Trial Tr. at 331:8-25; Green Trial Tr. at 530:4-11, 530:19-534:3; Krug Trial Tr. at 302:10-18; Rosenberg Trial Tr. at 76:8-12; Jurado Trial Tr. at 426:14-20, 427:6-13; Newman Trial Tr. at 669:12-671:7; Abelson Trial Tr. at 636:1-19.) Moreover, an analysis the IDPA performed of private market rates in Springfield also supports the conclusion that Medicaid reimbursement rates are significantly lower than private insurance reimbursement rates. (Pl.Ex. 41 at 273321.)

19. Dr. Flint also analyzed a physician's cost to practice in Cook County and concluded that the Medicaid rates do not even cover a physician's cost of overhead, much less provide any remuneration to the physician. (Flint Trial Tr. at 714:1-716:9; Pl.Ex. 105 at Bates No. MO3 000740-MO3 000741.) Dr. Flint's opinion was confirmed by numerous physician

witnesses at trial. (Abelson Trial Tr. at 636:1-19; Green Trial Tr. at 530:19-534:3; Krug Trial Tr. at 272:21-273:25, 274:23-276:10; Lelyveld Trial Tr. at 331:8-332:11, 333:9-334:3; Rosenberg Trial Tr. at 76:13-23; Jurado Trial Tr. at 428:13-429:5, 430:5-11.)

20. Dr. Flint concluded that, based on his analyses, insufficient access for Medicaid beneficiaries should be expected in Cook County. (Pl.Ex. 105 at MO3 00743.)

21. Medicaid also has a lengthy payment cycle. (Rosenberg Trial Tr. at 78:12-17; Krug Trial Tr. at 274:2-18 ("Medicaid is now not only our worst payer in terms of percent reimbursement, they are also the slowest to pay us."); Jurado Trial Tr. at 430:14-17 ("Well, usually for a private insurance, [the payment cycle is] about a few weeks to a month. For Medicaid cycle, it could be anywhere from two months to six months. It depends on the year."); Werner Dep. Tr. at 159:12-23; S. Saunders Dep. Tr. at 183:19-187:16.)

22. Physicians billing Medicaid must also deal with so-called "Medicaid hassles," which Dr. Flint described as annoyances serious enough to influence a physician's decision to participate in Medicaid or limit participation in Medicaid. (Flint Trial Tr. at 720:1-7.) Dr. Flint described these hassles as "claims processing, how quickly claims are paid, retroactive claim denials, how often claims are denied, Medicaid rule complexity, eligibility determination, all of the costs and the extent of the completion of the form, et cetera." (Flint Trial Tr. at 720:8-12.) Examples brought out by physicians testifying at trial included (1) Illinois Medicaid using a different form than other issuers which physicians had to submit in a specific format (Rosenberg Trial Tr. at 78:18-79:4); (2) a higher rate of rejection as compared to third-party payers (*id*); and (3) Medicaid only paying for one service per day, regardless of whether a Medicaid recipient receives and/or requires several different services at one time. (Krug. Trial Tr. at 276:11-278:20; Newman Trial Tr. at 666:13-669:10.)

23. A pediatrician practice relying solely on Medicaid beneficiaries maximum reimbursements could not survive since Medicaid pays nearly 10% less than the median practice costs. (Flint Trial Tr. at 714:1-716:9; Pl.Ex. 105, at Bates No. MO3 000740-MO3 000741; Pl.Ex. 56; Pl.Ex. 57; Pl.Ex. 59; Rosenberg Trial Trans. at 79:9-25; Green Trial Tr. at 539:5-14.)

***14** 24. Physician professional societies regularly complain to the IDPA regarding the low Medicaid reimbursement rates and physician participation. (D. Saunders 11/26/02 Dep. Tr. at 235:7-236:10, 241:6-15; Powers Dep. Tr. at 165:20-167:17; S. Saunders Dep. Tr. at 170:23-172:19, 173:9-174:7; Rosenberg Trial Tr. at 80:1-85:22, 93:5-94:20; Lelyveld Trial Tr. at 345:8-347:24; Krug Trial Tr. at 278:22-280:12; Pl.Ex. 46; Pl.Ex. 59; Pl.Ex. 94.)

25. The primary issue for the provider constituency of the Illinois Chapter of the American Academy of Pediatrics ("ICAAP") is increasing provider participation in the Medicaid program through increases in pediatric reimbursement rates. A coalition of pediatricians and child advocacy groups is advocating with the State to increase reimbursement rates to pediatricians in order to increase the numbers of physicians participating in the Medicaid program. (Pl.Ex. 46; Rosenberg Trial Tr. at 95:21-96:4; Green Trial Tr. at 544:22-546:4; S. Saunders Dep. Tr. at 170:23-172:19, 173:9-174:7, 175:1-21, 179:14-180:12, 183:19-187:16; Lelyveld Trial Tr. at 345:8-347:24.)

26. ICAAP was unable to recruit its own membership to participate more fully in the Medicaid program during the contract period in which IDPA paid ICAAP to try and recruit more providers to participate in Medicaid. (Lelyveld Trial Tr. at 346:24-347:24.)

27. Pediatric departments that practice at major hospitals in Cook County have large Medicaid patient populations and are sustaining significant losses each year due to low Medicaid reimbursement rates. (Pl.Ex. 55; Pl.Ex. 56; Pl.Ex. 57, Pl.Ex. 59; Abelson Trial Tr. at 636:1-19, 637:1-9, 639:5-14; Green Trial Tr. at 538:13-539:14; Lelyveld Trial Tr. at 327:5-15, 330:10-331:4, 331:8-332:11, 33:9-334:3; Jurado Trial Tr. at 430:21-431:7; Krug Trial Tr. at 271:4-19, 271:20-272:5, 272:21-273:25, 295:15-20, 308:11-14.)

28. As part of his analysis, Dr. Flint also looked into the effect that low reimbursement rates have on a physician's willingness to provide care to Medicaid patients, including a comparison of the physician's willingness to provide care to privately insured children. (Flint Trial Tr. at 716:10-723:21.) Dr. Flint has been actively studying this issue for 25 years, and to prepare his report he canvassed a wealth of literature on this topic. (*Id.;* Pl.Ex. 105 at Bates No. MO3 000741-MO3 000743.)

29. The major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in the decision to participate in the Medicaid program at all, to

participate in a limited fashion, or to participate fully. When Medicaid rates are too low, physicians will opt to treat non-Medicaid children first or exclusively. Pediatricians also limit their Medicaid practices because of an unpredictable Medicaid payment system and Medicaid payment delays. (Flint Trial Tr. at 719:4-23, 721:15-722:1; Pl.Ex. 105 at Bates No. MO3 000741-MO3 000743.)

***15** 30. Pediatric practices throughout Cook County have closed to new Medicaid patients due to economic problems caused by a high Medicaid pediatric population and low Medicaid reimbursement rates and slow Medicaid payment systems. (Flint Trial Tr. at 721:15-723:5; Lelyveld Trial Tr. at 337:19-338:4, 342:14-344:22; Pl.Ex. 52; Abelson Trial Tr. at 639:19-642:1; 644:5-18; Jurado Trial Tr. at 432:17-434:23, 435:18-20, 436:19-22; Newman Trial Tr. at 660:16-662:13; S. Saunders Dep. Tr. at 183:19-187:16; Krug Trial Tr. at 291:12-295:9, 306:19-307:10.)

31. Pediatric patients throughout Cook County who are on Medicaid are more likely to be seen at a federally qualified health clinic ("FQHC") or a resident clinic rather than by a private pediatrician due to a limited number of private physicians who accept Medicaid. (Krug Trial Tr. at 293:12-295:9, 306:19-307:10; Lelyveld Trial Tr. at 337:19-338:4, 344:15-22; Jurado Trial Tr. at 438:8-439:2; D. Saunders 7/29/03 Dep. Tr. at 143:15-146:17.)

32. Medical care provided by a private pediatrician is superior to the care provided by a clinic or emergency room because a private physician can provide consistency and a medical home for a child. (Rosenberg Trial Tr. at 98:15-100:5.)

33. FQHC's are created and located to serve a neighborhood or population that the federal government has determined is medically underserved. (Ellinger Trial Tr. at 844:12-845:25.) In such cases, FQHCs are located to serve areas in which there are an insufficient number of other doctors to provide care to Medicaid-enrolled children in that area. (*Id.;* Ellinger Dep. Tr. at 54:9-55:23.)

34. FQHCs are reimbursed based on a flat encounter rate, meaning that they receive reimbursement for every visit on a given day by an eligible and enrolled individual, whether the individual simply sees a doctor or receives more care. (Werner Trial Tr. at 1059:6-13.) The encounter rates are set by federal statute based on reasonable costs. (Werner Trial Tr. at 1059:6-1060:6.)

35. The University of Chicago hospitals' pediatric department had a clinic on the south side of Chicago. The clinic's mission was, in part, to provide care to the poor. Previously, the clinic made an economic decision to close its practice to Medicaid patients and to open new practices in areas that do not have large Medicaid patient populations due to the low reimbursement rates for Medicaid. Only recently has the clinic begun seeing Medicaid patients again. (Abelson Trial Tr. at 640:21-641:12, 642:15-643:8; Lelyveld Trial Tr. at 342:14-344:4; Pl.Ex. 52.) The clinic was reopened because University of Chicago hospitals agreed to absorb the losses incurred in operating the clinic since it serves as a training site for residency programs. (Abelson Trial Tr. at 640:21-641:12.)

36. Children's Memorial Hospital has plans to expand its pediatric specialty care clinics in suburban areas that have a low percentage of Medicaid recipients. It cannot afford to expand care in areas with a high population of Medicaid patients due to the low reimbursement rates for Medicaid. (Green Trial Tr. at 539:21-541:18.)

***16** 37. Dentists limit the number of Medicaid patients they will see because their practices would fail financially if they accepted all Medicaid patients who presented themselves for treatment due to the Medicaid reimbursement rates. (Jurado Trial Tr. at 426:14-427:18, 428:17-429:5, 430:5-17, 430:21-431:7, 431:17-21, 432:17-434:23, 435:2-20; Pl.Ex. 59; Pl.Ex. 89; Pl.Ex. 91; Pl.Ex. 94.)

38. A pediatric dentist is a dentist that has spent two or three years in a residency program treating children only. Pediatric dentists treat children using behavior management techniques through non-pharmacologic and pharmacologic methods. (Jurado Trial Tr. at 416:3-418:25.)

39. There are virtually no pediatric dentists in Cook County who accept Medicaid reimbursement. Dentists have difficulty referring children with Medicaid to a pediatric dentist in Chicago because virtually all of the pediatric dentists in Cook County do not accept Medicaid patients. (Jurado Trial Tr. at 436:8-18, 437:5-439:2, 451:22-452:11.)

40. Children on Medicaid are less likely to see a pediatric dentist than children with private insurance due to the limited number of pediatric dentists who accept Medicaid reimbursement. (Jurado Trial Tr. at 436:19-22, 440:8-14, 452:9-453:14.)

41. Children who receive primary care in clinic

settings ordinarily must wait long periods of time for an appointment and, for a walk-in emergency, must wait in line often for hours or return on a different day. The crowded nature of clinics operates as a disincentive to seeking routine and timely well-child care. Children served by private-pay pediatric practices ordinarily receive much prompter appointments and access to care for emergencies without undue waiting. (Krug. Trial Tr. at 292:6-293:11; Abelson Trial Tr. at 641:13-642:1; Lelyveld Trial Tr. at 337:19-338:4, 341:24-342:10, 344:15-345:7; Jurado Trial Tr. at 435:2-20, 436:10-22.)

42. Parents of young children from time to time need to speak with their pediatrician at night and on weekends. Twenty-four hour emergency call capabilities are an important component of a pediatrician's service, and it can frequently provide needed information and avoid unnecessary trips to the emergency room. (Rosenberg Trial Tr. at 53:19-54:1, 96:10-97:9, 99:14-100:5; D. Saunders 7/29/03 Dep. Tr. at 27:24-29:2; Lelyveld Trial Tr. at 338:5-19, 338:25-339:23.)

43. Children on Medicaid rarely get vision and hearing screens from physicians who provide EPSDT services. (Pl.Ex. 119 at M03 000217-M03 000220; Pl.Ex. 18-20; Pl.Ex. 73-88; Branch Trial Tr. at 493:13-18; Hannum Trial Tr. at 373:13-19.)

44. Board certification of a physician is considered a marker of quality, training and level of competence. (Rosenberg Trial Tr. at 41:21-42:16.) Plaintiffs are more likely to be treated by a doctor who is not a board certified pediatrician due to the limited number of private board certified pediatricians who accept Medicaid. (*Id.* at 101:17-102:18.)

***17** 45. A physician must "enroll" in the Medicaid program to receive reimbursement from IDPA. (Luttrell Dep. Trans at 32-7-33:12.) In order to enroll, a provider need not make any commitment to see a certain number of children. (Werner Dep. Tr. at 58:14-59:11; Luttrell Dep. Tr. at 31:14-20, 32:7-33:12.)

46. Of enrolled doctors in Cook County who billed for treating children between July 1, 1998 and December 31, 2001, 63% did not provide a single EPSDT screening examination to any recipient during that same period and approximately 6% of enrolled doctors provided only one well-child examination during that same period of time. (Pl.Ex. 118 at Bates No. MO3 000728-30; Darling Trial Tr. at 165:24-168:21.)

47. Most doctors in Cook County will either not see children on Medicaid or significantly limit the number of children on Medicaid that they will accept as patients. (Krug Trial Tr. at 289:24-291:11, 293:12-295:9, 306:19-307:10, 313:24-314:15; Lelyveld Trial Tr. at 337:12-338:4, 342:14-344:14; Pl.Ex. 52; Rosenberg Trial Tr. at 67:15-68:18; Green Trial Tr. at 539:15-540:21; Jurado Trial Tr. at 438:8-439:2: Newman Trial Tr. at 660:16-662:13.)

48. Many providers will refer or "dump" Medicaid patients on the few hospitals and physicians who will accept Medicaid patients. (Abelson Trial Tr. at 634:24-635:24; Newman Trial Tr. at 664:24-665:25; Krug Trial Tr. 289:24-291:11.)

49. Doctors who practice in Cook County have difficulty finding a pediatrician or specialist who will accept referrals of Medicaid patients. Many pediatricians and specialists in Cook County limit their practice by not accepting Medicaid patients or accepting only a limited number of Medicaid patients. By contrast, it is much easier to refer patients with other forms of health insurance. (Krug Trial Tr. at 291:12-293:11, 293:12-295:9, 306:19-307:10; Lelyveld Trial Tr. at 341:24-345:7, Pl.Ex. 52; Rosenberg Trial Tr. at 70:12-20, 71:24-73:7; Jurado Trial Tr. at 438:8-439:2; Newman Trial Tr. at 663:8-665:25.)

50. A substantial number of children on Medicaid have had adverse health outcomes because they have not been able to see a pediatrician regularly due to their difficulty in finding a pediatrician. In addition, waiting times in specialty treatment clinics for the plaintiffs are long and oftentimes put patients in danger. (Krug Trial Tr. at 284:23-287:9, 288:3-25; Lelyveld Trial Tr. at 338:25-341:7, 344:15-345:7; Rosenberg Trial Tr. at 71:24-72:20; Jurado Trial Tr. at 435:2-436:7.)

51. A higher percentage of patients who are on Medicaid do not have a regular pediatrician. A much lower percentage of patients with other forms of insurance do not have a regular pediatrician. (Krug Trial Tr. at 284:23-285:17, 287:16-288:2, 289:1-23, 306:2-307:10; Lelyveld Trial Tr. at 338:20-24, 341:16-23, 347:25-348:12; Rosenberg Trial Tr. at 73:3-7.)

52. The numbers of pediatric patients on Medicaid coming to emergency rooms to receive treatment for primary care issues because they cannot find a primary care physician to treat them has been increasing significantly due to a lack of pediatricians who accept Medicaid. (Krug Trial Tr. at 284:23-

287:9; Lelyveld Trial Tr. at 327:5-15.)

***18** 53. Medicaid recipients have difficulty locating quality pediatric primary and specialty care providers and pediatric dentists for their children. IDPA and IDHS do not provide assistance to Medicaid recipients in locating quality pediatric primary and specialty care providers and pediatric dentists, scheduling medical appointments, or in arranging for transportation to health care providers. Medicaid recipients may have to travel great distances to find a dentist or pediatric provider willing to accept Medicaid, if they can find one at all. Children on Medicaid frequently seek care at emergency rooms because they cannot find a pediatrician willing to accept Medicaid. Medicaid recipients often must wait several hours to see a provider at a clinic willing to accept Medicaid. (Branch Trial Tr. at 491:9-495:20; Hannum Trial Tr. at 371:4-374:9, 377:8-380:8, 380:20-381:14, 383:2-14; Craft Trial Tr. at 484:12-488:8; Mauk Trial Tr. at 225:2-243:8, 244:8-24; Rosenberg Trial Tr. at 69:22-70:22, 102:12-18; Rodriguez Trial Tr. at 397:22-398:22; Lopez Dep. Tr. at 18:22-26:18, 34:1-35:19, 75:19-79:12, 79:18-86:5.)

54. Medicaid recipients must often engage in extensive efforts to locate dentists and pediatric primary and specialty care providers willing to accept Medicaid, including seeking referrals from state agencies or local charities, calling physicians listed in the phone book, and paying for care out of their own pockets. Medicaid recipients are often referred by the IDPA's hotline to doctors who are unwilling to accept new Medicaid patients. (Branch Trial Tr. at 495:9-20; Craft Trial Tr. at 484:12-488:8; Mauk Trial Tr. at 242:20-243:8; Bassler Trial Tr. at 355:22-360:1; Rodriguez Trial Tr. at 394:1-397:21; Hannum Trial Tr. at 366:23-371:3; Ellinger Dep. Tr. at 118:18-22, 119:6-120:10.)

55. Several Medicaid recipients testified at trial about problems they have had with Medicaid, including:

a. Yesinia Rodriguez testified that upon enrollment in the Medicaid program, she was not given any information about locating a doctor, was never given a provider directory, and when she asked her own IDHS caseworker for assistance in locating a doctor, her caseworker said that she does not give referrals. (Rodriguez Trial Tr. at 393:21-394:15.) Rodriguez also called the IDPA-administered hotline for a physician referral. She was given the names of approximately ten different doctors who all practiced more than 30 miles away. Not one accepted Medicaid. (Rodriguez Trial Tr. at 394:16-395:15.) Rodriguez called the hotline back, and was given an additional 20 referrals. Once again, not one of the doctors accepted Medicaid. (Rodriguez Trial Tr. at 395:16-396:11.)

b. Elissa Bassler called the IDPA-administered hotline for a physician referral. She was given the names of eight doctors, none of whom would accept Medicaid. (Bassler Trial Tr. at 356:5-357:6.)

c. Benita Branch testified that the one doctor she could find to treat her children on Medicaid would not take appointments. If her children needed medical care, she would have to go in, take a number and wait to be seen-often one to two hours. (Branch Trial Tr. at 493:19-494:19.)

***19** d. Sara Mauk testified that one of the doctors her daughter saw made Medicaid patients wait for an examination until the doctor had finished examining patients with private insurance. (Mauk Trial Tr. at 226:11-227:2.) Mauk also testified that her children could only be seen on certain days of the week because those were designated as "Medicaid days" at the doctors' offices. (*Id.* at 227:11-24.)

e. Bassler testified that she has a son, who is covered under private insurance, and she also serves as guardian for an 11-year-old-girl who is covered under Medicaid. When attempting to take the 11-year-old to the doctor for a throat culture, Bassler called the IDPA's KidCare hotline and was given the names of eight doctors in her area who took Medicaid. When Bassler called these doctors, all of them said that they did not take Medicaid. Bassler also testified that for the 11-year-old's counseling, none of the counseling agencies would take Medicaid and she pays the sliding fee scale out of pocket. By contrast, she has had no problems arranging care for her son. She even recently switched to a new doctor which was one of the doctors that was on the list given to her by the IDPA hotline that would not take Medicaid. (Bassler Trial Tr. at 356:18-360:2.)

f. Mauk testified that she has two adopted children, who are covered under Medicaid, and one biological son who is covered under private insurance. When asked to compare her obtaining medical care for her adopted children as opposed to her biological child, Mauk noted that for her adopted children there "was a lot of delays and I had to be extremely persistent on even getting a timely visit with a doctor and getting an appropriate doctor. And it was always a three-to-six month wait before getting any type of service or evaluation." (Mauk Trial Tr. at 242:25-243:1-5.) For her biological son, Mauk stated that "it was just, you

know, a week or ten days and I had the referral or the evaluation or the service." (*Id.* at 243:6-8.)

g. Hannum has one biological daughter who is covered under private insurance and three adopted children covered through Medicaid. For her biological daughter, Hannum stated that she never had any problem finding health care because "[w]hatever doctor I took her to, they took the insurance she had." (Hannum Trial Tr. at 366:21-22.) By contrast, for her adopted children, the same doctor who she took her biological daughter to would not see her adopted children on Medicaid. (*Id.* at 366:23-367:14.)

h. Parents of Medicaid recipients have in some instances had to resort to paying for medical care out of pocket in order to get specialty care for their children. (Mauk Trial Tr. at 229:17-236:9, 239:25-241:6; Bassler Trial Tr. at 358:21-359:15; Hannum Trial Tr. at 378:2-10, 379:18-380:8, 380:20-382:9, 383:2-14.)

56. IDPA staff admit that if reimbursement rates were increased, more providers would participate in the Medicaid program. (Powers Dep. Tr. at 69:21-78:13; D. Saunders 11/26/02 Dep. Tr. at 235:7-236:10; Kane 6/06/02 Dep. Tr. at 69:19, 125:17-126:21, 149:22-150:20, 217:5-218:8; Parker Dep. Tr. at 201:5-202:4, 204:7-12; Werner Dep. Tr. at 133:21-142:21, 153:15-154:14, 155:14-156:14.)

***20** 57. IDPA staff have also admitted that IDPA reimbursement rates are low and not very attractive and that they are lower than the usual and customary charges of physicians. (Ellinger Trial Tr. at 835:23-836:3.)

58. IDPA staff further admit that the length of the IDPA payment cycle affects physicians' willingness to participate in the Medicaid program. (D. Saunders 11/26/02 Dep. Tr. at 235:7-236:10; Werner Dep. Tr. at 159:12-23, 160:18-24; Kane 6/06/02 Dep. Tr. at 206:16-207:3; Parker Dep. Tr. at 204:7-12.)

59. When IDPA has increased rates for office-based medical services, there has been a corresponding increase in the number of office-based services billed by providers. (Kane 6/06/02 Dep. Tr. at 125:17-126:21, 139:14-140:16, 149:22-150:20.)

60. Both Dr. Steven Krug, head of the emergency room at Children's Memorial Hospital, and Dr. Steven Lelyveld, from the University of Chicago hospitals' pediatric emergency room, testified that Medicaid-insured children do not have access to primary care equal to that of privately-insured patients. (Krug Trial Tr. at 306:19-307:10; Lelyveld Trial Tr. at 347:25-348:12.) Dr. Krug testified that the access of Medicaid-enrolled children is "vastly diminished" and "not remotely close" compared with that of privately-insured children. (Krug Trial Tr. at 307:1-2.)

C. EPSDT Provisions

61. EPSDT is an acronym that means early and periodic screening, diagnostic and treatment program. (D. Saunders Trial Tr. at 866:23-867:1.)

62. EPSDT screenings, which are commonly referred to as "well-child" checkups, include the following components, as listed in 42 U.S.C. § 1396d(r)(1)(B): comprehensive health and developmental history, including assessment of both physical and mental development; comprehensive unclothed physical exams; appropriate immunizations according to age and health history; laboratory tests, including lead toxicity screenings; health education, including anticipatory guidance, vision and hearing screenings; and dental screenings. (D. Saunders Trial Tr. at 867:21-868:2.)

63. Under the EPSDT program, Illinois has adopted a periodicity schedule (or a schedule of periodic examinations, tests and services) that calls for seven appointments for health screening services in the first year of life, four appointments in the second year of life, and a decreasing number of annual appointments as a child becomes older. The periodicity schedule also calls for annual vision, hearing and dental screens, and two blood lead screens (at 12 and 24 months of age).

64. Appendix 9 to the IDPA's Handbook for Providers of Healthy Kids Services sets forth the periodicity schedule. It is largely based on the American Academy of Pediatrics' guidelines, but also allows for the recommendations or guidelines of other professional organizations which may vary slightly from the American Academy of Pediatrics' recommendations. (D. Saunders Trial Tr. at 872:13-16; Def. Ex. 4 at App. 9.)

***21** 65. The panoply of EPSDT services for children on Medicaid in Illinois and the system used to inform them of those services is generally called the "Healthy Kids Program." (Ellinger Trial Tr. at 801:18-803:3, D. Saunders 5/02/02 Dep. Tr. at 15:20-21, 23:4-15, 27:2-22; Pl.Ex. 127.)

66. IDPA has developed the policies for the Healthy

Kids Program. The program is supposed to deliver scheduled preventive health care and early diagnosis and treatment for the plaintiffs. (Ellinger Trial Tr. at 797:6-10, 799:22-25; Pl.Ex. 127; Pl.Ex. 140; D. Saunders 5/02/02 Dep. Tr. at 31:8-33:15.)

67. Timely screening for general medical, vision, hearing and dental conditions and providing immunizations are critical parts of a child's health care plan. The importance and cost-effectiveness of primary and preventive health care are well-documented by the medical community. Preventive health care, early treatment of acute illnesses, and amelioration of chronic illnesses early in life may prevent more costly and personally challenging health problems later. For example, a child who is not screened for hearing loss at an early opportunity is at significant risk for speech and language deficiencies. Similarly, a child who does not receive early blood tests to detect lead poisoning is at risk for inpatient hospitalization, invasive chelation treatment, and subsequent developmental delays or permanent harm. (Rosenberg Trial Tr. at 49:12-53:6; Green Trial Tr. at 543:5-24; Krug Trial Tr. at 283:9-287:9; 305:24-306:9; Jurado Trial Tr. 408:1-415:22.)

68. Children on Medicaid should have a regular source of care, a "medical home" which is accessible and where they will receive additional well-child visits on a timely basis because the pediatrician will encourage them to receive well-child care and instruct them to do so. (Green Trial Tr. at 542:25-543:17, 543:21-24 .)

69. If children receive one well-child visit at a medical home, it is more likely that they will receive additional well-child visits on a timely basis because the pediatrician will encourage them to receive well-child care and instruct them to do so. (Green Trial Tr. at 542:25-543:17, 543:21-24.)

70. It is a pediatrician's responsibility to guide parents as to when they should bring their children to the doctor for well-child visits and pediatricians are the experts in providing this guidance to parents. (Green Trial Tr. 557:11-21.)

71. The only records IDPA maintains on the Level of care provided to the individual plaintiffs is claims data from providers. In other words, IDPA keeps a child's health history by recording those medical services for which a provider has billed IDPA and IDPA has reimbursed the billing provider. (Rosenberg Trial Tr. at 62:5-63:13; Ryan 7/11/02 Dep. Tr. at 223:24-224:14, 226:4-228:3, 228:17-229:9.) Each reimbursed physician service is called an "encounter." This data is maintained in the IDPA's Medicaid Management Information System ("MMIS"), which contains information on all services and associated payments, as well as information pertaining to the providers and recipients of each service. (Powers Dep. Tr. at 97:12-98:15.)

***22** 72. Another computer system, called Cornerstone, collates information about certain tests and immunizations provided to the plaintiffs. The Cornerstone system purports to compile data from IDPA's MMIS as well as the Cook County Department of Health, the City of Chicago Department of Health, and not-for-profit community health agencies. (D. Saunders 7/29/03 Dep. Tr. at 108:10-24; Wrincik Dep. Tr. at 24:6-25:7, 42:6-43:11, 45:14-18, 64:8-17.) Because the Cornerstone system compiles disparate information from so many different organizations, and performs little quality assurance of that data, the information in Cornerstone is not considered reliable. (Darling Trial Tr. at 185:18-188:15; Wrincik Dep. Tr. 26:16-22, 89:3-21.)

73. MMIS and Cornerstone include data from WIC (Women, Infant and Children) clinics (D. Saunders Trial Tr. at 966:14-967:5); Family Case Management (*Id.* at 968 :15-969:9); FQHCs (*Id.* at 1125 :5-16); Managed Care Organizations ("MCOs") (*Id.* at 1124:13-1125:4); and school-based clinics. (*Id.* at 1226:9-19.)

74. The plaintiffs retained Dr. Thomas Darling ("Dr.Darling") to analyze the MMIS encounter data to determine the level of well-child services, blood lead screens, vision screens and hearing screens that have been provided to the plaintiffs for the period of July 1, 1998 through December 31, 2001 (the "Data Period"). Dr. Darling also analyzed the Cornerstone data as well as the MMIS data for this same period to determine the level of immunizations provided to the plaintiffs. In performing his analyses, Dr. Darling looked at children in Cook County who were both continuously eligible and non-continuously eligible for Medicaid so long as those children were eligible within the age ranges specified in each analysis even if they had a break in eligibility. (Darling Trial Tr. at 129:11-130:12, 131:24-135:18, 171:4-172:14, 169:12-171:3, Pl.Ex. 118, Pl.Ex. 119.)

75. Dr. Darling received his Ph.D. in 1994 from the Rockefeller College of Public Affairs and Policy, State University of New York at Albany. He is on the faculty of The School of Public Affairs at the University of Baltimore in Baltimore, Maryland. Dr. Darling has extensive professional and academic experience in conducting sophisticated analyses of

large amounts of data, including working with a variety of state agencies on developing outcome-based performance measures regarding the provision of social services to children. (Darling Trial Tr. at 123:4-129:8, 130:21-131:23, Pl.Ex. 117.)

76. Dr. Darling put all of the MMIS and Cornerstone encounter data into a computerized database using the Microsoft Access computer program. In creating the computerized database, Dr. Darling made adjustments to the database to eliminate data concerning services provided on or after January 1, 2002. In completing both his Expert Report and his Supplemental Report, Dr. Darling did not look at encounter data for the period of January 1, 2002 through August 2002 because it was incomplete and, therefore, the results would have been unfairly skewed against the defendants. In his Expert Report, Dr. Darling also adjusted the database to eliminate data for children who were not continuously eligible for Medicaid from July 1, 1998 through December 31, 2001. In so doing, Dr. Darling retained data from 89.7% of the children who were eligible for Medicaid at some point during the data period of July 1, 1998 through December 31, 2001. (Pl.Ex. 119 at Bates No. MO3 000715.) In his Supplemental Report, Dr. Darling reran the analyses of this Expert Report and included the children who were not continuously eligible for Medicaid during the data period of July 1, 1998 through December 31, 2001. Adding in the non-continuously Medicaid-eligible children with continuously Medicaid-eligible children changed the results less than two percentage points. (Darling Trial Tr. at 135:20-142:15, 142:16-155:20, 171:4-180:6, Pl.Ex. 118 at Bates No. MO3 000710-MO3 000716, Pl.Ex. 119 at Bates No. MO3 000205-MO3 000206.)

***23** 77. Dr. Darling then analyzed the services provided to the plaintiffs during the Data Period across a broad set of defined age ranges corresponding to the age categories in the EPSDT periodicity schedule to determine the level of service the plaintiffs should have received. For example, the Illinois periodicity schedule states that an infant after leaving the hospital at birth should receive well-child exams at two weeks, one month, two months, four months, six months and nine months. (Pl.Ex. 127, App. 10, at Bates No. 269295.) Dr. Darling analyzed the number of well-child examinations that were received by each child who was between the ages of ten days and eleven months of age during the Data Period to capture these exams. The plaintiffs assumed that all Medicaid-eligible children born in a hospital in Cook County received one EPSDT well-child service before leaving the hospital after birth. Thus, Dr. Darling began this age category at ten days of age in order to factor out any services received in the hospital as part of the birth and postpartum services and he ended at eleven months of age to allow a window of two months to catch the sixth and last scheduled well-child examination (i.e., the exam that should be done at nine months). (Darling Trial Tr. at 142:16-149:4, 171:25-174:6; Pl.Ex. 118, at Bates No. MO3 000716-MO3 000717; Pl.Ex. 119 at Bates No. MO3 000206-MO3 000208.)

78. Dr. Darling performed similar analyses of children in the following age groups: children who were 11 to 23 months of age (to capture the exams that should be given at 12 months, 15 months and 18 months); children who were 23 to 35 months of age (to capture exams that should be given at age two); children who were 35 to 47 months of age (to capture the exams that should be given at age three); children who were 47 to 59 months of age (to capture the exams that should be given at age four); and children who were 59 to 71 months of age (to capture the exams that should be given at age five) during the Data Period. (Darling Trial Tr. at 149:13-155:20, 171:4-14, 174:19-175:20; Pl.Ex. 118 at Bates No. MO3 000718-MO3 000722; Pl.Ex. 119 at Bates No. MO3 000208-MO3 000215.)

79. Dr. Darling also analyzed the number of children who received blood lead screenings, vision screenings, hearing screenings, Haemophilius B(HIB) immunizations, Polio (1PV) immunizations, Diphtheria and Tetanus (DtaP) immunizations, and Measles, Mumps and Rubella (MMR) immunizations. Dr. Darling further analyzed some key age specific services among the full set of required EPSDT services. For example, Dr. Darling analyzed the number of children who received the appropriate number of blood-lead level screens between the ages of 11 and 37 months, and also the number of children who received HIB immunizations between 10 days and 11 months of age. (Darling Trial Tr. at 155:21-165:23, 176:17-190:2; Pl.Ex. 118, at M03 000723-M03 000728; Pl.Ex. 119, at M03 000216-M03 000230.)

80. Dr. Darling's analyses show that a majority of Medicaid-enrolled children in Cook County did not receive sufficient medically necessary preventive health care as specified under the Illinois periodicity schedule, and a significant number-one-third or higher-did not receive any preventive health care at all. (Pl.Ex. 118, Pl.Ex. 119.)

***24** 81. In performing his analysis of the number of children that received appropriate well-child examinations, Dr. Darling looked at two categories of

examinations. The first category consists of examinations in which doctors are required to provide all components of an EPSDT screening (Dr. Darling described these services as "Health Moms Healthy Kids" examinations or "HMHK examinations" because these services satisfy the requirements of the EPSDT program, which is sometimes referred to as "Healthy Moms Healthy Kids" program). The second category includes those services that IDPA counts as "well-child" examinations when responding to CMS-Form 416, FN12 which includes HMHK examinations as well as other services such as prenatal examinations for pregnant teenagers and exams that last five minutes. (Darling Tr. Transp. at 142:18-144:16; Pl.Ex. 118; Pl.Ex. 119.) This category includes examinations that do not satisfy the requirements of an EPSDT screen, although IDPA has characterized them as meeting the EPSDT screen requirements. (Rosenberg Trial Tr. at 63:5-64:19; Pl.Ex. 72 at Bates No. 278369-278370, Line 6.) Dr. Darling referred to these as "IDPA well-child examinations." Dr. Darling also examined a set of examinations broader than well-child examinations. This third category includes "sick kid" visits. Dr. Darling referred to this category of visits as "any child exams." Thus, "HMHK examinations" are a subset of "IDPA well-child examinations" which in turn are a subset of "any child examinations." (Darling Trial Tr. at 143:20-22, 144:2-4; Pl.Ex. 118; Pl.Ex. 119.)

FN12. This form will be described *infra.*

82. Dr. Darling omitted from his analysis services provided in the first ten days of life. His analysis assumed that virtually every baby born in Illinois receives a well-child checkup before being discharged from the hospital. Including those visits in the analysis would not provide an accurate picture of the number of children who receive preventive health care after they leave the hospital postpartum. (Darling Trial Tr. at 144:20-145:15; Pl.Ex. 118; Pl.Ex. 119.)

83. Based on Dr. Darling's analysis, looking at both continuously Medicaid-eligible and non-continuously Medicaid-eligible children, of the Medicaid-eligible children who should have received six screening examinations during this time period, 60.6% received two screening examinations or less, with 43% not receiving a single screening examination. Only 8.25% received the proper level of services. (Darling Trial Tr. at 146:8-149:4, 172:15-174:18; Pl.Ex. 118; Pl.Ex. 119, at Bates No. MO3 000207.)

84. Cornerstone data measures the number of well-child exams received by children enrolled in the IDHS Family Case Management Program. The Cornerstone report shows that 45.3% of children in Cook County had no well-child visits in the first year of life, 16.4% had only one well-child visit, 10.9% had two well-child visits, and only 27.3% had three or more well-child visits. (S. Saunders Trial Tr. at 1219:16-1221:16; Def. Ex. 70 at Bates No. 283340.)

***25** 85. According to the Illinois periodicity schedule, children between the ages of 11 months and 23 months should receive three screening examinations: at 12 months, 15 months and 18 months. (Rosenberg Trial Tr. at 60:16-21; Pl.Ex. 127, § HK-203.11 at Bates No. 269187.) Based on Dr. Darling's analysis, of the Medicaid-eligible children who should have received three screening examinations during this time period, 65.3% received one screening examination or less, with 49.7% not receiving a single screening examination. (Darling Trial Tr. at 149:11-152:10, 174:19-175:20; Pl.Ex. 118, Table 2 at Bates No. MO3 000718; Pl.Ex. 119, Table S2b at Bates no. MO3 000209.)

86. According to the Illinois periodicity schedule, children between the ages of 23 months and 35 months should receive one screening examination at 24 months. (Pl.Ex. 127, § HK-203.11 at Bates No. 269187.) Based on Dr. Darling's analysis, of the Medicaid-eligible children who should have received one screening examination during this time period, 64.0% received none. (Darling Trial Tr. at 152:11-153:10, 174:19-175:20; Pl.Ex. 118 Table 3 at Bates No. MO3 000719; Pl.Ex. 119 Table S3b at Bates No. MO3 000210.)

87. According to the Illinois periodicity schedule, children between the ages of 35 months and 47 months should receive one screening examination at 36 months. (Pl.Ex. 127, § HK-203.11 at Bates No. 269187.) Based on Dr. Darling's analysis, of the Medicaid-eligible children who should have received one screening examination during this time period, 64.2% received none. (Darling Trial Tr. at 153:11-154:7, 174:19-175:20; Pl.Ex. 119 Table 4 at Bates No. MO3 000720; Pl.Ex. 119 Table S4b at Bates No. MO3 000212.)

88. According to the Illinois periodicity schedule, children between the ages of 47 months and 59 months should receive one screening examination at 48 months. (Pl.Ex. 127, § HK-203.11 at 269187.) Based on Dr. Darling's analysis, of the Medicaid-eligible children who should have received one screening examination during this time period, 59.8% received none. (Darling Trial Tr. at 154:8-25, 174:19-

175:20; Pl.Ex. 118 Table 5 at Bates No. MO3 000721; Pl.Ex. 119 Table S5b at Bates No. MO3 00213.)

89. According to the Illinois periodicity schedule, children between the ages of 59 months and 71 months should receive one screening examination at 60 months. (Pl.Ex. 127, § HK-203.11 at Bates No. 269187.) Based on Dr. Darling's analysis, of the Medicaid-eligible children who should have received one screening examination during this time period, 54.9% received none. (Darling Trial Tr. at 155:1-20, 174:19-175:20; Pl.Ex. 119 Table 6 at Bates No. MO3 000722; Pl.Ex. 119 Table S6b at Bates No. MO3 000215.)

90. In assessing immunization rates, Dr. Darling utilized all data made available-MMIS data and Cornerstone data. (Darling Trial Tr. at 180:7-183:25; Pl.Ex. 119 at Bates No. MO3 000225-MO3 000227.) Dr. Darling analyzed the Cornerstone data even though he had concerns about its reliability. (Darling Trial Tr. at 185:18-188:15.)

***26** 91. According to the Illinois periodicity schedule, children between the ages of 10 days and 11 months should receive three Haemophilus B(HIB) immunizations: at 2 months, 4 months and at 6 months. (Rosenberg Trial Tr. at 61:22-24; Pl.Ex. 27, App. 10 at Bates No. 269295.) Based on Dr. Darling's analysis, 48% of Medicaid-eligible children in Cook County did not receive even one HIB immunization between the ages of 10 days and 11 months. Another 9.6% received only one HIB immunization and 15.2% received only 2 HIB immunizations. Only 27.2% of all Medicaid-eligible children between 10 days and 11 months received the requisite three HIB immunizations. (Darling Trial Tr. at 184:1-185:17; Pl.Ex. 119 at Bates No. MO3 000227-MO3 000229.)

92. According to the Illinois periodicity schedule, children between the ages of 10 days and 5.5 months should receive two polio (IPV) immunizations: at 2 months and at 4 months. (Pl.Ex. 127, App. 10, at 269295.) Based on Dr. Darling's analysis, the MMIS and Cornerstone data combined show that 52.3% of Medicaid-eligible children in Cook County did not receive even one IPV immunization between the ages of 10 days and 5.5 months of age. Another 15.5% of Medicaid-eligible children in Cook County received only one IPV immunization in the same time period. (Darling Trial Tr. at 188:16-189:7, Pl.Ex. 119 at Bates No. MO3 000228.)

93. According to the Illinois periodicity schedule, children between the ages of 10 days and 11 months should receive three diphtheria and tetanus (DtaP) immunizations: at 2 months, at 4 months and at 6 months. (Pl.Ex. 127, App. 10, at Bates No. 269295.) Based on Dr. Darling's analysis, the MMIS and Cornerstone data combined show that 46.6% of Medicaid-eligible children in Cook County did not receive even one DtaP immunization between the age of 10 days and 11 months of age. Another 20.1% of Medicaid-eligible children in Cook County received only one or two DtaP immunizations in the same time period. (Darling Trial Tr. at 188:16-23; 189:8-13; Pl.Ex. 119 at Bates No. MO3 000229.)

94. According to the Illinois periodicity schedule, children should receive one Measles, Mumps and Rubella (MMR) immunization, which is due between 12 and 18 months of age. (Pl.Ex. 127, App. 10, at Bates No. 269295.) Based on Dr. Darling's analysis, the combined MMIS and Cornerstone data show that 56.6% of Medicaid-eligible children in Cook County did not receive even one MMR immunization between the ages of 11 and 25 months of age. (Darling Trial Tr. at 188:16-23, 189:14-17; Pl.Ex. 119 at Bates No. MO3 000229-MO3 000230 .)

95. Dr. Darling's analysis shows that despite the fact that Medicaid-eligible children should receive a blood-lead screening at 12 and 24 months, 77.9% of Medicaid-eligible children in Cook County between the ages of 11 months and 23 months did not receive a blood lead screening test. Finally, 60.5% of children in Cook County between the ages of 11 and 37 months did not receive a blood lead screening test. (Darling Trial Tr. at 154:20-158:4, 175:21-176:21; Pl.Ex. 119, Table S7a, b, c, at Bates No. MO3 000216-MO3 000217; Pl.Ex. 127, § HK-203.31 at Bates No. 269192-269193.)

***27** 96. Beginning at age three, an objective vision screening, using a standard method, is recommended annually for children between the ages of 3 through 6, and at 8, 10, 12, 15, and 18 years of age, according to the recommendations of the American Academy of Pediatrics ("AAP"). Thus, according to IDPA's Handbook of Providers of Healthy Kids services, children should receive one of their vision examinations at 36 months and another at 48 months. (Pl.Ex. 127, § HK-203.61, Bates No. 269201.) However, the State's data show, for example, that of the Medicaid-eligible children between the ages of 35 months and 47 months who should have received a vision examination during this time period, 97.3% did not receive one. (Darling Trial Tr. at 158:2-159:21, 176:22-177:3; Pl.Ex. 119, Table S8a, Bates No. MO3 000218.) Of Medicaid-eligible children in Cook County between the ages of 47 and 59 months,

95.2% did not receive a vision examination during this time period. (Pl.Ex. 119, Table S8b, Bates No. MO3 000218.) Similarly, of Medicaid-eligible children in Cook County between the ages of 35 and 59 months, 94.2% did not receive a vision screening during this time period. (Pl.Ex. 119, Table S8c, Bates No. MO3 000219.)

97. Objective hearing screening, using a standard testing method, is recommended annually for children between the ages of 4 and 6, and at 8, 10, 15 and 18 years of age, according to the AAP's recommendations. Thus, children should receive one of their hearing examinations at 48 months. (Pl.Ex. 127, § HK-203.62, Bates No. 269295.) Of the Medicaid-eligible children between the ages of 47 months and 59 months who should have received a hearing examination during the time period, 93.6% did not receive one. (Darling Trial Tr. at 159:22-161:2, 177:4-178:25; Pl.Ex. 119, Table S9b, Bates No. MO3 000220.)

98. Dr. Darling's analyses are credible and reliable. His reports are incorporated herein as findings of fact by this court. (Pl.Ex. 118; Pl.Ex. 119.)

99. A standard measure of appropriate immunizations for 19-35 month old children is a vaccination series termed 4-3-1-3 (4 doses DTP, 3 doses polio, 1 dose measles, mumps and rubella and 3 doses HIB.) The 4-3-1-3 series should be completed by 18 months of age. (Rosenberg Trial Tr. at 61:6-21; S. Saunders Trial Tr. at 1157:10-1159:7.)

100. Cornerstone immunization data from August 2003 for Cook County children enrolled in Medicaid shows that less than 40% of these children had completed the 4-3-1-3 vaccination series by 36 months of age. (Joint Ex. 9; D. Saunders 7/29/03 Dep. Tr. at 106:18-108:24.)

101. Pursuant to 42 U.S.C. § 1396(r), IDPA is required to prepare a form known as CMS-416 to report the level of care that children on Medicaid receive. IDPA submits this form annually to CMS. (D. Saunders Trial Tr. at 977:8-23, 981:20-982:18; Pl.Ex. 72.)

102. The CMS-416 shows the number of EPSDT encounters for certain age groups, which include (i) birth to attainment of age one; (ii) age one to attainment of age three; (iii) age three to attainment of age six; (iv) age six to attainment of age 10; (v) age 10 to attainment of age 15; (vi) age 15 to attainment of age 18; and (vii) ages 19 and 20. (Pl.Ex. 72, Bates No. 278368, Line 2a.)

***28** 103. The EPSDT encounters that are measured by IDPA as part of its CMS-416 reporting are (i) the total number of initial and periodic screening services received by children, adjusted by the proportion of the year for which they are Medicaid eligible; (ii) the number of unique children receiving at least one well-child examination; (iii) the number of unique children receiving blood-lead screenings; (iv) the number of children receiving preventive dental care; (v) the number of unique children receiving vision screenings; and (vi) the number of unique children receiving hearing screenings. (Pl.Ex. 72, Bates No. 278369-278371, Line 6-6I; Bates No. 278371-278372, Line 9-9I; Bates No. 278374, Lines 14-14F; Bates No. 278373, Line 12b; Bates No. 278375, Line 17; and Bates No. 278375, Line 15; D. Saunders 7/29/03 Dep. Tr. at 244:9-245:12, 247:10-18.)

104. IDPA has prepared instructions on how its staff should compile data to complete the CMS-416 form. Evidence was presented that the IDPA skews the reported data to make it appear as though IDPA's performance is better than it actually is, as set forth below:

a. Under the CMS-416 methodology, IDPA calculates a "screening ratio" for several different age groups: birth to attainment of age 1; ages 1-2; ages 3-5; ages 6-10; ages 11-14; ages 15-18; and ages 19-20. The "screening ratio" is calculated by dividing the total number of well-child screens received by children on Medicaid by the "expected" number of well-child screens. The "expected" number of well-child screens, for purposes of the CMS-416 screening ratio, is the product of (a) the total number of children eligible for EPSDT services, multiplied by (b) the number of well-child screens expected to be received by a child in each age group, multiplied by (c) the average period of eligibility for those children eligible for EPSDT services. This "screening ratio" methodology leads to misleading results because it allows IDPA to count more screens for each child than is indicated by the periodicity schedule, so long as the total number of screens for each child is less than the total number of screens required for the entire period of time in which the child is counted, *e.g.*, a child who is 5 is counted in the 3-5 year-old category and IDPA will count up to three well-child exams per year per child because the Illinois periodicity schedule provides that a child receive 3 well-child exams in the three-year period of ages 3-5. Under the examples posed to defendants' witness Debbie Saunders, she conceded that if the 3-5 year-old group had two children who are continuously eligible for Medicaid throughout a reporting year,

and one child received two exams and the other child received no exams in the reporting year, the methodology used by IDPA would show a screening ratio of 100%. (D. Saunders Trial Tr. at 1093:8-1099:4.)

b. IDPA determines a child's age for purposes of deciding which age group to count that child in for purposes of the CMS-416 by looking at his age on September 30, the last day of the federal fiscal year for which IDPA is completing the CMS-416 report. (D. Saunders Trial Tr. at 1101:4-10; Pl.Ex. 72 at Bates No. 278367.) This also overstates IDPA's EPSDT performance. Under the examples posed to Debbie Saunders, she conceded that because the methodology IDPA uses to complete the CMS-416 forms looks at the child's age on September 30, it understates the number of well-child exams that child is expected to receive. For example, a child born on August 1 would be two months old through 13 months old during the fiscal year. IDPA methodology would find that such a child who only received two well-child exams while aged 2 months to 14 months had received 100% of the expected well-child exams because the child is one year old on September 30. The 416 methodology provides that a 1-year-old child should receive two well-child screens. (Pl.Ex. 72 at Bates Nos. 278368-278369, Lines 2a, 2b and 2c.) That child, however, should receive five well-child exams at 2 months, 4 months, 6 months, 9 months and 12 months. (D. Saunders Trial Tr. at 1101:20-1114:21.)

***29** c. Similarly, the CMS-416 methodology that IDPA uses adjusts the number of well-child exams required by a child who is eligible for Medicaid for less than one full year, and this also leads to results that overstate IDPA's EPSDT performance. Under an example posed to Debbie Saunders, she conceded that when a child is born on January 1 of a year and is eligible for Medicaid for 8 months, IDPA will only look for 4 exams because the child is eligible for only two-thirds of a year and the number of well-child exams is adjusted to show two-thirds of six. (D. Saunders Trial Tr. at 1114:22-1117:14.) However, in such a scenario, the child should receive well-child screens at birth, at two weeks, one month, two months, four months and six months, for a total of six well-child exams pursuant to the Illinois periodicity schedule. (Pl.Ex. 127, § HK-203.11, Bates No. 269187.) Here, a child who received four well-child screens would be considered to have received 100% of required well-child exams even though he did not receive the number set forth on the Illinois periodicity schedule. (D. Saunders Trial Tr. at 1114:22-1117:15.)

105. IDPA also overcounts the number of screening examinations for Medicaid-eligible children. It counts many types of doctor visits that do not and cannot comply with the EPSDT well-child screening criteria, including prenatal visits and brief visits with a nurse lasting only a few minutes. (D. Saunders Trial Tr. at 1119:7-1120:13; Pl.Ex. 72 at Bates No. 298369-278370, Rosenberg Trial Tr. 63:14-64:19.)

106. Although the CMS-416 data that IDPA reports to CMS are statewide, IDPA also breaks out the underlying data for Cook County and for MCOs operating in Cook County. (S. Saunders Trial Tr. at 1031:17-1034:18.)

107. Even based on Illinois' own CMS-416 Reports (which, as stated above, are overstated), for federal fiscal years 2002, 2001 and 2000, one-third of children in Cook County enrolled in Medicaid did not receive any well-child screening services that are necessary to discover conditions that need corrective treatment. (Pl.Ex. 73, Bates No. 280684, Line 10; Pl.Ex. 74, Bates No. 276725, Line 10; Pl.Ex. 75, Bates No. 276718, Line 10.)

108. Pursuant to data used in completing CMS-416 Reports for federal fiscal years 2000-2002:

a. Over one-half of Medicaid-enrolled children ages 1-5 in Cook County did not receive blood lead screenings. (Pl.Ex. 73, Bates No. 280683 and Bates No. 280686 show that 59,340 children out of 193,665 children in the 1-5 age range received blood lead screenings in federal fiscal year 2002; Pl.Ex. 74, Bates Nos. 276724, Line 1 (for age groups 1-2 and 3-5 shows 189,662 children eligible for EPSDT) and 276729, Line 14.1 (for age groups 1-2 and 3-5 shows 52,558 received lead blood screens); Pl.Ex. 75, Bates No. 276717, Line 1 (for age groups 1-2 and 3-5 shows 179,113 children eligible for EPSDT) and 276722, Line 14.1 (for age groups 1-2 and 3-5 shows 44,115 children received blood lead screens));

***30** b. Approximately 90% of Medicaid-enrolled children in Cook County did not receive a vision screening. (Pl.Ex. 73, Bates Nos. 280683, Line 1 (total of 595,007 children eligible for EPSDT services), and 280687, Line 16A (total of 139,412 unique children receiving vision screens); Pl.Ex. 74, Bates Nos. 276724, Line 1 (total of 580,538 children eligible for EPSDT services), and 276730, Line 16A (total of 75,940 unique children receiving vision screens); Pl.Ex. 75, Bates No. 276717, Line 1 (total of 549,761 children eligible for EPSDT services), and 276723, Line 16A (total of 41,987 unique children

receiving vision screens));

c. Approximately 80% of Medicaid-enrolled children in Cook County did not receive a hearing screening. (Pl.Ex. 73, Bates Nos. 280683, Line 1 (total of 595,007 children eligible for EPSDT services), and 280687, Line 15A (total of 122,936 unique children receiving hearing screens); Pl.Ex. 74, Bates Nos. 276724, Line 1 (total of 580,538 children eligible for EPSDT services), and 276730, Line 15A (total of 77,590 unique children receiving hearing screens); Pl.Ex. 75, Bates No. 276717, Line 1 (total of 549,761 children eligible for EPSDT services), and 276723, Line 15A (total of 30,618 unique children receiving hearing screens)); and

d. Approximately 75% of Medicaid-enrolled children in Cook County did not receive a dental screening. (Pl.Ex. 73, Bates Nos. 280683, Line 1 (total of 595,007 children eligible for EPSDT services), and 280685, Line 12B (total of 146,172 unique children receiving dental screens); Pl.Ex. 74, Bates Nos. 276724, Line 1 (total of 580,538 children eligible for EPSDT services), and 276728, Line 12B (total of 160,714 unique children receiving dental screens); and Pl.Ex. 75, Bates No. 276717, Line 1 (total of 549,761 children eligible for EPSDT services), and 276721, Line 12B (total of 146,162 unique children receiving dental screens)).

109. Five MCOs cover Medicaid-enrolled children in Cook County: Amerigroup Illinois, Inc.; Family Health Network; Harmony Health Plan of Illinois, Inc; Humana Health Plan, Inc.; and United Healthcare of Illinois, Inc. Fewer than 20% of the plaintiffs receive care from MCOs. (D. Saunders Trial Tr. at 923:4-15; Kane 12/03/02 Dep. Tr. at 256:2-8.)

110. MCOs are paid by IDPA on a capitated basis-a per member, per month fee for an enrollee based on age and sex. (D. Saunders Trial Tr. at 936:2-22; Werner Trial Tr. at 1057:9-1058:3.) Some MCOs contract to pay their physicians on a capitated basis and those physicians are not required to submit a claim form detailing services provided to receive payment from the MCO. (Goldsmith Trial Tr. at 507:4-508:14.)

111. Each of the five MCO contracts with the State provides that the MCO shall ensure that all of the children enrolled receive all EPSDT services and, at a minimum, that 80% of all children enrolled received EPSDT services. (Joint Ex. 20.) The State of Illinois is entitled to sanction MCOs for contractual noncompliance. The State has never enforced any provision of the five MCO contracts through available sanctions. (D. Saunders Trial Tr. at 1121:3-1122:5; D. Saunders 5/2/02 Dep. Tr. at 121:16-122:3; D. Saunders 11/26/02 Dep. Tr. at 304:13-305:4, 323:2-18, 320:14-322:24, 323:2-18; Ryan 11/26/02 Dep. Tr. at 373:24-373:23, 374:6-8, 374:14-16, 449:12-451:1, 462:6-9, 472:1-14, 473:20-474:2, 476:14-477:4, 478:22-480:2, 480:19-23; Parker Dep. Tr. at 83:20-22, 169:17-170:23; Carter Dep. Tr. at 66:5-17, 99:20-101:2; Joint Ex. 3-Joint Ex. 7.)

***31** 112. MCOs are required by contract to report all services provided to Medicaid recipients as if it were a fee for service (encounter data) to the IDPA. (D. Saunders Trial Tr. at 899:1-3.)

113. Encounter data reported to the IDPA from MCOs must meet the same edits as a fee for service claim, and IDPA rejects much of the MCO encounter data for failing to meet the edits of the claims processing system. (D. Saunders Trial Tr. at 898:15-899:18.)

114. If encounter data from MCOs for an individual is rejected, it is not included in the paid claims file for that individual. (D. Saunders Trial Tr. at 949:18-950:4.)

115. Based on the CMS-416 "participant ratios" for MCOs, the rates for receiving EPSDT services for MCO participants is no better than the rates for receiving care outside of MCOs. Using the CMS-416 methodology, IDPA calculates the "participant ratio." The numerator in the "participant ratio" is an unduplicated count of those children who received at least one well-child screening during the year covered by the 416 data. The denominator in the ratio is the product of three factors: (a) the number of total Medicaid-eligible children who should receive at least one well-child screening, multiplied by (b) the number of well-child screenings expected to be received by an individual in each age group in one year, multiplied by (c) the average period that each child in the age group was eligible for Medicaid during the year. In federal fiscal year 2002, (a) United Health Care of Illinois had a "participant ratio" for all age groups of .219 (Pl.Ex. 73, Bates No. 280689, Line 10); (b) Amerigroup Illinois had a "participant ratio" for all age groups of .418 (Pl.Ex. 73, Bates No. 280694, Line 10); (c) Family Health Network had a "participant ratio" for all age groups of .550 (Pl.Ex. 73, Bates No. 280699, Line 10); (d) Humana Health Plan, Inc. had a "participant ratio" for all age groups of .226 (Pl.Ex. 73, Bates No. 280704, Line 10); and Harmony Health Plan of Illinois had a "participant ratio" for all age groups

of .389 (Pl.Ex. 73, Bates No. 280709, Line 10.)

116. Annually, many of the MCOs prepare reports under the aegis of the National Committee on Quality Assurance ("NCQA"), the MCO credentialing organization. These are commonly known as HEDIS reports. (Ryan 11/26/02 Dep. Tr. at 359:17-360:4, 374:6-8, 374:14-16; 464:21-466:6; D. Saunders 7/29/03 Dep. Tr. at 88:6-21, 94:7-10; 94:20-95:5.)

117. On October 2, 2002, Nelly Ryan, IDPA Division of Medical Programs, wrote the five MCOs that provide services to Medicaid enrolled children in Cook County and outlined each MCO's malperformance in providing well-child exams (based on data used to prepare the CMS-416) and immunizations (based on Cornerstone data) to MCO-enrolled Medicaid-eligible children. Ryan indicated to each of the five MCOs that "from an analysis of the administrative data set and from the [MCO's] reports of HEDIS measurements and analysis of focused studies, [the MCO] is not yet achieving the participation goals set forth in the MCO contract at Article 5.13 Required Minimum Standards of Care." (Joint Ex. 8; Pl.Ex. 8, Pl.Ex. 12; Pl.Ex. 14; Pl.Ex. 16; Ryan 11/26/02 Dep. Tr. at 372:24-373:23; 374:6-8, 374:14-16, 449:12-451:1, 462:6-9, 472:1-472:14, 473:20-474:2, 476:14-477:4, 478:22-480:2, 480:9-23.)

***32** 118. Cornerstone immunization data from August 2003 for each MCO covering children on Medicaid in Cook County show that 60-70% of children enrolled in those MCOs have not completed the 4-3-1-3 vaccination series by 36 months of age. (Joint Ex. 10, Bates Nos. 285242-285244 (Humana Health Plan-only 29.32% of children in the plan had completed 4-3-1-3 shot series by 36 months of age), Bates Nos. 285245-285247 (Americaid Community Choice-only 29.05% of children in the plan had completed 4-3-1-3 shot series by 36 months of age), Bates No. 285248-285250 (Family Health Network-only 37.08% of children in the plan had completed 4-3-1-3 shot series by 36 months of age), Bates Nos. 285251-285253 (Harmony Health Plan-33.32% of children in the plan had completed 4-3-1-3 shot series by 36 months of age), and Bates Nos. 285254-285256 (United Healthcare-27.08% of children in the plan had completed 4-3-1-3 shot series by 36 months of age).

119. Based on data used to prepare the CMS-416 for federal fiscal year 2002, Medicaid-enrolled children in United Healthcare MCO had the following results:

a. Only 22% of children received a well-child screen. (Pl.Ex. 73, Bates No. 280689, Line 10 ("Participation Ratio");

b. Only 28% of children ages 3-20 received a dental screen; of 19,998 Medicaid-eligible children ages 3-20 in United Healthcare (Pl.Ex. 73 Bates No. 280688, Line 1 (total of children in age groups 3-5, 6-9, 10-14, 15-18, and 19-20)), only 5,536 children received preventive dental services. (*Id.* at Bates No. 280690, Line 12B total of children in age groups 3-5, 6-9, 10-14, 15-18, and 19-20);

c. Only 29% of children ages 1-5 received a blood lead screen; of 5,777 Medicaid-eligible children ages 0-5 in United Healthcare (Pl.Ex. 73 Bates No. 280688, Line 1 (total of children in age groups zero, 1-2, and 3-5)), only 1,166 children received blood lead screenings. (*Id.* at Bates No. 280691, Line 14A (total of children in age groups zero, 1-2, and 3-5));

d. Only 34% of children ages 3-20 received a hearing screen; of 19,998 Medicaid-eligible children ages 3-20 in United Healthcare (Pl.Ex. 73 Bates No. 280688, Line 1 (total of children in age groups 3-5, 6-9, 10-14, 15-18, and 19-20)), only 6,766 children received hearing screens. (*Id.* at Bates No. 280692, Line 15A (total of children in age groups 3-5, 6-9, 10-14, 15-18, and 19-20)); and

e. Only 40% of children ages 3-20 received a vision screen; of 19,998 Medicaid-eligible children ages 3-20 in United Healthcare (Pl.Ex. 73, Bates No. 280688, Line 1 (total of children in age groups 3-5, 6-9, 10-14, 15-18, and 19-20)), only 8,070 children received hearing screens. (*Id.* at Bates No. 280692, Line 16A (total of children in age groups 3-5, 6-9, 10-14, 15-18, and 19-20)).

120. No MCO that has ever contracted with IDPA to provide services to the Medicaid population in Cook County has met the EPSDT requirements in the MCO Contracts. (D. Saunders Trial Trans. at 1007:25-1008:8; Ryan 11/26/02 Dep. Tr. at 372:24-373:23, 374:6-8, 374:14-16, 449:12-451:1, 462:6-9, 472:1-472:14, 473:20-474:2, 476:14-477:4, 478:22-480:2, 480:19-23; D. Saunders 5/2/02 Dep. Tr. at 121:16-122:3; D. Saunders 11/26/02 Dep. Tr. at 309:12-18, 325:2-6, 325:13-17, 334:1-5, 334:11-15, 344:10-345:21; Carter Dep. Tr., 99:20-101:2.)

***33** 121. The State uses two documents to describe its Healthy Kids (EPSDT) program to families enrolling in Medicaid. The first is a four-page form, and is called "Healthy Kids: Good Health for Children and Teens" (IDPA Form 1123). (Joint Ex. 23; Lopez Dep. Tr. at 18:22-26:18, 34:1-35:19,

41:11-42:1, 46:7-48:10.) The second document is the KidCare Member Handbook, which is 89 pages long and explains (1) benefits, coverage and responsibilities such as co-pays; (2) premiums; (3) the periodicity schedule for examinations and immunizations; and (4) grievance and appeal forms. (Joint Ex. 11; Carter Dep. Tr. at 139:5-146:4; Longo Dep. Tr. at 91:15-93:14, 93:15-96:4, 96:11-97:21.)

122. Children and their families can apply for Medicaid coverage and be enrolled in three different ways. The documents describing the Healthy Kids Program that plaintiffs receive vary depending on which method they happen to choose. The three application methods are (1) applying for Medicaid benefits through a local IDHS office, either in person or by mail; (2) mailing a KidCare application to the IDPA KidCare central processing unit; or (3) completing a KidCare application with a KidCare application agent who then sends the KidCare application to the IDPA KidCare central processing unit. (Lopez Dep. Tr. at 13:18-14:15, 15:13-21, 18:22-26:18, 34:1-35:19, 41:11-42:1, 46:7-48:10; Ryan 7/11/02 Dep. Tr. at 45:1-46:10, 46:23-47:2, 50:8-51:5; Longo Dep. Tr. at 43:2-46:22, 49:15-52:21, 93:15-96:4.) IDPA uses KidCare application agents to assist applicants for KidCare in applying for coverage (but not in providing assistance in finding care).

123. Children who apply for Medicaid through the local IDHS office are supposed to be informed by local IDHS staff about the Healthy Kids Program when they apply and be given the four-page Form 1123 entitled Healthy Kids: Good Health for Children and Teens. (Lopez Dep. Tr. at 18:22-26:18, 41:11-42:1; Pl.Ex. 140.) The State does not provide the KidCare Member Handbook to any of the children and their families who apply at local IDHS offices. (Longo Dep. Tr. at 62:14-24, 63:1-17; Lopez Dep. Tr. at 41:11-42:1; Carter Dep. Tr. at 136:20-24.) Moreover, neither IDHS nor IDPA track or otherwise monitor whether these children and their families are actually told about the Healthy Kids program or receive Form 1123. (B. Lopez Dep. Tr., 69:19-71:15; N. Ryan 7/11/02 Dep. Tr., 184:22-186:14; K. Carter Dep. Tr., 149:2-21.) There are (a) no policies or procedures in place to govern how such oral notice is to be given, including content and manner; (b) no training manuals relating to advising recipients as to the Healthy Kids program; and (c) no accountability systems to assure that IDHS caseworkers actually give oral notice of EPSDT services/availability. (Lopez Dep. Tr. at 40:11-41:4, 69:19-71:15; Ryan 7/11/02 Dep. Tr. at 184:22-186:14; Carter Dep. Tr. at 129:14-23, 139:5-146:4; Rodriguez Trial Tr. at 394:1-15.)

124. Children who apply for KidCare through the IDPA KidCare central processing unit are provided with a copy of the KidCare Member Handbook, but not a copy of Form 1123. The staff at the IDPA KidCare central processing unit do not have any duty to call persons they enroll in the Medicaid program to orally explain the EPSDT program. In fact, IDPA has no written policy on how it orally informs children and families of the EPSDT program or the benefits of preventive health care when they are applying for Medicaid through the mail. (Longo Dep. Tr. at 43:2-46:22, 49:15-52:21, 62:14-24, 63:1-17, 91:15-93:14, 93:15-96:14, 96:11-97:21, 98:7-99:15, 105:13-19; Joint Ex. 11.)

***34** 125. KidCare application agents are neither instructed nor required to inform applicants about the specifics of the Healthy Kids program. (Longo Dep. Tr. at 48:18-21, 96:11-97:21, 98:7-99:15; Joint Ex. 11; Joint Ex. 21.) Thus, there is no reason to believe that children and their families who apply for KidCare through KidCare application agents uniformly receive any appropriate oral information about the EPSDT program or the benefits of preventive health care.

126. IDPA Form 1802 is a one-page document sent by the IDHS Central Office annually to all children enrolled in Medicaid to inform them about the EPSDT program. (Admitted, DRFFCL, DRPUF ¶ 257; Joint Ex.18; Joint Ex. 19.)

127. IDPA Form 2286 is sent to children prior to the due date of each periodic examination, as set by the EPSDT periodicity schedule for well-child exams. (Admitted, DRFFCL.) The notice only mentions well-child examinations, not blood lead screens or immunizations. (Pl.Ex. 37; Def. Ex. 76.) The form advises that plaintiffs "may" be due for an exam. (Admitted, DRFFCL; Pl.Ex. 37.)

128. There are no other forms that IDPA or IDHS use to disseminate information to children and families applying for Medicaid about the EPSDT services or the Healthy Kids program. (Carter Dep. Tr. at 139:5-146:4; Longo Dep. Tr. at 96:11-97:21; Lopez Dep. Tr. at 41:11-42:1.)

129. Many Medicaid recipients receive no EPSDT notices at all. (Hannum Trial Tr. at 365:21-23; Craft Trial Tr. at 484:2-11; Mauk Trial Tr. at 218:9-19.)

130. IDPA has not and does not survey or study whether recipients receive automated periodicity

notices or whether these notices are an effective way of notifying parents to take their children to medical providers. (D. Saunders Trial Tr. at 885:16-24; Carter Dep. Tr. at 139:5-146:4, 146:18-148:5, 149:2-21, 151:8-14; Ellinger Dep. Tr. at 84:21-85:7.)

131. IDPA does not evaluate the effectiveness of its notices or brochures as to particular recipients based on those recipients' individual Medicaid usage and history. (Admitted, DRPUF ¶ 274; Carter Dep. Tr. at 151:8-14.)

132. IDPA develops its written EPSDT notices-Forms 1123, 1802, and 2286-in-house. (Admitted, DRPUF ¶ 266; Carter Dep. Tr. at 139:5-146:4; Wyatt Dep. Tr. at 128:6-130:20; Joint Ex. 23; Joint Ex. 18; Pl.Ex. 37.) IDPA does not field test these forms with focus groups or other Medicaid recipient audiences. (Carter Dep. Tr. at 156:14-17.) IDPA also does not use outside linguists in developing or evaluating these materials to ensure that they are readable by persons with limited education, nor does IDPA use cultural experts to develop or evaluate them for people who are illiterate, have limited English proficiency, or limited American cultural literacy. (Wyatt Dep. Tr. at 128:6-130:20; Ellinger Dep. Tr. at 77:16-79:24; 80:1-14.)

133. IDPA has not studied the most effective mix of oral and written material for informing recipients about EPSDT. (Ellinger 7/17/03 Dep. Tr. at 85:18-86:2; Carter Dep. Tr. at 166:19-170:9.)

***35** 134. The plaintiffs retained Dr. Timothy Shanahan to analyze the EPSDT notices for readability and understandability by their target audience of Medicaid families in Cook County. (Pl.Ex. 102 (Shanahan Expert Report).) Dr. Shanahan received his Ph.D. in education at the University of Delaware. He is a professor at the University of Illinois at Chicago and director of the UIC Center for Literacy. He has served on and is chairing national panels on literacy and reading, has published 150 articles on these subjects, and has won several awards, including an award from the International Reading Association for research on document readability. He has substantial knowledge of the literacy of low-income populations in Cook County, the design of documents intended to provide health information to low-income populations in Cook County, and the analysis of documents intended to provide health information to low-income populations in Cook County. Virtually all of his work on designing or analyzing documents has involved target audiences of low-income people in Cook County. (Shanahan Trial Tr. at 559:6-566:4, 570:16-571:18.)

135. Dr. Shanahan opined that the readability of documents used for public health purposes should have difficulty levels of approximately grades four to six. (Shanahan Trial Tr. at 577:5-20, 598:9-16, 602:5-11; Pl.Ex. 102, Bates No. MO3 000176.) He further opined that the State's written methods for informing families about EPSDT services are ineffective because they are too difficult to read for many parents and children. According to Dr. Shanahan, parts of IDPA Form 1123, used to inform families who are enrolling in Medicaid about the Healthy Kids program, are geared to grade seven. FN13 (Shanahan Trial Tr. at 590:12-592:25; Pl.Ex. 102, Bates Nos. MO3 000170-MO3 000172.) Dr. Shanahan also stated that the child screening examination and immunization forms included in IDPA Form 1123 are difficult to read. The IDPA Form 2286, a letter sent to parents informing them that their child is due for a checkup, is geared to an eighth-grade reading level and is too difficult to read for many families enrolled in Medicaid. FN14 (Shanahan Trial Tr. at 581:1-589:9; Pl.Ex. 102, MO3 000175.) Finally, Dr. Shanahan stated that the 89-page manual is even more complex. (Shanahan Trial Tr. at 569:16-570:15.)

> FN13. Dr. Shanahan analyzed three of the four pages of Form 1123 (he did not analyze the cover page). The pages he looked at are: 244004 (same as Joint Ex. 23, Bates No. 27742), 244005 (same as Joint Ex. 23, Bates No. 277743) and 244006 (same as Joint Ex. 23, Bates No. 277744.)
>
> FN14. Pl.Ex. 37, Bates No. 269358 and Def. Ex. 76, Bates No. 277745, are the same notice with different type fonts. Dr. Shanahan analyzed Pl.Ex. 37.

136. If health information is especially long, such as 80 pages, or more difficult than the reading competency among the target population, then the best and only way to communicate the information is to combine an oral presentation with the written material. (Shanahan Trial Tr. at 569:16-570:15.)

137. For health-related informational materials targeted to low income populations, the fourth to sixth grade level will successfully communicate to the largest segment of the target population. The higher the grade level, the more challenging the document is for increasingly larger numbers of people. (Shanahan Trial Tr. at 577:5-20, 598:9-16, 602:5-11; Pl.Ex. 102, Bates No. MO3 000176.)

***36** 138. In Cook County, any document written at the eighth grade level would present a significant challenge to at least 200,000 people over the age of 25 according to the U.S. census. (Shanahan Trial Tr. at 585:13-24, 587:5-588:12; Pl.Ex. 102, Bates No. MO3 000176.)

139. The IDPA Form 2286, which is the letter sent to parents informing them that their child is due for a checkup, is geared to the eighth grade level and is "much too hard ... [and has] formatting problems ... that would make it even harder." As such, it "would miss a significant portion of, say, the low income population in Chicago." (Shanahan Trial Tr. at 588:14-589:9, 589:12-590:10; Pl.Ex. 102, Bates Nos. MO3 000175-MO3 000176.)

140. As to all of the documents Dr. Shanahan analyzed, he summarized, "My testimony is that these documents are difficult. And if this is the primary way of putting this information out, a significant portion of the population won't understand them." (Shanahan Trial Tr. at 608:4-6; Pl.Ex. 102, Bates No. MO3 000176.)

141. The court finds Dr. Shanahan's testimony and report to be reliable and credible.

142. IDPA and IDHS do not have written policies regarding how to inform applicants or recipients who are blind or deaf about EPSDT, and it has no materials or people to effectively provide the necessary information to these recipients. (Lopez Dep. Tr. at 40:11-41:4.)

143. IDPA and IDHS do not have EPSDT notices in any languages other than English or Spanish. (Admitted, DRFFCL, DRPUF ¶ 278.)

144. IDPA and IDHS do not have any written policies regarding how to inform applicants who do not speak English or Spanish about EPSDT. (Lopez Dep. Tr. at 40:11-41:4.) The State does not translate IDPA Forms 1123, 1802, and 2286 into any languages other than English and Spanish. (Admitted, DRPUF ¶ 278.) IDPA and IDHS have not presented any evidence of any other methods for publicizing the EPSDT program to non-English and non-Spanish speaking populations.

145. IDPA has in the past recognized that in order to get recipients' attention with respect to health care issues, "you have to have multiple methods multiple times." (Longo Dep. Tr. at 106:1-108:17; D. Saunders 7/29/03 Dep. Tr. at 39:23-40:20.) Accordingly, when IDPA has attempted to increase the number of children *enrolled* in the KidCare program, it has used various methods including (i) public service announcements on television and radio; (ii) public presentations at fairs and festivals; (iii) public presentations at community meetings; (iv) grants to community groups to assist in promoting KidCare to hard-to-reach groups or targeted groups such as families in certain ethnic groups, families in rural areas, and families who do not speak English; (v) radio, television, newspaper, and community advocacy directed to African-American families; (vi) radio, television, newspaper, and community advocacy directed at Hispanic and Spanish-speaking families; (vii) sponsorship of events such as the Ringling Brothers Barnum and Bailey Circus; (viii) general advertising radio, newspaper, and bus billboards in the Chicago area; (ix) mass transit advertising; and (x) distribution of KidCare-branded objects such as bookmarks, tattoos, stickers, coloring books, crayons, balloons, pins, and hand fans at fairs. (Admitted in part, DRPUF ¶ ¶ 230, 231; DUF ¶ 93; Longo Dep. Tr. at 106:1-108:17; D. Saunders 7/29/03 Dep. Tr. at 39:23-40:20.)

***37** 146. However, in providing information about EPSDT to those already enrolled in Medicaid, IDPA has not used *any* of these methods. (Carter Dep. Tr. at 166:19-170:9; Ellinger Dep. Tr. at 85:18-86:2.)

147. The State has not issued guidance or instructions to non-primary care medical providers (such as emergency room doctors, hospitals, and specialists) about informing emergency room, acute care or specialty patients about EPSDT services. (Carter Dep. Tr. at 166:19-170:9.)

148. The State does not provide financial incentives for successful referrals of children receiving Medicaid to EPSDT providers. (Admitted, DRFFCL, DRPUF ¶ 304.)

149. Neither IDPA nor IDHS has widely disseminated information regarding the availability of EPSDT and the benefits of preventive health care by outreach activities such as (i) the development of cooperation agreements with local school districts, public health agencies, clinics, hospitals and other health care providers, including developmental disability and mental health providers, or with charities, to notify the constituents of EPSDT; (ii) using the media for public service announcements and advertisements of EPSDT; or (iii) developing posters advertising EPSDT for display in hospital and clinic waiting rooms. (Carter Dep. Tr. at 166:19-170:9; Ellinger Dep. Tr. at 85:18-86:2; S. Saunders Dep. Tr. at 238:16-241:4; Lopez Dep. Tr. at 87:13-

20.)

150. IDPA provides a general hotline to field all calls from recipients or applicants who may have questions of any kind. (Admitted, DUF ¶ 97.)

151. The hotline manual used to guide the staff who answer hotline calls is over 1,000 pages and contains information on various aspects of the Medicaid program for adults as well as children. (Admitted, DRFFCL, DRPUF ¶ 314.) There was no evidence that hotline operators are trained in any appropriate way to provide this broad range of information. Moreover, the hotline is often understaffed and as a result has had a call abandonment rate as high as 25%. (Carter Dep. Tr. at 162:11-165:4.)

152. For Medicaid recipients who request assistance in finding a doctor, the hotline provides names of doctors "participating" in Medicaid in the caller's zip code. However, IDPA includes in its hotline referral database every doctor who has billed Medicaid for a service even once within the prior 18 months. (Admitted, DRFFCL; Carter Dep. Tr. at 162:11-165:4; Parker Dep. Tr. at 187:15-24.) IDPA does not determine, at the time it gives out the name of a specific doctor, whether that doctor is then taking new Medicaid patients. (*Id.*)

153. Doral Dental Services of Illinois, the administrator of IDPA's dental program, maintains a provider database of dental providers enrolled in the Medicaid program in Cook County. Doral also provides a general hotline for recipients.

154. Doral's network provider database includes dental providers who have not billed Medicaid for a single service within the preceding 30 months. Throughout that 30-month period, that provider's referral status remains as whatever that provider last designated as their referral status and there is no notation of any inactivity made in Doral's network provider database. (Wiertzema Trial Tr. at 462:12-464:14.)

***38** 155. IDPA does not attempt to maintain information regarding the willingness or availability of doctors listed in the hotline database to accept Medicaid patients (Admitted, DRPUF ¶ 324; Luttrell Dep. Tr. at 32:7-33:12; Parker Dep. Tr. at 187:15-24; Carter Dep. Tr. at 162:11-165:4), although more than 60% of the doctors in Cook County who had treated children from July 1, 1998 through December 31, 2001 had not provided a single preventive care service to a Medicaid child. (Pl.Ex. 118, Bates Nos. MO3 000728-MO3 000730; Darling Trial Tr. at 165:24-168:21.)

156. IDPA does not attempt to maintain information regarding the number of Medicaid patients a given provider in the hotline database will accept. (Admitted, DRFFCL, DRPUF ¶ 325; D. Saunders 5/2/02 Dep. Tr. at 195:12-17.) IDPA does not request information from enrolled providers on their availability to accept Medicaid patients. (*Id.*) Physicians will stay on the IDPA hotline referral list as an active provider even if their practice is closed to new Medicaid patients, and even if the practice has turned down Medicaid patients in the past; IDPA does not attempt to keep track of this information. (Luttrell Dep. Tr. at 32:7-33:12; Parker Dep. Tr. at 187:15-24; Carter Dep. Tr. at 162:11-165:4.)

157. IDPA leaves it to the recipient to call individual physicians from the referral list to determine if that physician is accepting Medicaid patients. IDPA does no follow-up to determine whether a recipient who has been given a physician referral through the hotline was able to see that physician or any physician. (Admitted, DRFFCL; Luttrell Dep. Tr. at 32:7-33:12; Carter Dep. Tr. at 162:11-165:4, 166:19-170:9.) In fact, parents of children on Medicaid call many doctors referred by the hotline and are rejected for treatment because the doctor will not accept Medicaid reimbursement. (Rodriguez Trial Tr. at 394:16-396:11; Mauk Trial Tr. at 356:6-367:14; 358:9-13; 359:16-360:1.)

158. In providing referrals, the hotline staff does not have information about, and does not consider, quality of care issues, such as waiting times for appointments, board certification of physicians, or availability of office hours of physicians. (Admitted, DRFFCL; Parker Dep. Tr. at 208:19-22.)

159. IDHS local office staff is instructed by IDPA policy that they have responsibility for providing assistance to clients in finding physicians and dentists and in scheduling doctor or dentist appointments for children enrolled in Medicaid. (Pl.Ex. 140; D. Saunders 5/2/02 Dep. Tr. at 61:7-62:4.) But IDHS local offices do not have access to any computer database containing names of available physicians to make referrals to children on Medicaid; and IDHS local office staff does not receive training on how to make referrals for children on Medicaid to available physicians. (B. Lopez Dep. Tr. at 16:2-17, 18:22-26:18, 40:11-41:4, 75:19-79:12, 79:18-86:5.) Local offices initially refer clients to the local clinics (the so-called "safety net"), and some of the staff might then look at a written physician list if the person cannot be seen at the clinic. (*Id.*) The doctor list is

compiled solely based on the fact that in the past a provider has billed Medicaid for at least one service. (Admitted in part, DRPUF ¶ 344; D. Saunders 5/2/02 Dep. Tr. at 61:7-62:4.) Some IDHS caseworkers are unaware that local offices even have referral books with doctor lists and do not know what to do when asked by recipients for help finding a doctor. (Rodriguez Trial Tr. at 394:9-15.)

***39** 160. IDHS local office staff do not have any information regarding the availability of doctors enrolled in the Medicaid program to accept a new Medicaid patient. Local IDHS office staff do not have any information on the specialties nor the board certification status of doctors enrolled in the Medicaid program. (Lopez Dep. Tr. at 18:22-26:18, 75:19-79:12; Rodriguez Trial Tr. at 394:9-15.)

161. IDHS local office supervisors do not check to ensure that IDHS local office caseworkers offer assistance in locating providers, and local IDHS office staff do not keep records of any referrals to physicians that they have made for children on Medicaid. (Lopez Dep. Tr. at 18:22-26:18, 75:19-79:12.)

162. IDHS local offices do not provide the IDPA KidCare Hotline number to clients seeking information about physicians. (Lopez Dep. Tr. at 18:22-26:18, 75:19-79:12.)

163. IDHS local office staff do not have a procedure in place for updating the information on physician referrals contained in the physician binders in the local offices. (Lopez Dep. Tr. at 75:19-79:12.)

164. IDHS local office staff do not call or otherwise communicate with physicians prior to making a referral for a recipient and they do not check with a Medicaid recipient after making a referral to a physician to ensure that the client was able to see that doctor. (Lopez Dep. Tr. at 18:22-26:18, 75:19-79:12.)

165. IDHS local office staff do not keep records on how many or which clients call back after being referred to a physician for another referral. (Lopez Dep. Tr. at 18:22-26:18, 75:19-79:12.)

166. IDHS local office staff also do not have a system for assisting recipients in scheduling appointments with doctors. (Lopez Dep. Tr., 18:22-26:18, 79:18-86:5.)

167. The State neither attempts to identify those Medicaid-enrolled children outside of MCOs who have not received mandated EPSDT services, nor follows up with them to ensure that they do. (Parker Dep. Tr. at 154:2-156:20; Ryan 7/11/02 Dep. Tr. at 266:21-267:5; Luttrell Dep. Tr. at 57:21-58:5; Ellinger Dep. Tr. at 106:14-20.)

168. The State provides case management services to some children through the IDHS Family Case Management program. (Admitted, DRFFCL; admitted in part, DRPUF ¶ 379.) This case management program has limited eligibility and limited enrollment (under 30,000 children were enrolled in May 2003). (DRPUF ¶ 383; Joint Ex. 15; S. Saunders Trial Trans. at 1223:25-1225:22.) The State once operated a case management system in which physicians were paid to manage Medicaid children's care. However, the State discontinued the program although it was popular with doctors who "support[ed] the notion of families staying with them...." (Ellinger Trial Trans., 809:21-810:19.)

169. IDHS also administers a nutrition program-the Women, Infant, and Children program-that encourages immunizations. (Admitted, DRFFCL, DRPUF ¶ 286.) This program also has a limited enrollment. (Admitted, DRPUF ¶ ¶ 389, 290; Joint Ex. 15; S. Saunders Trial Tr. at 1223:25-1225:22.)

***40** 170. The State also administers a few other programs that State witnesses admitted either serve very small percentages of children or provide very limited services such as the Early Intervention Program which refers approximately 12,000 children statewide primarily to non-physician providers and provides no well-child care (S. Saunders Trial Tr. at 1225:23-1226:9); school-based health centers which do not serve children younger than pre-adolescence (*Id.* at 1226:10-15); and Healthy Families and Parents Too Soon which serve less than 4,000 children statewide. (*Id.* at 1226:20-25.)

171. These limited case management programs have had some success in increasing the number of children receiving some EPSDT services. (Joint Ex. 14; Joint Ex. 17.)

172. The State performs no investigation and has no policies directed to whether individual children are actually receiving appropriate care. For example:

a. The State has not evaluated the level or quality of health education being provided by EPSDT providers, including the need for making EPSDT visits. (Admitted, DRFFCL, DRPUF ¶ ¶ 397, 398.)

b. The State has not evaluated whether EPSDT providers appropriately schedule return EPSDT visits

for recipients. (Admitted, DRFFCL, DRPUF ¶ 399.)

c. The State has not studied or evaluated whether geographic, demographic, or ethnographic factors amongst the plaintiffs influence EPSDT usage. (Admitted in part, as to ethnographic factors only, DRFFCL; admitted in part, DRPUF ¶ 402; Ellinger Dep. Tr. at 107:12-108:7.)

d. The State does not follow up to determine why no EPSDT services have been billed as to certain recipients. (Longo Dep. Tr. at 98:7-99:15; A. Kane 6/6/02 Dep. Tr. at 148:3-7, 153:22-154:21, 157:18-158:14.)

e. The State does not engage in outreach efforts to increase the level of EPSDT services received by the great majority of the plaintiffs (Parker Dep. Tr. at 154:2-156:20; Carter Dep. Tr. at 166:19-170:9; Lopez Dep. Tr. at 87:13-20, 88:2-89:20, 91:3-9.)

f. The State does not conduct "chart reviews" to assure that all EPSDT services are being provided to the Children. (Admitted, DRFFCL, DRPUF ¶ 409.)

g. If an invoice from a provider shows that the child did not receive a full EPSDT screen, the State takes no action to determine whether the child is receiving appropriate EPSDT services. (Parker Dep. Tr. at 154:2-156:20.)

h. The State does not require that providers submit any EPSDT reports or other information on the care provided to children; instead, the State relies solely on the invoices for services. (Powers Dep. Tr. at 97:12-98:15.)

i. The State brought forth no evidence that it conducts in-person checks of providers to determine whether they supply the full complement of EPSDT services, nor did the State present any evidence that it checks whether a provider has received appropriate training to deliver the full complement of EPSDT services.

j. The State does not evaluate the quality of EPSDT services provided, or whether providers carry out all EPSDT components. (A. Kane 6/6/02 Dep. Tr. at 149:12-16, 149:22-150:20, 151:8-11, 151:15-18; Werner Dep. Tr., 173:3-8.)

***41** k. The State does not require caseworkers at or after intake eligibility interviews at local offices to inquire whether families and children have regular doctors and to identify possible doctors for families and children who do not have a doctor. (Lopez Dep. Tr. at 18:22-26:18, 75:19-79:12.)

l. The State does not collect survey or other data that would allow the quality of EPSDT services to be evaluated. (A. Kane 6/6/02 Dep. Tr. at 149:12-16, 149:22-150:20, 151:8-11, 151:15-18; Parker Dep. Tr. at 208:19-22.)

m. The State does not pay incentives for providers whose patients receive the full schedule of EPSDT services. (Admitted, DRFFCL, DRPUF ¶ 423; A. Kane 6/6/02 Dep. Tr. at 200:3-7, 200:19-20.)

n. The State does not evaluate whether acute care services received by children receiving Medicaid are related to inadequate receipt of EPSDT services. (A. Kane 6/6/02 Dep. Tr. at 148:3-7, 153:22-154:21, 157:18-158:14; Longo Dep. Tr. at 98:7-99:15.)

o. The State does not evaluate the distribution of information regarding transportation assistance for EPSDT, or its provision of transportation assistance to the plaintiffs, and has not evaluated transportation as a factor in whether recipients will or will not receive EPSDT services. (Lopez Dep. Tr. at 79:18-86:5.)

p. The State fails to assist with scheduling appointments and does not keep records of requests for scheduling or transportation assistance for EPSDT services. (Lopez Dep. Tr. at 18:22-26:18, 79:18-86:5.)

q. The State does not have any quality assurance programs in place so that Medicaid policies such as EPSDT are carried out by other State agencies serving children on Medicaid such as DCFS. The IDPA only reviews other agencies if it hears complaints. (Powers Dep. Tr. at 175:6-176:7.)

173. Children in Cook County must receive prior approval from Dyntek (an IDPA transportation subcontractor) before they can receive any transportation assistance. Dyntek staff make all decisions as to what type of assistance will be provided such as whether a child's medical condition precludes medical transportation by bus. (Pl.Ex. 62; Pl.Ex. 63.)

174. Dyntek does not sufficiently subcontract with Medicaid providers to serve the plaintiffs and thus requests for transportation from hospitals are routinely delayed or are not usable due to tardy or absent transportation providers. (Lopez Dep. Tr. at 79:18-86:5.)

IV. Conclusions of Law FN15

FN15. Citations to the Findings of Facts are abbreviated as "FOF."

A. Equal Access

As noted above, 42 U.S.C. § 1396a(a)(30)(A) requires that a state Medicaid plan enlist sufficient providers such that care is available "at least to the extent that such care and services are available to the general population in the geographic area...." Plaintiffs' argument that the defendants have violated this "equal access" provision has three components: (1) the law requires that Medicaid reimbursement rates paid to health care providers be sufficient to provide Medicaid recipients access to health care equal to that of the generally insured population; (2) the arbitrary and capricious manner in which the defendants set reimbursement rates has resulted in rates that are far too low to result in equal access to care; and (3) plaintiffs endure obstacles to finding care not faced by privately insured patients and, as a result, the health problems they experience are both more acute and more preventable.

***42** Prior to trial the court ruled that in determining whether equal access to medical care exists, the relevant population for purposes of this comparison is the insured population and does not include the uninsured. *Arkansas Medical Soc'y, Inc.*, 6 F.3d at 527 ("To suggest that Congress appropriated vast sums of money and enacted a huge bureaucratic structure to ensure that recipients of the federal Medicaid program have equivalent access to medical services as their uninsured neighbors (i.e. close to none) is ridiculous."); H.R.Rep. No. 1010-247 , 101st Cong., 1st Sess. 390 (1989) reprinted in 1989 U .S.C.C.A.N.2060, 2116 ("compare the access of beneficiaries to the access of other individuals in the same geographic area with *public or private coverage* ....") (emphasis added).

In determining whether equal access to medical services exists, at least one court has looked at a variety of factors including (1) the level of reimbursement to participating physicians in the market and the costs of providing such services; (2) the level of physician participation in the Medicaid program; (3) whether there are reports that recipients are having difficulty obtaining care; (4) whether the rate at which Medicaid recipients utilize healthcare services is lower than the rates at which the generally insured population uses those services; and (5) whether defendants have admitted that reimbursement rates are inadequate. *See Clark v. Kizer*, 758 F.Supp. 572, 576 (E.D.Cal.1990) *aff'd in relevant part sub nom, Clark v. Coye*, 967 F.2d 585 (9th Cir.1992). As will be seen, while these factors are not addressed *seriatim*, nearly all are incorporated into the analysis below.

The starting point for the issue of equal access must be the rates Illinois Medicaid pays to medical providers for providing services to Medicaid patients. Rates and equal access simply cannot be divorced. The Seventh Circuit contemplated as much in *Methodist Hospitals* when it noted that states "may behave like other buyers of goods and services in the marketplace: They may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears." 91 F.3d at 1030. The court in *Methodist Hospitals* made clear that for a state to satisfy the "equal access" provision its rates need only "produce a *result*, not ... employ any particular methodology for getting there." 91 F.3d at 1030 (emphasis in original). Thus, looking only at the end result of equal access, the court does not consider whether rates are set in an arbitrary and capricious manner. The relevant inquiry, as *Methodist Hospitals* suggests, is whether the rate paid by the IDPA is sufficient to enlist enough providers so that plaintiffs have equal access to medical services. FN16 The evidence plaintiffs brought forth in this case, which takes a number of forms, conclusively establishes that the rates paid by the Illinois Medicaid program are insufficient to entice medical providers to provide services to Medicaid patients. These rate payments, along with other considerations discussed below, show that the Medicaid recipients do not have "equal access" to medical services.

FN16. The case on which plaintiffs rely for the argument that arbitrary and capricious rate setting violates the equal access provision is *Rite Aid of Penn. v. Houstoun*, 171 F.3d 842, 852 (3d Cir.1999). That case expressed disagreement with the Seventh Circuit's approach in *Methodist Hospitals* allowing states to behave like other buyers of goods in setting their market rates. The Third Circuit noted that "[w]e decline to adopt that approach because ordinarily, at least, a state may not act arbitrarily and capriciously, although other actors in the market may do so if they choose." *Id.* at 852. Needless to say, *Methodist Hospitals* is the precedent binding on this court, and that case makes clear that the only relevant inquiry is the result and not the methodology

for getting there. 91 F.3d at 1030.

***43** The court begins with the expert report and testimony of Dr. Flint. Dr. Flint surveyed the literature published in the medical field and opined that rates paid for providing services to Medicaid-enrolled patients is the factor that most influences a physician's decision whether, and to what extent, to treat Medicaid patients. (FOF ¶ ¶ 28-29.) Moreover, he researched the amount paid under Medicaid and compared it to rates paid under Medicare and private insurance in Cook County. (FOF ¶ ¶ 15-20.) Dr. Flint's analysis showed that Medicaid's reimbursement rates are far below those of other payers in the market. (*Id.*) Indeed, his analysis showed that Medicaid, at most, paid 55% of the rate that Medicare paid for the same service. (*Id.*) If Medicaid paid only 55% of the Medicare rate, the Medicaid rate was even a lower percentage of the rates paid by private insurance, which the testimony showed was greater than the rate paid by Medicare. (*Id.*)

As part of his analysis Dr. Flint also analyzed a physician's cost of overhead, meaning the cost of operating a practice before there is any compensation for the physicians in the practice. (FOF ¶ 19.) Dr. Flint's analysis noted that current Medicaid rates would not even cover a physician's cost of overhead. (*Id.*) Dr. Flint's testimony and his report were persuasive evidence that the rates Illinois Medicaid pays simply do not entice medical providers to participate in Medicaid and, therefore, fails to afford plaintiffs equal access to medical care. If rates are the most important factor in determining whether and to what extent to see Medicaid patients, and if Medicaid pays significantly lower than other payer types, then it follows, as Dr. Flint testified, that insufficient access for Medicaid recipients "should be expected" in Cook County. (FOF ¶ 20.) Dr. Flint's conclusions were not rebutted. The State's expert, Todd Menenberg, did not consider Dr. Flint's analysis and did not present a competing analysis of a doctor's costs to practice or the level of reimbursement rates compared to other payers in Cook County. FN17

> FN17. The court, in a pretrial ruling *in limine,* barred Mr. Menenberg from opining on the level of reimbursement rates at trial for three reasons. First, in his expert report Mr. Menenberg considered the uninsured in his opinion on equal access. As noted above, the appropriate measure of equal access is based on the insured population in the geographic area. Second, Mr. Menenberg only compared Illinois' Medicaid rates to rates set by a selected group of other states. Doctors in Illinois, however, would not consider Medicaid rates set by these other states in considering whether to serve children covered by Medicaid in Cook County. They would, instead, look to what other payers in Cook County are paying. Mr. Menenberg's report also provided no analysis confirming that these other states were, in fact, providing equal access to Medicaid recipients as required under federal law. Finally, while Mr. Menenberg took issue with any comparison between Medicaid rates and Medicare rates, he admitted that he was unaware of how Medicare rates are set. The evidence at trial established that Medicare rates are, in fact, highly relevant in setting rates of all kind, and any opinion to the contrary is based on a misunderstanding of how rates for medical services are established. (FOF ¶ 16.)

Dr. Flint's analysis in his report and his trial testimony were persuasively supported by extensive trial testimony from numerous medical providers. This included testimony from Drs. Rosenberg, Krug, Lelyveld, Jurado, Green, Abelson and Newman. Combined, these doctors serve all portions of Cook County. The doctors each confirmed Dr. Flint's opinions that reimbursement rates for pediatric care (1) are insufficient to cover overhead costs; (2) result in significant losses for doctors and hospital pediatric departments and clinics with a significant volume of Medicaid patients; and (3) render providers unable to meet the demands of the Medicaid populations they serve. (FOF ¶ ¶ 19-24, 27, 30-31, 37, 39.)

The doctors' testimony did not relate solely to rates, and numerous other portions of their testimony is persuasive in establishing that plaintiffs do not have equal access to medical care. Testimony showed that Medicaid-enrolled children face conditions such as longer waiting times for care (FOF ¶ ¶ 41, 50, 53), a more limited population of providers willing to provide care (FOF ¶ ¶ 47-49), and multiple trips to the doctor for services which could be addressed in one visit. (FOF ¶ 22.) All in all, the doctors painted a picture of Medicaid-enrolled patients being afforded a significantly lesser degree of access to care than that enjoyed by privately-insured children.

***44** Two doctors, Dr. Krug, head of the emergency room at Children's Memorial Hospital, and Dr. Lelyveld, from the University of Chicago hospitals' pediatric emergency room, each testified that Medicaid-insured children do not have access to

primary care equal to that of privately-insured patients. (FOF ¶ 60.) Dr. Krug testified that the access of Medicaid-enrolled children is "vastly diminished" and "not remotely close" to that of privately-insured children. (*Id.*)

Drs. Krug and Lelyveld also testified that Medicaid-enrolled pediatric patients are more likely to have no primary care provider than privately-insured patients. (FOF ¶ 51.) Several of the physicians testified that doctors will either not see Medicaid-insured children at all or will significantly limit the number of Medicaid-enrolled children they will accept. (FOF ¶ 47.) All of the physicians testified that when they attempt to refer patients for pediatric specialty care, it is far more difficult to find a doctor willing to accept a referral for a Medicaid-enrolled child than it is for a privately-insured child. (FOF ¶ 49.)

There was also testimony by the physicians that the health problems of children on Medicaid are of a different degree than children with private insurance and are indicative of a population without access to a medical home where they can receive anticipatory guidance, preventive care and early diagnosis. (FOF ¶ ¶ 32, 50-53 .) Dr. Krug testified that Medicaid patients in the emergency room frequently come in with conditions that privately-insured patients do not typically have and which reflect a lack of primary care, including untreated bone fractures or advanced asthmatic conditions. (FOF ¶ 50.) In addition to asthma, Dr. Lelyveld also included gastroenteritis, flu and diabetes as other conditions frequently presented with more aggravated or serious symptoms by Medicaid-enrolled children as a result of lack of primary care. (*Id.*) Indeed, many of the physicians testified that Medicaid children frequently use the emergency room as a source of primary care because they simply have nowhere else to go. (FOF ¶ 52.)

The physicians testifying at trial also brought forth persuasive evidence concerning non-rate factors that would influence a doctor's decision to open his or her practice to Medicaid patients. Dr. Flint noted that these non-rate factors have been dubbed as Medicaid "hassles" in medical literature. (FOF ¶ 22.) Some of these so-called Medicaid hassles are, perhaps, predictable. For example, each physician testified that Medicaid has a very long payment cycle, which was identified as an important factor in determining whether to participate in the Medicaid program. (FOF ¶ 21.) Moreover, many physicians testified that IDPA would arbitrarily reject Medicaid claims and had instituted billing policies and developed forms that served as a disincentive for provider participation. (FOF ¶ 22.) Other Medicaid hassles discussed at trial ranged from the bizarre to the irrational. Dr. Krug testified that Medicaid had "disenrolled" him from its provider database for no reason, despite the fact that he provides care to thousands of Medicaid-enrolled children every year. (*Id.*) Several other doctors testified that the IDPA refused to pay providers for more than one service per day, regardless of the number of services that a child needs or receives. (*Id.*) As explained in an example by Dr. Krug, "You know, a kid falls off the monkey bar and hits his head, and, you know, that is a concern. He has also lacerated his knee. That needs to be done as well. We can and should bill for both of those services, but we'll only get paid [by Medicaid] for one of them." (Krug. Trial Tr. at 276:19-25.) Defendants have asserted no conceivable medical reason for such a policy, and no argument was or can be made that a similar restriction was encountered by physicians when they seek Medicare or private insurance payments. These hassles provide evidence supporting that a physician would simply choose not to see Medicaid patients rather than deal with the hassles.

***45** The testimony of these doctors was not rebutted and is highly persuasive in establishing the level of access provided to Medicaid recipients. Defendants, in response to this testimony, argue that it only establishes that medical professionals want higher reimbursement rates from the IDPA. To the extent that this argument suggests that the witnesses were biased and, therefore, that the court should place little weight on their testimony, such argument is rejected. The court observed the testimony of these doctors and did not notice even a hint of bias. Each doctor was a highly trained medical professional who had dedicated his life to the provision of medical services to children. Their testimony made abundantly clear that their interest was in the health and well-being of children.

The testimony of the medical providers, along with Dr. Flint's expert report and trial testimony, was corroborated by evidence presented by certain Medicaid recipients. Six Medicaid recipients testified at trial as to their actual experiences attempting to find primary care doctors or specialists who accepted Medicaid for their children. None of these witnesses were able to access medical care in a manner equal to that of the generally-insured population. (FOF ¶ ¶ 53-55.) Several of the witnesses were in the unique position of being able to compare their experiences in finding doctors to treat their children covered under Medicaid with their experiences finding doctors to treat their children covered under private insurance. (FOF ¶ 55(e), (f) & (g).) As these witnesses testified, obtaining medical services for their children covered

under private insurance was not a difficult task, while attempting to obtain care for their children covered under Medicaid was a much more difficult and frustrating process. (*Id.*) These witnesses also testified in detail that State programs designed to provide assistance for finding doctors were unhelpful and they were not able to locate doctors on their own. (FOF ¶ ¶ 53, 54, 55(a) & (b).)

Once again, the defendants have not effectively rebutted any of the above evidence. As plaintiffs point out, the defendants have no knowledge regarding the state of access for Medicaid-enrolled children in Cook County and have never tried to learn what the level of access might be. Employees of the IDPA freely admit that rates are low and not very attractive and are set without regard to the effect such rate-setting will have on access, even though they acknowledge that an increase in rates would increase the number of providers who would participate in the Medicaid program. (FOF ¶ ¶ 10, 56, 57, 59.) At trial there was evidence presented of the raw number of providers who are "enrolled" in Medicaid, but the court agrees with plaintiffs that this does not establish equal access. All a provider needs to do to become enrolled is to fill out a form. (FOF ¶ 45.) There is no obligation to treat even a single Medicaid patient and the provider would remain enrolled so long as he or she billed Medicaid once for a service over an 18-month period. (FOF ¶ 152.) These very same doctors that may have enrolled in Medicaid may be unwilling to accept new Medicaid patients or may have stopped seeing Medicaid patients entirely within the last 18 months.

***46** Contrary to this analysis of raw numbers of providers enrolled in Medicaid, plaintiffs presented an analysis by Dr. Darling which attempted to analyze how many doctors provide a service (specifically well-child examinations) to Medicaid-enrolled children in Cook County. Dr. Darling first looked at all doctors who billed at least one service of any kind for a Medicaid-enrolled child during the three and one-half year period from July 31, 1998 to December 31, 2001. (FOF ¶ 74, 76.) He determined that 10,494 doctors billed IDPA for at least one service provided to a Medicaid-enrolled child in Cook County between the ages of 10 days and 18 years, and 7,131 doctors billed IDPA for a service provided to a child between the ages of 10 days and 7 years. (FOF ¶ 46.) Dr. Darling's analysis also showed that over a 31/2 year period more than half of these doctors never provided even a single well-child examination and that the vast majority of well-child services are billed by only a very small minority of the doctor community. (*Id.*) As this analysis suggests, only a small subset of doctors provide significant levels of well-child services to plaintiffs and reliance on the enrolled doctors as an indicator of access to care creates an overstated picture.

While the court will address below in the EPSDT portion of this opinion Mr. Menenberg's disagreements with Dr. Darling's methodology, for purposes here Mr. Menenberg did not undercut Dr. Darling's analysis. In fact, Mr. Menenberg's analysis supports Dr. Darling's conclusions in this regard. Dr. Darling analyzed mainstream providers of medical care while Mr. Menenberg also included "safety net" care provides such as FQHCs and public health clinics. Under Mr. Menenberg's analysis there were 11,767 providers who had provided a well-child examination in the relevant time period using the broader IDPA definition of a well-child exam (only 4,266 provided an HMHK exam). (Def. Ex. 1 at 19-22.) According to Mr. Menenberg, based on this number of providers, each provider would have to serve "approximately 87 children" which, in his estimation, gives plaintiffs sufficient access to medical care. But Mr. Menenberg also showed that more than half of all these providers serving Medicaid-enrolled children in Cook County have served 10 or fewer unique Medicaid-enrolled children. (*Id.*) This confirms exactly what Dr. Darling stated, that most services are being provided by a small subset of providers. Certainly each provider as Mr. Menenberg defined that term was not seeing 87 children.

Moreover, the court also takes issue with the inclusion of these so-called "safety net" providers in the equal access analysis. The inquiry is, after all, of *equal* access and not simply of access. The plaintiffs are entitled to the same level of medical care as is provided to children covered under private insurance. That must include mainstream medical care. Evidence at trial established that children need a medical "home" where they can be provided regular and ongoing services. (FOF ¶ ¶ 32, 68.) Also, in certain instances parents of children need access to their physician on nights or weekends. (FOF ¶ 42.) Such services simply cannot be provided by these safety net providers. Indeed, the evidence further showed that these FQHCs and public health clinics have long lines which, in some instances, may place patients in danger. (FOF ¶ ¶ 41, 50, 53.) That, according to several doctors, often results in patients coming to the emergency room seeking treatment for primary care. (FOF ¶ ¶ 52-53.) Since the plaintiffs are entitled to access equal to that of children with private insurance, the appropriate measure must be that of mainstream medical care that privately insured

children are likely to receive.

***47** Wherefore, based on the entire record, the court finds that the plaintiffs have met their burden of establishing that the defendants have violated their rights by failing to provide them with equal access to medical services. Plaintiffs simply do not have access to medical services which is equal to that of privately insured children.

B. EPSDT Provisions

The plaintiffs' claims under the EPSDT provisions take two parts. First, they allege that the defendants have failed to make "effective" efforts to inform them about the EPSDT program. Their second theory is that the defendants have failed to connect children to EPSDT services and have failed to establish a Medicaid program designed to provide all such services to all Medicaid-enrolled children on a timely basis.

1. Effective efforts to inform

Under 42 U.S.C. § 1396a(a)(43)(A) , a state Medicaid plan must provide for the informing of all persons under the age of 21 who are eligible for Medicaid of the availability of the EPSDT services described in 42 U.S.C. § 1396d(r) and of the need for age-appropriate immunizations against vaccine-preventable diseases. The defendants must provide for a combination of written and oral methods and must "effectively" inform all EPSDT eligible individuals (or their families) about the EPSDT program. 42 C.F.R. § 441.56.

Once again, the plaintiffs' proof in support of their argument that they have not been informed of the availability of EPSDT services and immunizations takes several different forms. The court begins with the testimony of the IDPA employees, who described many of the IDPA's procedures and practices with regard to informing Medicaid recipients of EPSDT services.

Initially, these employees documented the different ways a child can be enrolled in Medicaid and the different notices and information provided under each method of enrollment. For example, the first method under which a child may enroll in the Medicaid program is to apply through their local IDHS office. (FOF ¶ 122.) At this time the recipients are supposed to be informed orally by local IDHS staff about the Healthy Kids Program (which, as noted above, is the Illinois EPSDT program, *see* FOF ¶ 65) and are to be given IDPA Form 1123, entitled Healthy Kids: Good Health for Children and Teens. (FOF ¶ 123.) These recipients who apply at local IDHS offices are not provided the 89 page KidCare Handbook. (FOF ¶ ¶ 122-23.) Neither the IDPA nor the IDHS have (1) any policies or procedures in place to govern how oral notice is to be given to these recipients, including the content and manner of such notice; (2) any training manuals relating to advising recipients as to the Healthy Kids program; and (3) any accountability system to assure that IDHS caseworkers actually give oral notice of EPSDT services. (FOF ¶ 123.)

A second method for enrollment in the Medicaid program is by mailing a KidCare application to the IDPA KidCare central processing unit. (FOF ¶ 122.) A recipient who chooses this method for enrollment will be provided a copy of the 89 page KidCare Handbook but not IDPA Form 1123. (FOF ¶ 124.) Moreover, staff at the IDPA KidCare central processing unit do not have any duty to call persons they enroll in the Medicaid program to orally explain the EPSDT program. (*Id.*) IDPA has no written policy on how it orally informs children and their families of the EPSDT program or the benefits of preventive health when they are applying through the mail. (*Id.*)

***48** Finally, a recipient may be enrolled in the Medicaid program by completing a KidCare application with a KidCare application agent who then sends the KidCare application to the IDPA KidCare central processing unit. (FOF ¶ 122.) KidCare application agents are neither instructed nor required to inform applicants about the specifics of the Healthy Kids program. (FOF ¶ 125.) There was no evidence presented that children and their families who apply for KidCare through KidCare application agents uniformly receive any appropriate oral information about the EPSDT program or the benefits of preventive health.

Also related to the issue of EPSDT notices are IDPA Forms 1802 and 2286. Form 1802 is a one-page document sent by the IDHS Central Office annually to all children enrolled in Medicaid to inform them about the EPSDT program. (FOF ¶ 126.) Form 2286 is sent to children prior to the due date of each periodic examination as set by the EPSDT periodicity schedule for well-child examinations. (FOF ¶ 127.) This notice only mentions well-child exams and not blood lead screens or immunizations. (*Id.*) It advises plaintiffs that they "may" be due for an exam. (*Id.*) Neither IDPA nor IDHS disseminate information about the Healthy Kids program to children and families applying for Medicaid using any other forms.

(FOF ¶ 128.) Many Medicaid recipients never receive any of these EPSDT notices at all. (FOF ¶ 129.) IDPA has not surveyed and does not study whether recipients receive automated notices or whether these notices are an effective way of notifying parents to take their children to medical providers. (FOF ¶ 130.) IDPA develops all of its written EPSDT notices in-house and does not field test these forms with focus groups or other Medicaid recipient audiences. (FOF ¶ 132.) IDPA also does not use outside linguists in developing or evaluating these materials and has not studied what the most effective mix of oral and written material for informing recipients about EPSDT services would consist of. FN18 (FOF ¶ ¶ 132-33.)

> FN18. On a related note, plaintiffs also offered evidence concerning the methods the defendants used to provide assistance to Medicaid recipients. As this evidence shows, these methods were ineffective. The parents of Medicaid enrolled children testified that the physician referral hotline administered by IDPA gave out referrals to physicians who were not even accepting Medicaid patients. (FOF ¶ 55(a), (b) & (e).) Employees of IDPA testified that they do not investigate the capacity of physicians on the referral list to accept new patients nor do they confirm whether the physicians are even still participating in the Medicaid program. (FOF ¶ ¶ 152, 155-164.) The local offices administered by the IDHS, which serve as the primary personal contact that Medicaid recipients have with the state agencies, are staffed with caseworkers who offer no assistance in referring recipients to doctors. (FOF ¶ ¶ 159-60.)

Plaintiffs supplemented this testimony from the IDPA employees with testimony and an expert report from Dr. Timothy Shanahan. Dr. Shanahan was retained to analyze the EPSDT notices sent by IDPA for readability and understandability by their target audiences in Cook County. Dr. Shanahan opined that the readability of documents used for public health purposes should have difficulty levels of approximately grade four to six. (FOF ¶ 135.) His opinion was that the IDPA's written methods for informing families about EPSDT services are ineffective because they are too difficult to read for many parents and children. (FOF ¶ ¶ 135-140.) He summarized by noting, “My testimony is that these documents are difficult. And if this is the only way of putting this information out, a significant portion of the population won't understand them.” (FOF ¶ 140.) Dr. Shanahan noted that when documents are especially long, or when more difficult than the reading competency among the target population, the best and only way to communicate the information is to combine oral presentations with the written material. (FOF ¶ 136.)

***49** Finally, plaintiffs also argue that the results of the EPSDT program, which will be discussed more fully below, illustrate that defendants have not effectively informed them of the EPSDT services. If, plaintiffs argue, the defendants were effectively notifying them of the availability of EPSDT services, then the level of services should have been much higher than it actually turned out to be.

Weighing all of the above evidence, the court finds that plaintiffs have supplied sufficient proof showing that the defendants have not effectively informed them of the availability of EPSDT services. As the evidence showed, IDPA provided differing forms of information depending on the manner in which a recipient applied for benefits, with no apparent reason for the differences. Even when IDPA has a policy of providing oral notice to recipients, there is no practice for ensuring that such notice is effectively given and no training to suggest what effective oral notice entails. The written EPSDT notices provided by IDPA only mention well-child examinations and omit notice of lead-blood screens or immunizations. Furthermore, as the evidence at trial showed, these notices are often not received (indeed, there was no testimony from any recipient that they had in fact received such EPSDT notices) and IDPA has never bothered studying whether these notices reach their intended audience or whether they effectively convey information about the availability of EPSDT services.

Moreover, the court finds the Expert Report and testimony of Dr. Shanahan persuasive. While defendants take issue with many of his opinions, the central premise of his testimony and report is clear. Public health documents such as those provided by defendants are often difficult documents from a readability and understandability standpoint. Informing families of EPSDT services solely on the basis of the documents provided by IDPA would be ineffective and would miss a significant portion of the target population. Thus, to effectively inform Medicaid recipients such written materials need to be supplemented by oral presentations. It is difficult for IDPA to refute this contention insofar as it has recognized as much in other scenarios. IDPA employees have stated that to attract recipients' attention “you have to have multiple methods multiple times.” (FOF ¶ 145.) Moreover, when IDPA

attempted to increase the number of children *enrolled* in the KidCare program, IDPA used a wide variety of methods such as public service announcements, public presentations at fairs and festivals, public presentations at community meetings, grants to community groups, radio, television, newspaper and community advocacy directed to African-American and Hispanic families, sponsorship of events such as a circus and general advertising through radio, newspaper, bus billboards, mass transit advertising and distribution of bookmarks, coloring books, crayons and other items at fairs. (*Id.*)

***50** None of these methods have ever been used to inform recipients of the availability of EPSDT services. Instead, the IDPA provides different information depending on how one applies. Only under one method of application is oral guidance even supposed to be given, but no one can say how often it is given or whether it is at all. IDPA's method for informing recipients that services are due is simply to mail out notices, the readability of which has never been determined. IDPA further has no idea whether these notices reach the recipients or, if they do, whether they are even considered. This, simply put, is not effective notice of the availability of EPSDT provisions. As will be seen below, the ineffectiveness of this notice shows up in the number of EPSDT services that plaintiffs actually receive.

2. EPSDT services

The Medicaid Act requires states to provide Medicaid-enrolled children with certain medical services, including well-child examinations and immunizations, known as EPSDT services. *See* 42 U.S.C. § 1396d(r). In addition, the Medicaid Act further requires that states provide any follow-up or corrective services that may be necessary based on the results of any EPSDT screenings. *See* 42 U .S.C. § 1396a(a)(43)(C). These EPSDT requirements differ from merely providing "access" to services; the Medicaid statute places affirmative obligations on states to assure that these services are actually provided to children on Medicaid in a timely and effective manner. *See, e.g.,* *Stanton v. Bond*, 504 F.2d 1246, 1250 (7th Cir.1974) ("The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the 1967 act and by the interpretative regulations and guidelines."). Significantly, plaintiffs do not suggest that the inquiry is whether or not some children receive EPSDT services. Certainly some do, and it would be unrealistic to hold the IDPA liable for not providing EPSDT services to every single child. Instead, plaintiffs' theory is that the IDPA has not established a Medicaid program designed to provide all EPSDT services to all Medicaid-enrolled children on a timely basis. Based on the evidence received at trial, the court agrees.

The Medicaid Act requires states to adopt a "periodicity schedule" for screening services that "meets reasonable standards of medical and dental practice" and sets forth the stages at which recipients should receive such services. *See* 42 U.S.C. § 1396d(r)(1)-(4) ; 42 C.F.R. § 441.58. IDPA has adopted a periodicity schedule based on the recommendations of the American Academy of Pediatrics that incorporates the nationally recognized schedule for immunizations, and calls for seven appointments for well-child screenings in the first year of life, with a decreasing number of annual appointments as the child becomes older. *See* 89 Ill. Admin. Code § 140.488.

***51** Nearly everyone involved in this case on the defendants' side has declared, practically in unison, that the periodicity schedule is but a "recommendation." No witness for the defendants explained in great detail what this means. The court understands defendants to be suggesting that because, in their mind, the periodicity schedule is only a so-called "recommendation," it is acceptable if plaintiffs are not afforded all of these services. There is no basis for such a belief. While the American Academy of Pediatrics may have recommended a certain schedule for well-child screenings and immunizations, federal law requires states to adopt a periodicity schedule that meets reasonable standards of medical and dental practice. *See* 42 U.S.C. § 1396d(r)(1)-(4). In conformance with federal law, the State of Illinois adopted the recommendations of the American Academy of Pediatrics for the number and timing of well-child examinations. This periodicity schedule, therefore, is a required component of Illinois' EPSDT program. Any suggestion that it serves as a "recommendation" or that children need not be provided all such services is simply baseless.

States are required under the Medicaid Act to maintain data on EPSDT services provided to Medicaid-enrolled children. *See* 42 U.S.C. § 1396a(a)(43)(D). The primary source of data the State of Illinois uses to measure the EPSDT services provided to children is the "paid claims" data maintained within IDPA's MMIS database. Regarding immunizations, IDPA also maintains a separate data system known as Cornerstone, which

attempts to capture immunization services provided through various public health agencies. MMIS and Cornerstone are the defendants' best-available resources for determining the medical services provided to the Medicaid-enrolled children and are used by the defendants (1) for their own internal analyses of the care provided; (2) for analyzing the performance of contractors such as MCOs; and (3) for reporting requirements to the federal government.

The data contained in these databases was analyzed by Dr. Darling in both his original Expert Report and Supplemental Report. FN19 He adjusted the data he was given to limit his analyses to services provided during the period of July 1, 1998 to December 31, 2001 (the "Data Period"). (Pl.Ex. 118 at 4-6.) Exclusions made within the data given to Dr. Darling were explained in his report. For example, to limit the entries to the Data Period he was examining, Dr. Darling deleted eligibility records for recipients (1) who were born after December 31, 2001; (2) who were first eligible for Medicaid after December 31, 2001; and (3) with certain anomalous records where an eligibility date preceded the recipient's date of birth. *Id.* These adjustments reduced the number of unique recipients from 957,710 to 910,451. (*Id.*) Dr. Darling deleted those entries with a date of service after December 31, 2001 and all service records for which no matching recipient could be found in the adjusted eligibility data. (*Id.* at 6.)

> FN19. Discovery in this case can best be described as a difficult process. In August 2002, the defendants provided the plaintiffs the data from MMIS. The defendants represented in their discovery responses that the data consisted of "all encounter data for children involved in this action." (Pl.Ex. 116, Ex. B.) This representation was never amended by the defendants. Dr. Darling performed his analysis based on this data and prepared his original report. That report was tendered to the defendants on March 3, 2003. In June 2003, the defendants tendered Mr. Menenberg's report to the plaintiffs. Mr. Menenberg's report analyzed not only the MMIS data but also additional data from the IDHS Cornerstone database. The Cornerstone data, however, was not provided to the plaintiffs until May 30, 2003, more than 45 days after the defendants provided this data to Mr. Menenberg, three months after Dr. Darling completed his initial report and about two weeks before the defendants turned over Mr. Menenberg's report. Indeed, as one of his critiques of Dr. Darling's analysis, Mr. Menenberg asserted that Dr. Darling's analysis was flawed because it did not take into account the Cornerstone data, which neither Dr. Darling nor the plaintiffs had even been provided. Plaintiffs were granted leave by Magistrate Judge Martin Ashman to supplement Dr. Darling's analysis to account for this Cornerstone data and to address other criticisms made by Mr. Menenberg. Both Dr. Darling's original Expert Report and his Supplemental Report were accepted into evidence at trial.

***52** In his initial report, Dr. Darling also adjusted the data to limit his analyses to services provided to recipients who were continuously Medicaid-eligible during the time periods he analyzed. (*Id.* at 6-8.) Dr. Darling explained that he did this for two reasons. First, he stated that the State had more limited opportunities to provide services to non-continuously eligible children and, second, because these recipients could have received unrecorded services while not covered under Medicaid. (*Id.* at 6-8.) This adjustment reduced the number of recipients analyzed from 910,451 to 818,019, a reduction of just under 10%. (*Id.*) In response to Mr. Menenberg's criticism of this continuously-eligible limitation, in his Supplemental Report Dr. Darling later reran his analysis including all 910,451 recipients and his overall results were very similar. (Pl.Ex. 119.)

Significantly, through his analysis Dr. Darling set out to determine the level of services that had been provided to Medicaid-enrolled children in Cook County on a timely basis. Therefore, he established age ranges in order to capture whether or not services were being provided to the plaintiffs in accordance with the Illinois periodicity schedule. For example, according to the periodicity schedule a child should receive 6 screening services after leaving the hospital and prior to one year of age (at 2 weeks, 1 month, 2 months 4 months, 6 months and 9 months). To evaluate the extent to which such services were actually received, Dr. Darling analyzed the services given to children between the ages of 10 days and 11 months. FN20 Similarly, to evaluate whether children were receiving appropriate screenings services due at 12 months, 15 months and 18 months, Dr. Darling analyzed services received by children between 11 and 23 months. Dr. Darling conducted additional analyses of the well-child services provided to Medicaid-enrolled children in Cook County through age five.

FN20. Dr. Darling explained why his analysis was limited to children between the ages of 10 days and 11 months. This limitation is discussed in FOF ¶ ¶ 72 and 82.

Based on this methodology, Dr. Darling showed that more than half of the children between 10 days and 11 months, who should have received six screening services, received none. Even under the IDPA's broader definition of a "well-child" examination, which includes a five-minute exam with only a nurse, Dr. Darling showed that approximately 45% of children received no well-child exams during this period. In addition, nearly 60% of children between the ages of 11 and 23 months received zero well-child exams, and over 70% received zero well-child exams between 23 and 35 months and between 25 and 47 months.

In his Supplemental Report, Dr. Darling added the non-continuously eligible recipients. Concerning well-child exams, adding these non-continuously eligible recipients yielded only negligible changes of no more than 2%. (Pl.Ex. 119 at 2-20.) In his Supplemental Report Dr. Darling also re-analyzed immunization data to include information from the Cornerstone database. With this data included, the records showed that with respect to every immunization analyzed, roughly 50% or more of the eligible recipients had not received a timely immunization. (Pl.Ex. 119 at 21-26.)

***53** In addition to the testimony and reports of Dr. Darling, the plaintiffs also looked at Cook County-specific reports prepared by the State showing the number of EPSDT services provided to children. These Cook County-specific reports are prepared in the same manner and with the same data as the statewide CMS-416 reports submitted to the federal government under 42 U.S.C. § 1296a(a)(43)(D).

The methodology used in creating these reports overstates the actual level of EPSDT services provided. For example, for purposes of the CMS-416 forms IDPA counts many types of doctor visits that do not and cannot comply with EPSDT well-child screening criteria, including short visits where a patient may not even see a doctor. (FOF ¶ 105.) These reports also count well-child exams received by children far in excess of the number of exams required under the Illinois periodicity schedule (FOF ¶ 104(a)), and use a cut-off date of September 30 to establish a child's age, even though this makes it seem as though a child has received all of his or her screens when he or she may have received less than half of them. (FOF ¶ 104(b) & (c).)

Even though overstated, the Cook County specific reports show that the level of EPSDT services provided to children are inadequate. These forms show that for the years 2000 through 2002, approximately one-third of Medicaid-enrolled children in Cook County did not receive any well-child screening services and 75% did not receive a dental screening. (FOF ¶ ¶ 107-08.) Based on this data, IDPA notified the MCOs providing services to children in Cook County that each was failing to meet the participation requirements set forth in their contractual "minimum standard of care." (FOF ¶ ¶ 109, 117.)

In response to this evidence, the defendants (1) attempt to impugn the very data they tendered in discovery and which they submit to the federal government and (2) rely on Mr. Menenberg's critiques of Dr. Darling's methodology. Concerning argument (1), according to defendants, the "paid claims" used in MMIS and Cornerstone databases underreport the number of services provided to the plaintiffs. Because the data are underreported, defendants submit that Dr. Darling's analyses must be flawed. For example, defendants argue (a) that encounter data may not be submitted by physicians to particular MCOs and, therefore, may not be submitted to the IDPA; (b) that large numbers of MCO encounter data may be rejected by the IDPA because the encounter data does not meet the edits of the claims processing system; (c) that because FQHCs billings are based on an encounter rate, which includes all services provided to a child for that day, and because the services on the encounter line are often limited to one service, the FQHCs do not provide an accurate measure of the services a child received during a visit; and (d) that other providers in IDPA's provider network provide services to Medicaid eligible children but may or may not bill for these services or may or may not list all services provided in a particular encounter.

***54** These arguments are unpersuasive. Initially, most are based only on speculation. No witness with direct personal knowledge testified as to the operation of the entities the defendants claim provide services to Medicaid-enrolled children but do not bill or otherwise report such data to IDPA. In fact, much of the evidence showed that the types of entities defendants discuss do bill the IDPA for services they provided and were, therefore, analyzed by Dr. Darling. Exhibit 12 to Mr. Menenberg's report sets forth a list, derived from the State's MMIS data of providers that provided EPSDT services, that includes FQHCs, encounter rate clinics, health

departments and school based/linked health clinics.

Moreover, with regard to FQHCs, no witness verified or even testified that FQHC's might perform two or more well-child services but only provide the procedure code for one. Testimony showed that FQHCs bill for each encounter according to a CPT-code, and there is no evidence to support the speculation that if the FQHC was providing a well-child examination, it would not identify the appropriate CPT-code for that encounter.

As for the MCOs, which serve less than 20% of the plaintiffs, defendants argue that because doctors are normally paid on a capitated basis, they would have no incentive to record each service they provided to the plaintiffs. No evidence was presented on how to estimate or quantify such a purported understatement, and the defendants acknowledged that their contracts with the MCOs require that MCOs bill for every encounter. (FOF ¶ 112.) Moreover, only a portion of the doctors enrolled in MCOs are paid on a capitated basis. (FOF ¶ 110.) Thus, in essence, the defendants argue that only some fraction of those doctors fail to bill appropriately. This evidence is simply unpersuasive.

With regard to public health clinics and school-based clinics, once again no witness testified concerning the billing practices at such clinics or whether underbilling of services would exist. Instead, Mr. Menenberg's report shows that public health clinics and school-based clinics do bill IDPA for services provided and their billing information is in the MMIS data.

Finally, and more fundamentally, Dr. Darling's analysis provides the opportunity to examine the actual level of the shortfall in the number of services that should have been provided to the plaintiffs and whether, realistically, those services could have been provided without anyone billing the IDPA. As will be seen, to support the defendants' argument, there would have to be more free services provided than services actually billed.

Dr. Darling's Table 1 in his March 3, 2003 report shows of 112,512 children who should have received 6 well-child screening services, 58,794 received zero and 10,508 received one. Comparing the number of services that were provided to these children with the number of services that would have been billed had all 112,512 children in this age group received all 6 scheduled screenings shows that during the period of July 1, 1998 through December 31, 2001, only approximately 170,000 out of a total of over 675,000 scheduled EPSDT services were received by children from 10 days to 11 months of age. This represents a shortfall of over 500,000 services.

***55** Applying this analysis to the continuously Medicaid-eligible children through age 5 that Dr. Darling analyzed, IDPA records reflect approximately 330,000 services were given out of a total of more than 1.2 million services that should have been given. Thus, children under 5 received almost 900,000 fewer well-child examinations than called for by the Illinois periodicity schedule.

For the defendants to argue that the number of services listed above are provided somewhere by someone who does not bill the IDPA is sheer fantasy. There was absolutely no evidence brought forth corroborating such a theory and, quite simply, it strains the imagination to believe that this many services are provided for free by some provider the IDPA cannot even name. As defendants point out, even if the MMIS and Cornerstone data were underreported to a significant degree, the level of services provided to the plaintiffs is inadequate. The court finds defendants' arguments attacking their very own data which, once again, is submitted to the federal government as required by federal law, to be completely unpersuasive.

Defendants' reliance on Mr. Menenberg's critiques of Dr. Darling's methodology fares no better. Mr. Menenberg lodged a variety of attacks on the methodology of Dr. Darling, but all ultimately fail. First and foremost, Dr. Darling and Mr. Menenberg took two separate approaches, and Mr. Menenberg's analysis, as it relates to the provision of EPSDT services, is unhelpful. While Dr. Darling examined the medical services provided to the plaintiffs within certain age groups to assess whether EPSDT services have been provided on a timely basis, Mr. Menenberg measured all services provided to the plaintiffs to measure whether children have access (not equal access) to services. FN21 This did not address nor undercut Dr. Darling's analysis in any way. Mr. Menenberg himself conceded that he was not comparing his analysis to the Illinois periodicity schedule and that Dr. Darling's analysis "might" be helpful in that regard. (Menenberg Trial Tr. at 1306:3-9.)

> FN21. Even assuming that Mr. Menenberg's analysis had relevance to the EPSDT provisions, which it does not, plaintiffs persuasively point out that Mr. Menenberg's results overstate the level of access to services. For example, Mr. Menenberg

> included every visit to a doctor, such as well-child visits, sick child visits and trips to the emergency room or to a "safety net" clinic for an acute condition. This is not relevant toward the question of whether children are able to obtain regular well-child care. Mr. Menenberg also excluded all children that became eligible for Medicaid prior to July 1, 1998, even though he admitted he had all of the encounter information for these children within the Data Period. As plaintiffs point out, under Mr. Menenberg's analysis the defendants' position in this case would be better if the average number of visits to doctors were as high as possible. By excluding children eligible before July 1, 1998, Mr. Menenberg's analysis by its nature includes every child that should have received seven exams during the Data Period and excludes virtually all of the children who should have received one. Thus, nearly all of the children that would increase the number of examinations were included in Mr. Menenberg's analysis while he eliminated those that would lower the number of exams.

Mr. Menenberg also attacked Dr. Darling's report and testimony in several other respects (many of which were introduced for the first time at trial). For example, Mr. Menenberg argued that Dr. Darling's methodology was flawed because Dr. Darling only addressed those children who were entirely within the studied age ranges during the Data Period. FN22 Mr. Menenberg argued that because of this exclusion Dr. Darling did not consider anywhere between 660,000 and 742,000 services provided to the children.

> FN22. Plaintiffs presented the following example of Dr. Darling's exclusion. A child born March 1, 1998 would be excluded from Dr. Darling's analysis because that child was not both 10 days and 11 months old during the Data Period. Instead, the child would have been 4 months old at the start of the Data Period.

Mr. Menenberg's critique, however, once again focused on looking at the total number of services provided. As plaintiffs have repeatedly pointed out, Dr. Darling's analyses examined something separate, that being the percentages of children who were receiving timely EPSDT services in accordance with the periodicity schedule. If Dr. Darling were to have included these partial year increments, his analysis would have been inaccurate for showing the total number of services that were provided according to the Illinois periodicity schedule. FN23 Mr. Menenberg and Dr. Darling took separate approaches and Mr. Menenberg's criticisms never fully account for what exactly Dr. Darling was attempting to show. As such, the court finds these criticisms unpersuasive.

> FN23. If Dr. Darling had included these children in his analysis, the most services that a child born on March 1, 1998 could have received would have been three, even if the child had received all six scheduled services on a timely basis. Including such children would have understated the percentage of children receiving proper numbers of timely EPSDT services.

***56** Based on the entire record, the court finds that the plaintiffs have shown that they are not being provided EPSDT services under the defendants' State Plan and that the defendants are in violation of federal law. The IDPA has not established a Medicaid program designed to provide all EPSDT services to all Medicaid-enrolled children on a timely basis.

CONCLUSION

For all of the reasons set forth above, the court declares that the defendants' policies and practices have violated and are violating the rights of the plaintiffs under 42 U.S.C. § 1396a(a)(30)(A) and the EPSDT provisions. This case will be called for status on September 14, 2004 at 9:30 a.m. to discuss further proceedings relating to an appropriate injunction to remedy the defendants' violations. Furthermore, the plaintiffs are awarded their costs and reasonable attorneys' fees, the amount of which to be determined upon entry of final judgment in accordance with Local Rule 54.3. It is so ordered.

N.D.Ill.,2004.
Memisovski ex rel. Memisovski v. Maram
Not Reported in F.Supp.2d, 2004 WL 1878332, Med & Med GD (CCH) P 301,515

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Slip Copy, 2005 WL 342106 (S.D.N.Y.), Med & Med GD (CCH) P 301,587
Briefs and Other Related Documents

United States District Court,S.D. New York.
Lakisha REYNOLDS, Georgina Bonilla, April Smiley, Lue Garlick, Adriana Calabrese, Jenny Cuevas, and Elston Richards, on their own behalf and on behalf of all others similarly situated, Plaintiffs,
v.
Rudolph GIULIANI, as Mayor of the City of New York, Jason Turner, as Commissioner of the New York City Human Resources Administration, Brian J. Wing, as Commissioner of the New York State Office of Temporary and Disability Assistance, and Barbara Debuono, as Commissioner of the New York State Department of Health, Defendants.
No. 98 Civ.8877(WHP).

Feb. 14, 2005.

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Yisroel Schulman , New York Legal Assistance Group, New York, NY, for Plaintiffs.
Scott Rosenberg , The Legal Aid Society, Civil Division, New York, NY, for Plaintiffs.
Kenneth Rosenfeld , Northern Manhattan Improvement Corp., New York, NY, for Plaintiffs.
Jonathan L. Pines , Office of the Corporation Counsel of the City of New York, New York, NY, for City Defendants.
Charles A. Miller , Covington & Burling, Washington, D.C., for City Defendants.
James M. Hershler , William H. Bristow, III, Assistant Attorneys General of the State of New York, New York, NY, for State Defendants.

AMENDED MEMORANDUM AND OPINION

PAULEY, J.
***1** This class action was brought on behalf of qualified welfare beneficiaries who claim to have been deprived of federally sponsored cash assistance, food stamp and Medicaid benefits in violation of federal and state law. Plaintiffs brought this action against Rudolph Giuliani as Mayor of the City of New York and Jason Turner as Commissioner of the New York City Human Resources Administration ("HRA") (collectively, the "City defendants"), as well as Brian J. Wing as Commissioner of the New York State Office of Temporary and Disability Assistance ("OTDA") and Barbara DeBuono as Commissioner of the New York State Department of Health ("DoH") (collectively, the "State defendants"). The Complaint ("Compl.") alleges violations of the Food Stamp Act, 7 U.S.C. § 2020 *et seq.*, the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, and New York law. The Complaint further alleges that those violations support individual claims pursuant to 42 U.S.C. § 1983. Plaintiffs seek declaratory relief and a permanent injunction ordering defendants to process applications for food stamps, Medicaid and cash assistance in accord with federal and state law. For the following reasons, plaintiffs' requested relief is granted.

As required by Rule 52, this Court sets forth its findings of fact and conclusions of law.

FINDINGS OF FACT

I. *Background*

The factual background and regulatory framework undergirding plaintiffs' claims are set forth in three prior memoranda and orders of this Court. *See Reynolds v. Giuliani*, 35 F.Supp.2d 331 (S.D.N.Y.1999) (*"Reynolds I"*); *Reynolds v. Giuliani*, 43 F.Supp.2d 492 (S.D.N.Y.1999) (*"Reynolds II"*); *Reynolds v. Giuliani*, 118 F.Supp.2d 352 (S.D.N.Y.2000) (*"Reynolds III"*).

Following enactment of the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"), FN1 the City defendants began converting their Income Support Centers-the primary vehicle for distributing public assistance-into Job Centers to comply with PRWORA. The City defendants operate twenty-nine Centers that are either Job Centers or Income Support Centers scheduled for conversion to Job Centers. (Declaration of Patricia Smith, dated Feb. 2, 2001 ("Smith Decl.") ¶ ¶ 2-3.) On average, those Centers process between 12,000 and 15,000 applications for public assistance each month. (Smith Decl. ¶ ¶ 2-3.) Many of those applications are combined with applications for food stamps and Medicaid. (Smith Decl. ¶ ¶ 2-3.)

> FN1. PRWORA replaced the Aid to Families With Dependent Children ("AFDC") program with the Temporary Assistance for Needy Families ("TANF") program.

On December 16, 1998, plaintiffs filed this action alleging that certain policies and practices of HRA

and OTDA prevent eligible individuals from applying for and timely receiving food stamps, Medicaid and cash assistance. *Reynolds I*, 35 F.Supp.2d at 337. Plaintiffs claim that defendants are violating federal and state law by: (1) failing to provide or accept initial applications and improperly deterring potential applicants; (2) failing to make correct eligibility determinations and failing to provide immediate needs grants or expedited food stamp service to eligible applicants on a timely basis; (3) failing to make eligibility determinations regarding applicants' food stamp and Medicaid applications separate from the eligibility determinations regarding their cash assistance applications; and (4) failing to provide applicants with timely and adequate written notices of determinations of their eligibility for these benefits. (Compl.¶ ¶ 3, 255-57, 260, 262-64.)

***2** On January 25, 1999, this Court granted a preliminary injunction requiring the City defendants to accept and process applications for food stamps, Medicaid and cash assistance. *Reynolds I*, 35 F.Supp.2d at 347-48. That injunction also barred the City defendants from opening any new Job Centers or converting existing Income Support Centers to Job Centers pending a hearing on the adequacy of a corrective action plan. *Reynolds I*, 35 F.Supp.2d at 347-48.

On February 5, 1999, the Food and Nutrition Service at the U.S. Department of Agriculture ("USDA") concluded that the converted Job Centers were impeding access to public assistance. (*See* Declaration of Steven Ptak, dated Feb. 2, 2001 ("Ptak Decl.") Ex. 3: Attach. at 6-14.) The USDA report requested a corrective action plan and recommended that OTDA monitor local district operations to ensure compliance with all applicable food stamp regulations. (Ptak Decl. Ex. 3: Attach. at 6-24.)

In response to the USDA report, OTDA staff reviewed operations at twelve Job Centers. OTDA concluded that "New York City had implemented corrected procedures to address the deficiencies identified in the USDA Program Access Review." (Ptak Decl. Ex. 13.) OTDA further found that the City was fulfilling its obligations under federal and state law. (*See* Ptak Decl. Ex. 13: Attach. at 2 (draft report, Ex. 16).)

On May 24, 1999, this Court approved the City defendants' corrective action plan ("CAP") and modified the preliminary injunction to permit the City defendants to open three additional Job Centers. *See Reynolds II*, 43 F.Supp.2d at 497-98. The CAP specified that individuals seeking benefits would be informed of their right to apply for them during their initial contact with any Job or Income Center. *See Reynolds II*, 43 F.Supp.2d at 495-96. The CAP also provided for training, audits and a "spot check" program of unannounced inspections. (Declaration of Jacquelyn Flaum, dated Feb. 1, 2001 ("Flaum Decl.") ¶ 3.)

In July and August 1999, OTDA reviewed nine Centers and again concluded that the Job Centers were fulfilling their responsibilities to public assistance applicants. (Ptak Decl. Ex. 21 at 1, Ex. 24.) Consequently, on December 10, 1999, the City defendants applied for a further modification of the preliminary injunction and offered results from an August 1999 audit of applications submitted from May through July 1999 (the "August 1999 Audit"). After a three-day hearing in December 1999 and January 2000, this Court found that the City defendants had failed to demonstrate sufficient improvement to warrant modification of the preliminary injunction. *See Reynolds III*, 118 F.Supp.2d at 352. Additionally, this Court denied the State defendants' motion to dismiss the complaint and their application to modify the preliminary injunction. This Court also certified a class consisting of "all New York City residents who have sought, are seeking, or will seek to apply for food stamps, Medicaid, and/or cash assistance at a Job Center." *Reynolds III*, 118 F.Supp.2d at 392.

***3** On February 8, 2001, plaintiffs consented to vacatur of that portion of this Court's January 25, 1999 Order staying the opening of new Job Centers and the conversion of existing Income Support Centers to Job Centers. That concession was based on the results of an audit of applications filed in September 2000 at Job Centers and Income Support Centers to measure their performance (the "September 2000 Audit"). The September 2000 Audit focused on the twenty-nine Centers where benefits applications were being processed and reviewed a statistically significant sample of applications filed in New York City.

In April 2001, this Court conducted a bench trial. The September 2000 Audit was the centerpiece of the trial. The City defendants presented testimony from Patricia M. Smith, Executive Deputy Director of the Family Independence Administration, Dr. Jessica Pollner, an expert in statistical analysis (Trial Transcript ("Trial Tr."), at 69), and William Waldman, an expert in the operation and administration of public assistance programs and in national human services policy as it affects state

public assistance programs. (Trial Tr. at 177.) Plaintiffs' only witness was Richard Faust, an expert in sampling and statistics.

II. *City Defendants*

A. *The Application Process*

While the application process for public assistance varies depending on the Center, a client's first interaction is with a receptionist. (City Defendants' Proposed Findings of Fact ("City Defs. Findings") ¶ 3.) If a prospective applicant indicates a desire to apply for public assistance benefits, the receptionist is required to provide an Applicant Job Profile, i.e., an application, to be completed by the applicant. (City Defs. Findings ¶ 3.) Once the application is completed, the receptionist checks to see if the applicant has an active or pending case at another Income Support or Job Center. (City Defs. Findings ¶ 3.) After an application is completed, a Center employee registers it in the State's computerized Welfare Management System ("WMS") database. A registration number is assigned memorializing the application date. (City Defs. Findings ¶ 3; Smith Decl. ¶ ¶ 7-8.)

Once the application is registered, a Center employee interviews the applicant to determine eligibility. (City Defs. Findings ¶ 4.) At Job Centers, that interview must cover subjects including emergency assistance, employment counseling and general eligibility guidelines for the different public assistance programs. (City Defs. Findings ¶ 4.) In addition, eligibility interviewers are required to address various social issues that may arise. For example, applicants who are victims of domestic violence are referred to an HRA domestic violence liaison. (City Defs. Findings ¶ 4.) Applicants for ongoing assistance who have an immediate need may also be eligible for "pre-investigative" grants during the time their application is pending. (City Defs. Findings ¶ 4; Smith Decl. ¶ 10.)

***4** During the eligibility interview, a Center worker reviews the application to determine whether the applicant needs immediate benefits, and completes a history sheet explaining why the applicant came to the Center and identifying any needs. (City Defs. Findings ¶ 5; Smith Decl. ¶ 11.) When determining whether applicants are eligible for pre-investigative benefits, family size, income, resources, citizenship or immigration status and identification are considered. (City Defs. Findings ¶ 5; Smith Decl. ¶ 11.) Applicable codes are entered into the WMS and forms including, *inter alia,* an expedited service worksheet for food stamps; a Form 145HH, notifying the applicant of HRA's decision to grant or deny an immediate needs grant and/or expedited food stamps; a Form DSS-3575, authorizing the payment of any immediate benefit; a Form DSS-3574, authorizing the issuance of expedited food stamps; and the form DSS-3517, which provides demographic data about the applicant are completed. (City Defs. Findings ¶ 5; Smith Decl. ¶ 11.) In addition, appointment referrals are made and applicants are finger-imaged. (City Defs. Findings ¶ 5; Smith Decl. ¶ 11.) After review by a Center supervisor, the paperwork is entered into the WMS and applicants receive written notice of any decision on their benefits applications.

A "Notice of Decision on Food Stamps and/or Cash Assistance to Meet an Immediate Need" is issued advising applicants whether they will receive an immediate needs grant or expedited food stamps, and the reason for the decision. (City Defs. Findings ¶ 30.) Applicants withdrawing their applications receive a "Notification of Application Withdrawal" informing them that they may qualify for food stamps or Medicaid even though they did not complete their cash assistance applications. (City Defs. Findings ¶ 30.) Finally, an "Action Taken on Your Application" form is provided to advise applicants of their eligibility for assistance. (City Defs. Findings ¶ 30.) If the application is denied, that form explains the reasons for the denial and advises applicants of their right to a fair hearing if they wish to challenge the denial. (City Defs. Findings ¶ 30.)

B. *The September 2000 Audit*

The September 2000 Audit was conducted pursuant to a protocol established by the parties from a statistically significant sample of applications filed in September 2000 at 29 Income Support and Job Centers in New York. (*See* Fourth Report of Plaintiffs' Expert Richard Faust ("Fourth Faust Rep.") ¶ ¶ 6-13; City defendants' Expert Jessica Pollner's Report ("Pollner Rep.") at 5.) The audit assessed whether: (a) expedited food stamp and immediate needs cash grants were timely provided to those eligible for such grants; (b) applications for food stamps, Medicaid and cash assistance were withdrawn based on inaccurate or misleading information; (c) separate food stamps and Medicaid determinations or referrals were made as required when cash assistance applications were denied or withdrawn; and (d) notice concerning expedited food stamps, immediate needs cash grants, Medicaid and cash assistance was timely and adequate. (Fourth Faust Rep. ¶ 14; Pollner Rep. at 5.)

***5** A sample of 597 applications was selected from a population of 13,972 names within the City defendants' Eligibility Verification Review ("EVR") database. The sample included applications filed in September 2000 and applications filed prior to that time that were withdrawn or rejected on the same day they were filed. (Fourth Faust Rep. ¶ ¶ 6, 9, 11-12; Declaration of Jessica Pollner ("Pollner Decl.") at 1-3.) The EVR data system captures information from the WMS regarding applicants scheduled for an appointment with an EVR office. (Fourth Faust Rep. ¶ 7.) The parties then selected 559 applications from the EVR list for review. (Fourth Faust Rep. ¶ 11 .)

The EVR database did not include applications withdrawn on the day they were filed. To address that omission, the parties sampled applications filed in September 2000 that were not entered into the EVR system by collecting case files for all September 2000 applications identified as withdrawn or rejected on the first day (the "withdrawn sample"). (Fourth Faust Rep. ¶ ¶ 8, 12; Pollner Rep. at 2-3.) A total of 37 such cases were selected for audit, 36 of which were used in the audit results. (Fourth Faust Rep. ¶ 12; Pollner Rep. at 2-3.) FN2

> FN2. The EVR data system captures information from the WMS regarding applicants scheduled for an appointment with an EVR office and contains the greatest number of applications filed in any given month. (Fourth Faust Rep. ¶ 7.)

However, the data supplied by the City defendants did not represent all withdrawn cases recorded on the application logs. (Fourth Faust Rep. ¶ 13.) Thus, plaintiffs created a supplemental list of withdrawn applications from the logs maintained by the Job Centers and drew a supplemental sample from that list. That supplemental list contained an additional 825 names. At the direction of this Court, HRA attempted to locate the files for those applications but succeeded in retrieving only two (the "supplemental withdrawn sample"). (Fourth Faust Rep. ¶ 13.)

The September 2000 Audit minimized disputes over data from applicant files. (Fourth Faust Rep. ¶ 27; Plaintiffs' Proposed Findings of Fact ("Pls.Findings") ¶ 34.) The parties disagreed over only 8 of the 559 EVR sample, and 8 of the withdrawn and supplemental withdrawn sample cases. (Pls. Findings ¶ 34; Fourth Faust Rep. ¶ 27.)

However, after the September 2000 Audit was completed, the City defendants embarked unilaterally on a second review of cases for which the plaintiffs and the City defendants had both concluded that either (1) expedited food stamps or immediate needs cash grants were erroneously denied, or (2) an application was withdrawn based on inaccurate or misleading information. Based on this second review, the City defendants changed their determinations in 34 cases. (Declaration of Michael Bermudez, dated Mar. 9, 2001 ("Bermudez Decl.") ¶ ¶ 5, 16-20, 22; Deposition of Michael Bermudez, dated Mar. 19, 2001 ("Bermudez Dep."), at 69-70, 82-83.)

The City defendants engaged in opportunistic rummaging within the data set that led to a significant change in their statistics. Specifically, the City defendants determined that the relevant pool was the total number of applications rather than the total number of *eligible* applications. That alteration of the denominator had a profound effect on statistical comparisons of the City defendants' success rates. This Court agrees with plaintiffs that the proper base from which HRA's success or failure rates are calculated is the number of eligible applicants, not the number of overall applicants. Compliance with the food stamp, Medicaid and cash assistance laws should be measured according to how many eligible applicants are incorrectly denied benefits. FN3 Moreover, because the City defendants' second review was dehors the agreed-upon protocol for the September 2000 Audit and not subject to challenge by plaintiffs, it does not bear the same indicia of reliability as the earlier results.

> FN3. *See, e.g.*, *Reynolds v. Giuliani*, 35 F.Supp.2d 331, 334 (S.D.N.Y.1999) ("The State agency must provide *eligible* applicants that complete the initial application process with food stamps as soon as possible.") (citing 7 U.S.C. § 2020(e)(3) and 7 C .F.R. § 273.2(g)) (emphasis added); *see also Catanzano v. Wing*, 103 F.3d 223, 229 (2d Cir.1996) ("A state's Medicaid plan must make 'medical assistance' available to *qualified recipients."*) (citing 42 U.S.C. § 1396d(a)) (emphasis added).

***6** Faust also evaluated the EVR sample of 559 cases for possible bias. Because the size of the population sampled was unknown, the total withdrawn population could not be identified. (Fourth Faust Rep. ¶ ¶ 40-42.) Nevertheless, Faust concluded that "based on the sampling protocol, the 36 withdrawn applications audited from the initial withdrawn list should be representative of the ... applications initially retrieved.... [T]here is no reason to expect any better performance among the non-retrieved

applicants than among the retrieved applications." (Fourth Faust Rep. ¶ 43.) Thus, although the City defendants lack accurate information concerning the number of withdrawn applications, this Court concurs with Faust that there is no reason to expect any better performance among the non-retrieved applications than among the retrieved ones.

In contrast, Pollner combined the EVR sample with the withdrawn sample. (Supplemental Report of Jessica Pollner ("Supp. Pollner Rep .") at 1-2.) While Faust considered that statistical method inappropriate, he nevertheless re-ran his results combining the 36 applications in the withdrawn sample with the EVR sample, thereby testing Pollner's procedure. Faust concluded that combining the samples did not significantly affect the overall audit procedures. (Fourth Faust Rep. ¶ ¶ 45-46.)

Therefore, this Court finds that the September 2000 Audit was conducted in accord with generally accepted survey principles and generally recognized statistical standards. Specifically, this Court concludes that: (1) the EVR sample is representative of the EVR population from which it was selected; (2) the inclusion of the withdrawn sample in the results of the September 2000 Audit does not materially alter the outcome; (3) the data gathered was accurately reported; and (4) the data was analyzed in accord with accepted statistical principles. *See* Manual for Complex Litigation (4th) § 11.493. The findings of the September 2000 Audit are discussed below.

1. *Expedited Food Stamps*

The Food Stamp Act requires that states provide food stamps to certain needy households on an expedited basis. *See* 7 U.S.C. § 2020(e)(9). All applicants for food stamps must be screened to determine whether they qualify for expedited issuance of food stamps. *See* 7 U.S.C. § 2020(e)(9) ; 7 C.F.R. § 273.2(i)(2). New York law requires that eligible applicants be provided with expedited food stamps within five days. *See* 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a); *see also* 7 U.S.C. § 2020(e)(9) (seven-day requirement). It bears noting that the statutory regimes focus on *eligible* applicants. *See* 7 U.S.C. § 2020(e)(3) ; 7 C.F.R. § 273.2(g) ; 42 U.S.C. § 1396d(a).

Faust's and Pollner's calculations show nearly identical citywide performance in providing expedited food stamp service within the five-day period set forth by New York State law: 69 percent versus 69.31 percent, respectively. (Pls. Ex. 49: Fourth Faust Rep., Table C-2; Pollner Supp. Rep. at 14, Table 13.) Both parties agree that the Job Centers provide expedited food stamp services within five days to no more than 72 percent of the applicants who receive expedited food stamps and that the citywide average is approximately 69 percent. (Pls. Ex. 49: Fourth Faust Rep., Table C-2; Pollner Supp. Rep. at 14, Table 13.) FN4

FN4. Using a compliance rate that compares the number of applicants who received food stamps within the federally required seven days with the total number of applicants who were eligible for expedited food stamps, Faust calculated that 303 applicants were approved for expedited food stamps citywide and that 72 other applicants were eligible for expedited food stamps but were incorrectly denied. (Supp. Pollner Rep. Queries C-8 & C-15 at Attach. 16.) An additional 23 grants were authorized but not issued. (Supp. Pollner Rep. Attach. 16, Query C-5.) Thus, from the pool of 398 applicants eligible for expedited food stamps, 259 eligible applicants, or 65.07 percent, received expedited food stamps within seven days.

***7** Faust and Pollner were in substantial agreement concerning the percentage of applicants properly denied expedited food stamps because of ineligibility. Faust calculated that 33 percent of applicants were actually ineligible to receive expedited food stamps. (Fourth Faust Rep., Table C-3, at Pls. Ex. 49.) Pollner's original report showed that applicants were properly denied expedited food stamps because they were ineligible 42.67 percent of the time. (Pollner Rep. at 15 (Table 10).) Even taking Pollner's revised data, the percentage of ineligibles only increased to 45.09 percent. (Supp. Pollner Rep. at 6; Fourth Faust Rep. Table C-3, at Pls. Ex. 49.) Accordingly, the range of eligible applicants who were denied expedited food stamps is between 57.33 percent (Pollner) and 67 percent (Faust).

2. *Immediate Needs Grants*

Where applicants for Medicaid, food stamps or cash assistance are in immediate need, temporary assistance must be granted pending completion of an eligibility investigation. N.Y. Soc. Serv. Law § 133; *see Gonzales v. Blum*, 486 N.Y.S.2d 630, 632 (Sup.Ct.1985) ("There is no doubt that this section establishes the right of public assistance applicants to pre-investigative relief should it appear that they are in immediate need."). Applicants in need are entitled to immediate needs grants even when ongoing

eligibility has not yet been established. *See* 18 N.Y.C.R.R. § 351.8(c)(4).

Faust and Pollner were in virtual agreement concerning the City defendants' rate of compliance with the same-day requirement once an immediate needs grant was authorized: 69 percent versus 69.31 percent, respectively. (Pls. Findings ¶ 58.) Both experts agree that the Job Centers provided immediate needs grants on the same day as requested to no more than 79.33 percent of the eligible applicants. (Pls. Findings ¶ 58; Supp. Pollner Rep., Table 4 at 9.)

The experts' conclusions regarding eligible applicants who never received immediate needs cash grants are again substantially similar. Pollner concluded that 54.06 percent of citywide applicants were correctly denied immediate needs grants (Supp. Pollner Rep. Table 5 at 9), compared to Faust's 51 percent. (Pls. Ex. 49: Fourth Faust Rep., Table B-3.) This minor discrepancy is attributable to the City defendants' data rummaging. FN5

> FN5. The City defendants maintain that examining the number of grants issued the day following the application is relevant for determining their level of compliance. But even then, Pollner calculates that only 72.82 percent of eligible applicants received immediate needs grants on the same day or the next day citywide. (Pls. Findings ¶ 63, Table 12.)

3. *Separate Determinations for Foods Stamps and Medicaid*

The September 2000 Audit also addressed the issue of whether HRA workers made separate determinations for food stamps and Medicaid when cash assistance applications were denied.

Federal law provides that "no household shall have its food stamp benefits denied solely on the basis that its application to participate in another program has been denied or its benefits under another program have been terminated without a separate determination by the State agency that the household failed to satisfy a food stamp eligibility requirement." 7 C.F.R. § 273.2(b)(3). If the cash assistance application is denied or withdrawn, the applicant is not required to submit a new application for food stamps. 7 C.F.R. § 273.2(b)(3).

***8** The Medicaid program contains a similar requirement. Individuals or households wishing to apply for Medicaid benefits must be given the opportunity to do so. *See* 42 U.S.C. § 1396a(a)(8) ; 42 C.F.R. § 435.906. Medicaid applications must be processed within 45 days, except in circumstances where the applicant claims to be eligible for Medicaid because of a disability, in which case the application must be processed within 90 days. *See* 42 C.F.R. § 435.911(a)(1)-(2). A state agency cannot deny an application for Medicaid benefits solely because the cash assistance application was denied or withdrawn. *See* 42 C.F.R. § 435.909. Nor may the State require that the individual or family in such circumstances submit a new Medicaid application. *See* 42 C.F.R. § 435.909.

Both experts concluded that the City defendants made separate food stamp determinations when denying cash assistance applications only sporadically. (Fourth Faust Rep. ¶ 64 (6 percent); Supp. Pollner Rep., Table 19, at 20 (14.20 percent).) Separate determinations for Medicaid benefits after cash assistance was denied were made less than 11 percent of the time. (Fourth Faust Rep. ¶ 66 (8 percent); Pollner Rep. Table 19, at 20 (10.34 percent).)

4. *Application Withdrawals*

Federal law requires that if a Medicaid application is withdrawn, the administering agency must send a notice to the applicant confirming the withdrawal. *See* 42 C.F.R. § 435.913. The state agency, here HRA, or the state-delegated agency, may not deny Medicaid benefits solely because the cash assistance application has been withdrawn, nor may the cash assistance applicant be required to submit a new Medicaid application. *See* 42 C.F.R. § 435.909.

Federal law also requires that case files document withdrawal of a food stamp application and the advice to a household of its right to reapply for food stamp benefits. *See* 7 C.F.R. § 273.2(c)(6). Where a cash assistance application is withdrawn, the applicant cannot be required to submit a new application for food stamps. *See* 7 C.F.R. § 273.2(b)(3).

The experts spar over the number of applications withdrawn based on erroneous information provided by Center employees to applicants. Faust concludes that 49 percent of cash assistance applications, 45 percent of food stamp applications and 56 percent of Medicaid applications were withdrawn based on misleading information from City workers. (Fourth Faust Rep. ¶ 63.) Pollner found a significantly lower

incidence of improperly induced withdrawals. However, her conclusion was based on all applications (Supp. Pollner Rep., Tables 16-18, at 17-19), rather than only those that were withdrawn.

Pollner's comparison uses the wrong yardstick. (Fifth Faust Rep. ¶ 45.) The accurate measure is all *withdrawn* applications because they are the relevant population for inquiry. (*See* Fifth Faust Rep. ¶ 45.) This Court accepts Faust's data because Pollner's tables have been adjusted to reflect the already-rejected second review of individual cases conducted by the City defendants. FN6

> FN6. Plaintiffs present persuasive documentation demonstrating how, for each case in dispute, they reached the conclusion that the application was withdrawn based on inaccurate and misleading information. (*See* Declaration of Randall Jeffrey, dated Feb. 9, 2001 ("Jeffrey Decl.") at 7, 9, 10, 11, 17.) Notably, the City defendants dramatically reduced the number of applications that they characterized as withdrawn based on inaccurate or misleading information between the time of their expert's initial report and her supplemental report. (*Compare* Pollner Rep. at 19-20, *with* Supp. Pollner Rep. at 18-19, Table 18.)

5. *Provision of Notices*

***9** Both federal and New York law require that notice be provided for any decision regarding an application. All notices must include the action taken by the agency and the laws and regulations on which that action was based. Additional requirements include the reason for any denial or the amount of the benefit granted, the effective date and the certification period. *See* 7 C.F.R. § 273.10(g)(1) (food stamps); 42 C.F.R. § § 435.911 , 435.912 (Medicaid); 18 N.Y.C.R.R. § § 351.8(b) , 358.2.2(a).

Faust calculated performance measures regarding notices for five types of grants: expedited food stamps service, immediate needs grants, ongoing food stamps, Medicaid and cash assistance. Faust also referred to the date on notices to determine whether they were timely provided. (Fourth Faust Rep. ¶ 69.) The City defendants limited their inquiry to two notices: the W-145HH ("Notice of Decision on Food Stamps and/or Cash Assistance to Meet an Immediate Need") and the M-3 ("Action taken on your Application: Public Assistance, Food Stamps, and Medical Assistance Coverage"). (*See* Supp. Pollner Rep., Table 15B at 16; Supp. Pollner Rep., Query E-2, at Attach. 16.) Pollner did not report on whether either of those notices were completed accurately or timely. This Court finds the statistical data presented by Faust to be more reliable. Faust's data shows, *inter alia*, the following significant failings:

a. For food stamp applicants who did not receive expedited food stamps ("EFS"), the Form W-145HH was in the case file 70 percent of the time but included a reason for non-issuance only 48 percent of the time. (Fourth Faust Rep. ¶ 72.)

b. For applicants who received EFS, the Form W-145HH was in the case file and included the amount of the grant 81 percent of the time; the date of issuance 22 percent of the time; and the time covered by the grant 15 percent of the time. (Fourth Faust Rep. ¶ 73.)

c. For applicants who indicated an immediate need but did not receive a grant, the Form W-145HH was in the case file 78 percent of the time. (Fourth Faust Rep. ¶ 74.)

d. The Form M-3 was in the case file for those denied ongoing cash assistance in 87 percent of the cases, and was in the case file with the correct address in 71 percent of the cases. (Fourth Faust Rep. ¶ 78.)

e. When the Form M-3 was in the case file and the cash assistance application was denied, the form for each assistance denial and reasons for the denial were completed 49 percent of the time. (Fourth Faust Rep. ¶ 79.)

f. When the Form M-3 was in the case file and the food stamp application was denied, the form for food stamp denials and the reasons for the denial were completed 48 percent of the time. (Fourth Faust Rep. ¶ 81.)

C. *Other Performance Measures*

Apart from the September 2000 Audit, plaintiffs offered other evidence of the City defendants' non-compliance. These measures of performance include Program Evaluation Review Team audits ("PERT audits"), State Program Access Reviews ("PA Reviews") and Management Evaluation Reviews ("ME Reviews") of the Centers, and ongoing performance reviews by the USDA for compliance with food stamp program procedures.

***10** The PERT audits revealed that Job Centers and Income Support Centers inappropriately denied expedited food stamps in 23.2 and 27.6 percent of the reviewed cases, respectively. (Pls. Findings ¶ 84.) In terms of the rate with which the Centers failed to issue expedited food stamps on a timely basis, the results were 24.7 and 35.8 percent, respectively. (Pls.

Findings ¶ 85.) For issuance of immediate needs grants, the PERT audits found that the Centers improperly denied cash grants in 33.3 and 52 percent of the cases, respectively. (Pls. Findings ¶ 86.)

The PERT audits indicated that Job Centers failed to make separate food stamps determinations in 97 percent of the cases, while Income Support Centers failed in 78.5 percent of the cases. (Pls. Findings ¶ 87.) Job and Income Support Centers did not make separate Medicaid determinations in 86.9 and 68.4 percent of the cases reviewed, respectively. (Pls. Findings ¶ 87.)

The PERT audits yielded results roughly similar to the September 2000 Audit regarding the City defendants' provision of adequate notices. For example, in approximately 12 percent of the cases reviewed citywide, W-145HH forms were missing from case files, indicating a failure to notify applicants of the eligibility determination for immediate needs grants or expedited food stamps. (Pls. Findings ¶ 87.)

In November 1999, the USDA conducted performance reviews and noted problems such as inadequate case file determinations, improper denials of expedited food stamps, incorrect completion of expedited screening sheets (Form W-140K), failure to make separate determinations of eligibility for food stamps and untimely or missing notices. (Pls. Ex. 144 at 4-6, 8.) The Health Care Finance Administration ("HCFA"), the federal agency in charge of the Medicaid program, also reviewed applicant files in 1999 and found instances where applications were denied without a referral for an independent Medicaid determination. (Pls. Ex. 88 at 9-10, 22.)

Plaintiffs assert that these studies further establish the City defendants' failure to comply with federal and state law. However, plaintiffs' reliance on prior reviews captures the world's largest welfare system in a still portrait and overlooks the City defendants' efforts toward compliance. Instead, these reviews set a benchmark against which the City defendants' remedial measures should be evaluated. Since they were conducted, the City defendants have undertaken various policy initiatives to improve the Centers' performance in providing eligible applicants with Medicaid, food stamps and cash assistance, which are relevant to determining compliance with state and federal law. For example, the policy directive adopted as part of the Corrective Action Plan makes clear that all individuals have the right to apply for benefits on their first day of contact with a Center. (*See* Policy Directive 99-06R(2); Policy Bulletin 99-13; Center Operations Memorandum CD 99-3.) The City defendants have sought to enforce this policy through various means including training, audits and the agency's "spot check" program, which was implemented in 1999 in order to determine whether Centers were adhering to HRA's mandate to permit applicants to apply and be seen by a worker on the same day.

***11** In terms of initiatives regarding immediate needs grants, HRA issued policy directives and conducted training to underscore that applicants' emergency needs must be met before turning to issues of employment and self-sufficiency. (*See* Policy Directives 00-62, 99-06R(2), 99-06(RR), 99-07R(3) , 99-08R(4) , 99-11R(4); Policy Bulletin 99-13; Smith Decl. ¶ 20.) Since the preliminary injunction issued, HRA increased the number of immediate needs grants distributed each month from less than 5,000 to over 10,000, while the number of applications has remained fairly constant at around 15,000 per month. (*See* Smith Decl. ¶ 21, Ex. 1(A).)

Additionally, HRA has issued policy directives and conducted training to emphasize that applicants should be screened for expedited food stamp service, and that they may be eligible for expedited food stamps even if it appears that they may not meet the necessary requirements for program participation. (*See* Policy Directives 99-06R(2), 99-08R(4), 99-60RR; Policy Bulletin 99-13; Smith Decl. ¶ 27.) Further, applicants are no longer required to complete a separate form for expedited service. (*See* Smith Decl. ¶ 11.) Instead, the screening questions are now on the application. (*See* Smith Decl. ¶ 11.) Eligible applicants are notified and an electronic benefit transfer ("EBT") card is furnished to them. (*See* Smith Decl. ¶ ¶ 25-26.) HRA also began a citywide program in 2000 that now permits Center workers to open a separate non-public assistance food stamp case without the transfer of files to an NPA Center. (Trial Tr. at 137.)

Separate determinations for Medicaid cases are made by HRA's Medicaid Assistance program. Thus, if cash assistance is denied for reasons that would not apply automatically to Medicaid, a separate Medicaid determination is required. (*See* Trial Tr. at 138.) Prior to the August 1999 audit, referrals to the Medicaid Assistance Program were not tracked. (Trial Tr. at 138.) In 2000, HRA initiated an automated "reminder" system that combs the WMS, culls cases where public assistance was rejected or closed, identifies those requiring a separate Medicaid determination and then accesses the Medicaid

eligibility database to determine whether action was taken. (*See* Smith Decl. ¶ 29; Declaration of Seth Diamond ("Diamond Decl.") ¶ 2.)

HRA also expanded several initiatives intended to oversee Center operations as a whole. A number of these initiatives are conducted through the Office of Quality Assurance ("OQA"), which consists of the Office of Eligibility Monitoring, the Office of Audit and Quality Control and the Office of Corrective Action Innovation. To avoid federal sanctions for payment errors, the Office of Eligibility Monitoring performs monthly audits of all active TANF and food stamp cases. (*See* Declaration of Rochelle Abdullah, dated Feb. 1, 2001 ("Abdullah Decl.") ¶ 7, Exs. 2, 3.) Congruent with these reviews, the Audit and Quality Control Office evaluates all federal and state audits to ensure that error rates reported for New York City are based on complete and accurate information. (*See* Abdullah Decl. ¶ 6.) In 1998, the Office of Corrective Action Innovation established the PERT audit procedure to improve oversight of the Centers. Although the PERT audit protocol envisions three visits per year by state reviewers to each Center, the City defendants have fallen short of that regimen. (*See* Abdullah Decl. ¶ ¶ 11-12, Exs. 5, 6.)

***12** In May 2000, HRA started compiling a monthly "Job Stat" report to evaluate each Center's performance in specific areas, including employment, administration and self-sufficiency progress. (Smith Decl. ¶ 37; Declaration of Andrew Bush, dated Mar. 9, 2001 ("Bush Decl.") ¶ ¶ 4-5, 7.) The Job Stat report enables performance comparisons among Centers as well as performance tracking of each Center over time. (Bush Decl. ¶ 7.) Additionally, HRA launched an initiative called "CenterStat" to evaluate the data compiled in the JobStat reports and develop Center-specific solutions. (Bush Decl. ¶ ¶ 21-24.)

III. *State Defendants*

A. *Office of Temporary and Disability Assistance (OTDA)*

OTDA supervises all social services work performed by local government units and regulates the financial assistance granted by the State. (Ptak Decl. ¶ 6.) While OTDA oversees rules promulgated by local governments, those regulations become effective automatically within thirty days if OTDA does not invalidate them. (Ptak Decl. ¶ 8.) Although OTDA prescribes minimum qualifications for local social services department staff, it lacks authority to hire or terminate local HRA staff. (Ptak Decl. ¶ 11.) Rather, OTDA supervises the local districts' compliance with food stamp regulations. (Ptak Decl. ¶ 3; Pls. Ex. 33 at 18.) Under a delegation of authority from OTDA, New York's fifty-eight local social services districts, including New York City, administer the food stamp program within their districts. (Ptak Decl. ¶ 3.)

As part of its supervisory function, OTDA monitors food stamp program access in the Job and Income Support Centers in four ways: (1) PA Reviews; (2) ME Reviews; (3) operational review; and (4) corrective action plan ("CAP") follow-up review. (Deposition of Rosella Bryson, dated Feb. 15, 2001 ("Bryson Dep.") at 53-54.) The PA reviews help ensure compliance with food stamp procedures. (State Defendants Post-Trial Memorandum of Law ("State Defs. Mem.") at 10 .) The ME reviews, conducted on a cyclical basis, measure compliance with USDA objectives. (Ptak Decl. ¶ ¶ 2, 7, 50.) During 2000 and 2001, OTDA conducted PA and ME reviews at all Job Centers and completed food stamp reviews at five Income Support Centers. (Ptak Decl. ¶ ¶ 11, 52.) However, the PA and ME reviews were not conducted at regular intervals, and OTDA has no policy regarding how much time may elapse between those reviews. (State Defs. Ex. NN at 59.)

A January 1999 USDA Report noted a "lack of effective state agency oversight at local district offices." (Pls. Ex. 33 at 17.) Further, the Report commented that "[s]ubstantial non-compliance with the [Food Stamp Act] and regulations has gone undetected and unaddressed at the local level." (Pls. Ex. 33 at 17.) In 2000 and 2001, OTDA reported the results of its various reviews to the City defendants and required CAPs on a Center-by-Center basis. (Ptak Decl. ¶ ¶ 52-53.)

***13** In March 2001, OTDA notified HRA about its reviews of food stamp program access in New York City and summarized the findings of the PA reviews, ME reviews and CAP follow-up reviews. (Ptak Supp. ¶ 18; State Defs. Ex. NNN.) That notification required HRA to submit quarterly reports to OTDA until all outstanding issues were resolved. (Ptak Supp. ¶ 18; State Defs. Ex. NNN.)

OTDA also issued directives requiring adherence to specific program requirements, including the separate determination of eligibility for food stamps. (Ptak Decl. ¶ ¶ 40, 43; Ptak Supp. ¶ 17.) In January 2000, HRA issued a policy directive providing that when a public assistance application is withdrawn or denied, but the applicant wants to proceed with a food stamp eligibility evaluation, HRA staff must register and accept the case in all Centers. (Ptak Decl. ¶ 40.)

Nevertheless, in October 2000, OTDA advised HRA that the ME reviews had demonstrated that this policy had not been implemented in compliance with the initial schedule. (Ptak Decl. ¶ 40.) In response, OTDA directed HRA to investigate and address its failure to make separate determinations. (Ptak Decl. ¶ 40.) OTDA also required that HRA submit a plan for citywide implementation of OTDA's policy directive regarding separate food stamp determinations. (Ptak Decl. ¶ 40.) HRA submitted a draft policy directive, which, at the time of trial, was still under review by OTDA. (Ptak Supp. ¶ 16; State Defs. Ex. KKK.) Further, in March 2001, OTDA directed HRA to furnish monthly written confirmations that OTDA's policy concerning separate food stamp determinations are being implemented. (Ptak Supp. ¶ 17.)

OTDA also has monitored and requested improvements to HRA's EVR process. In December 2000, in accord with USDA mandates, OTDA directed HRA to cease its policy of denying food stamp applications when applicants fail to keep a scheduled EVR appointment. (Ptak Decl. ¶ 45; State Defs. Ex. JJ.) In January 2001, HRA agreed in writing that it would comply with OTDA's directive. (Ptak Decl. ¶ 45; Ptak Supp. ¶ 13.)

In tandem with the layers of supervision detailed above, OTDA provides a system of fair hearings for public assistance applicants to review decisions by local social service officials regarding such assistance. (State defendants' Findings of Fact ("State Defs. Findings") ¶ 148.) OTDA employs approximately 125 administrative law judges and supervising administrative law judges to conduct these hearings. (Declaration of Russell J. Hanks, dated Feb. 2, 2001 ("Hanks Decl.") ¶ 3.) Approximately 90 of those judges are assigned to administer fair hearings in the New York City district. (Hanks Decl. ¶ 4.)

B. *New York State Department of Health (DoH)*

As part of its supervisory function, DoH evaluates changes in federal law such as welfare reform that impact the Medicaid program and disseminates information regarding those changes to the local districts for implementation. (Declaration of Betty Rice ("Rice Decl.") ¶ 19.) DoH provides legal interpretations of such changes to determine whether state law and regulations should be amended to conform to revised federal requirements. (Rice Decl. ¶ 20.) DoH also consults with New York State agencies that may be affected by new legislation. (Rice Decl. ¶ 21.) DoH notifies local districts, such as New York City, of federal and state mandates, provides training in the implementation of policies, and develops various reference tools that summarize procedures for receipt of Medicaid. (*See* State Defs. Findings ¶ 82.) Once DoH has completed its issuance of written guidance to the local districts on new federal and state mandates, it provides ongoing technical assistance and training for each district. (Rice Decl. ¶ 27.)

***14** DoH trains HRA staff regarding Medicaid issues. (Rice Decl. ¶ 28; Declaration of Cornelia McElligot, dated Feb. 2, 2001 ("McElligot Decl.") ¶ 8.) Further, DoH coordinates Medicaid Technical Advisory Group ("MTAG") meetings with New York City. (McElligot Decl. ¶ 9; Rice Decl. ¶ 31.) DoH also conducts "Targeted Case Reviews" or Medicaid Eligibility Quality Control ("MEQC") reviews, under a federal waiver. The MEQC reviews are conducted in accordance with HCFA requirements. (Deposition of Betty Rice, dated Feb. 16, 2001 ("Rice Dep.") at 21.)

In early 1998, DoH learned that the City defendants intended to convert certain Income Support Centers to Job Centers. (Rice Decl. ¶ 6.) The State defendants acknowledge that this litigation was DoH's first notice of complaints regarding inappropriate denials, withdrawals and deterrence of Medicaid applications at certain Centers. (State Defs. Findings ¶ 101.) DoH reacted by issuing instructions to local districts to bring them into compliance. (Rice Decl. ¶ 5.) DoH further collaborated with the City defendants to review and approve corrective changes in the City's policy directives regarding the application process. (McElligot Decl. ¶ 7 .)

In early 1999, DoH provided HCFA with information concerning DoH's administration of the Medicaid program, including the monitoring of social services districts. (Rice Decl. ¶ 15.) In addition, DoH participated in developing a statewide work plan to review program access, case reviews, and for unannounced visits to local districts. (Rice Dep. at 97; McElligot Decl. ¶ 14.)

In August 2000, in response to federal efforts to improve low-income families' ability to enroll in Medicaid, DoH formulated a work plan for Medicaid program access. That work plan included reviews of the State's Medicaid eligibility policy as well as the Medicaid eligibility status of TANF cases closed since the implementation of PRWORA. (State Defs. Exs. RRR, VVV, ZZZ; Rice Decl. ¶ 17; Rice Dep. at 95-101.)

After learning of plaintiffs' allegations, DoH revised

its policy directives and required HRA employees to monitor referrals for separate Medicaid determinations. (Rice Decl. ¶ 48.) HRA distributed a brochure titled "You Can Still Apply for Medicaid," explaining that applicants may still be eligible for Medicaid benefits even if they are denied cash assistance. (Rice Decl. ¶ 49 .) DoH also clarified an applicant's entitlement to a separate Medicaid determination in the event cash assistance is denied. (Rice Decl. ¶ 51.)

CONCLUSIONS OF LAW

I. *The City Defendants*

A. *Legal Standard and Private Rights of Action Under the Food Stamp and Medicaid Acts*

A party seeking a permanent injunction must demonstrate irreparable harm and must actually succeed on the merits. *See* Amoco Prod. Co. v. Vill. of Gambell, 480 U.S. 531, 546 n. 12 (1987) ; *Reuters Ltd. v. United Press Int'l, Inc.*, 903 F.2d 904, 907 (2d Cir.1990) ; *Civic Assoc. of the Deaf v. Giuliani*, 915 F.Supp. 622, 631 (S.D.N.Y.1996). It is necessary to show that the irreparable injury is likely, not merely possible. *See JSG Trading Corp. v. Tray-Wrap, Inc.*, 917 F.2d 75, 79 (2d. Cir.1990). As discussed at length in *Reynolds I,* plaintiffs have established the irreparable harm threatened by an erroneous denial of benefits. *See* 35 F.Supp.2d at 338-40.

***15** Plaintiffs assert private rights of action based on defendants' violations of the Food Stamp and Medicaid Acts, and further contend that these violations support individual claims under § 1983. *See Reynolds I*, 35 F.Supp.2d at 336-37. Section 1983 imposes liability on those who, acting under color of state law, deprive a person "of any rights, privileges, or immunities secured by the Constitution and laws" of the United States. 42 U.S.C. § 1983. FN7 To seek redress through § 1983, a plaintiff "must assert the violation of a federal *right,* not merely the violation of a federal *law."* *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) (emphasis in original). The City defendants contend that neither the Food Stamp Act nor the Medicaid Act creates a right for individuals to enforce system wide compliance.

> FN7. Although municipalities may not be held liable under § 1983 on a theory of respondeat superior, they may be liable under § 1983 if "execution of a government's policy ... whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy" causes the deprivation of federal rights. *Pembaur v. City of Cincinnati*, 475 U.S. 469, 475 (1986) ; *Monell v. Dep't of Social Servs.*, 436 U.S. 658, 691-92 (1978). When a municipality's failure to train its employees in some relevant respect amounts to "deliberate indifference," that failure is tantamount to a policy or custom and is thus actionable under § 1983. *City of Canton, Ohio v. Harris*, 489 U.S. 378, 389 (1989).

In determining whether a statutory provision creates a federal right, courts must consider three factors: (1) "Congress must have intended that the provision in question benefit the plaintiff"; (2) "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"; and (3) "the statute must unambiguously impose a binding obligation on the States." *Blessing*, 520 U.S. at 341. Additionally, as clarified by the Supreme Court in *Gonzaga University v. Doe,* a federal right must be "unambiguously conferred" to support a cause of action under § 1983. 536 U.S. 273, 283 (2002) ("[I]t is *rights,* not the broader or vaguer 'benefits' or 'interests,' that may be enforced under the authority of [Section 1983]." (emphasis in original)).

The provision of the Medicaid Act that plaintiffs claim was violated requires that "medical assistance ... shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). As explained below, this provision gives rise to a § 1983 claim under *Blessing.*

First, the section is framed unambiguously in terms of eligible individuals' rights. *See* 42 U.S.C. § 1396a(a)(8) (Medicaid benefits "shall be furnished" to *eligible applicants*); *see also Cannon v. Univ. of Chicago*, 441 U.S. 677, 692 n. 13 (1979) (for statute to create private rights, its text must be "phrased in terms of the persons benefited"); *Touche Ross & Co. v. Redington*, 442 U.S. 560, 576 (1979) (rights-creating statutes typically phrased with unmistakable emphasis on benefited class). Eligible applicants are the intended beneficiaries under § 1396(a)(8) since they are to receive Medicaid benefits with reasonable promptness. *See Sabree v. Richman*, 367 F.3d 180, 189 (3d Cir.2004) (holding that § 1396a(a)(8) creates a privately enforceable right because, *inter alia,* plaintiffs were intended beneficiaries); *see also Bryson v. Shumway*, 308 F.3d 79, 88 (1st Cir.2002) (holding that § 1396a(a)(8) creates privately enforceable rights under § 1983).

***16** Second, the right conferred is neither vague nor amorphous. *See* *Sabree*, 367 F.3d at 189 ("[T]he rights sought to be enforced by [plaintiffs under § 1396a(a)(8)] are specific and enumerated, not 'vague and amorphous" '); *Bryson*, 308 F.3d at 89 (holding that § 1396a(a)(8) satisfies second *Blessing* factor).

Finally, this provision unequivocally binds the states. The Medicaid Act "mandates that state plans 'must' provide that medical assistance 'shall' be provided with reasonable promptness. These are not mere guidelines but, rather, requirements which states must meet under the Medicaid system." *Bryson*, 308 F.3d at 89; *Mendez v. Brown*, No. Civ.A. 03-30160-KPN, 2004 WL 626550, at *5 (D.Mass. Mar. 26, 2004) (§ 1396a(a)(8) confers a private right of action under § 1983 whether "analyzed strictly under *Blessing* or through the filter of *Gonzaga"*); *see also* *Sabree*, 367 F .3d at 189 ("[T]he obligation imposed on the states [under § 1396a(a)(8)] is unambiguous and binding.").

Similarly, the provisions of the Food Stamp Act at issue here confer enforceable rights under § 1983. As this Court discussed at some length in *Reynolds I*, Congress intended those provisions to benefit eligible applicants such as plaintiffs, the provisions are unambiguous and they impose unequivocal obligations on the states. *See* 35 F.Supp.2d at 340-41 (discussing 7 U.S.C. § § 2020(e)(2)(B) , 2020(e)(3) , 2020(e)(9)).

The legislative history of the Food Stamp Act also evinces Congress' intent to permit private rights of action. Subsequent to the 1977 amendments, the House Agricultural Committee Report stated that the "administrative remedies against the state contained in section 11(f) and elsewhere should not be construed as abrogating in any way private causes of action against states for failure to comply with federal ... requirements." H.R.Rep. No. 464 , 95th Cong., 1st Sess. 398. As explained by the Seventh Circuit, "[t]he explicit statement that administrative remedies do not abrogate a private party's right to sue and the specific acknowledgement of cases based on that right clearly indicate congressional intent to allow a private remedy based on the Food Stamp Act." *Haskins v. Stanton*, 794 F.2d 1273, 1275 (7th Cir.1986); *see also* *Gonzales v. Pingree*, 821 F.2d 1526, 1528 (11th Cir.1987) (noting that, under *Atkins v. Parker*, 472 U.S. 115 (1985), food stamps are a matter of "statutory entitlement").

B. *Compliance Requirements*

Having determined that plaintiffs may pursue their Food Stamp and Medicaid Act claims under § 1983, FN8 it is necessary to decide what level of compliance is required under these statutes. The City defendants contend, based on the funding provisions of the Food Stamp and Medicaid Acts, that only substantial compliance is required under those laws. Those funding provisions, sections 2020(g) and 1396c, respectively, are phrased as directives to the state agencies tasked with administering the Food Stamp and Medicaid programs. *See* 7 U.S.C. § 2020(g) (food stamp funding may be terminated when a state fails to comply with federal standards without "good cause"); 42 U.S.C. § 1396c (authorizing the cessation of payments to a state if, *inter alia*, "there is a failure to comply substantially with any such provision [of the Medicaid Act]"); 42 U.S.C. § 1396b(u)(1)(A)-(B) (the federal agency may waive such reductions if a state is unable to reach the permissible error rate "despite a good faith effort").

> FN8. Because this Court has determined that plaintiffs have enforceable rights under § 1983, it is unnecessary to decide whether the Food Stamp and Medicaid Acts themselves create individually enforceable rights. However, as *Gonzaga* observed, "implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983," since "in either case we must first determine whether Congress intended to create a federal right." 536 U.S. at 283.

***17** The City defendants' argument is unavailing because it is the text of the Food Stamp and Medicaid Act provisions at issue-and not the funding provisions-to which this Court must look in determining the level of compliance required. As noted by the Ninth Circuit, "[t]he funding standard is not intended to be the measure of what the [Food Stamp and Medicaid Acts] require; it is intended to measure how great a failure to meet those requirements should cause funds to be cut off." *Withrow v. Concannon*, 942 F.2d 1385, 1387 (9th Cir.1991) ("[W]e are not convinced ... that the standard for termination of federal funding ... is the appropriate one to define the rights of applicants and recipients of program benefits."); *see also* *Bleecker Charles Co. v. 350 Bleecker St. Apartment Corp.*, 327 F.3d 197, 203 (2d Cir.2003) (to determine meaning of statute, court should look to the language of the statute itself and need look no further if those words are unambiguous).

The plain language of § 1396a(a)(8) states in mandatory, not precatory, terms that Medicaid benefits "shall be furnished" to persons eligible to receive them. 42 U.S.C. § 1396a(a)(8). The relevant provisions of the Food Stamp Act are phrased in similar mandatory terms. *See, e.g.,* 7 U.S.C. § 2020(e)(2)(B) ("[A] State agency ... shall provide timely, accurate, and fair service to applicants for, and participants in, the food stamp program ... [and] shall develop an application containing the information necessary to comply with this chapter."). The language of these provisions is unambiguous and requires that state agencies "shall" or "must" provide the specified benefits to eligible applicants. The plain language thus requires that state agencies comply strictly with their obligations to provide food stamps and Medicaid benefits to eligible applicants. *See Withrow*, 942 F.2d at 1387-88 (holding that strict, not substantial, compliance is required under Food Stamp and Medicaid Acts); *Haskins*, 794 F.2d at 1277 (same).

This interpretation does not encroach on a municipal government's conduct of its internal affairs because "[t]he Act itself imposes the burden." *Haskins* 794 F.2d at 1277; *see also Withrow*, 942 F.2d at 1388 ("The fact that absolutely perfect compliance is unattainable does not of itself preclude an injunction requiring the state to comply with the regulations."). Nor does this holding disturb the principle that district courts have discretion when deciding whether injunctive relief is warranted. "[A]n injunction is not required whenever an agency that is otherwise in full compliance fails in one or a very few sporadic instances." *Withrow*, 942 F.2d at 1388. "There is however, doubtless a point at which any failure of total compliance is truly *de minimus*, where the state has come to comply 'as strictly as is humanly possible,' and it is within the discretion of the district court to deny injunctive relief." *Withrow*, 942 F.2d at 1388. Accordingly, the City defendants are obliged to comply strictly with the Food Stamp and Medicaid Acts.

C. *City Defendants' Compliance*

***18** Whether the City defendants are complying with the Food Stamp and Medicaid Acts is a fact-specific question. Remedial measures undertaken to redress deficiencies in performance are relevant to whether a "policy or custom" exists for purposes of § 1983 liability. *See City of Canton*, 489 U.S. at 389. Rather than gauging compliance by reference to a specific numeric standard, it is appropriate to consider whether the City defendants have invested the resources and human capital to ensure provision of welfare benefits. (*See* Trial Tr. at 226.)

1. *Expedited Food Stamps*

Plaintiffs seek to hold the City defendants liable for failing to comply with New York's five-day requirement for expedited food stamps under 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a), which they assert as a pendent state law claim. (Compl.¶ 7.)

To determine whether a statute creates a privately enforceable right of action under New York law, a court must consider: "(1) whether the plaintiff is one of the class for whose particular benefit the statute was enacted; (2) whether recognition of a private right of action would promote the legislative purpose; and (3) whether creation of such a right would be consistent with the legislative scheme." *Henry v. Isaac*, 632 N.Y.S.2d 169, 170 (App. Div.2d Dep't 1995) (quoting *Sheehy v. Big Flats Cmty. Day*, 73 N.Y.2d 629, 633 (1989)).

First, just as plaintiffs are intended beneficiaries of the Food Stamp Act, they are intended beneficiaries of 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a). New York Social Services Law § 62 provides that "each public welfare district shall be responsible for the assistance and care of any person who resides or is found in its territory and who is in need of public assistance and care which he is unable to provide for himself." N.Y. Soc. Serv. Law § 62, subd. 1; *see Jones v. Berman*, 37 N.Y.2d 42, 54-55 (1975). The City thus bears responsibility for providing public assistance to qualified welfare beneficiaries such as plaintiffs. 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a) implements that directive with respect to expedited food stamps. Buttressing this conclusion, New York courts have inferred private rights of action for similar statutory provisions. *See, e.g., Doe v. Dinkins*, 600 N.Y.S.2d 939, 943 (App. Div. 1st Dep't 1993) (upholding injunction for City's failure to comply with 18 N.Y.C.R.R. § § 491.3(g)(1)(i) and 491.10(o)(9)(iv)); *Lamboy v. Gross*, 513 N.Y.S.2d 393, 396-98 (App. Div. 1st Dep't 1987) (upholding preliminary injunction for violation of administrative directive 83 ADM-47).

Second, recognizing a private right of action under 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a) promotes the legislative purpose, enshrined in Article XVII § 1 of the State Constitution, mandating aid to the needy. *See Wilkens v. Perales*, 128 Misc.2d 265, 268, 487 N.Y.S.2d 961 (Sup.Ct.1985) ("Aid to the needy is not dependent upon governmental compassion but is a fundamental right."). Private claims under 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a) will aid in

effectuating that mandate.

***19** Third, recognizing a private right to enforce 18 N.Y.C.R.R. § 387 .8(a)(2)(i)(a) is consistent with the legislative scheme because it helps to ensure that public officers charged with implementing a state constitutional mandate will perform that duty. *See Wilkens*, 128 Misc.2d at 268. FN9

> FN9. The exercise of supplemental jurisdiction over plaintiffs' state law claim comports with the values of judicial economy, fairness and comity set forth in *United Mine Workers of America v. Gibbs*, 383 U.S. 715, 726 (1966). Whether the City defendants are in compliance with New York's five-day limit for expedited food stamps hinges on the same findings-namely, the September 2000 Audit-on which plaintiffs' federal claims rest. *See Leonard v. Dutchess County Dep't of Health*, 105 F.Supp.2d 258, 261 (S.D.N.Y.2000) (exercising supplemental jurisdiction where plaintiff's state and federal claims rested on identical facts). Further, plaintiffs' state law claim is neither novel nor complex. The straightforward issue is whether the City defendants must provide expedited food stamps within five days or within the seven-day federal limit. Finally, New York courts have inferred private rights of action from similar regulations.

Defendants rely on *Concourse Rehabilitation & Nursing Center v. DeBuono* for the proposition that plaintiffs cannot enforce a state law against a state entity in federal court. *See* 179 F.3d 38, 43-44 (2d Cir.1999) ("[T]he failure of a State authority to comply with State regulations cannot alone give rise to a § 1983 cause of action."). While that proposition is correct, *Concourse* is inapposite because the plaintiff in that case attempted to assert a state law claim through § 1983 against a state defendant. *See Concourse*, 179 F.3d at 43-44. Here, by contrast, plaintiffs assert their 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a) cause of action as a pendent state law claim. It is not engrafted on § 1983. Moreover, while New York City exercises "a slice of state power" as a social services district, *Holley v. Lavine*, 605 F.2d 638, 644 (2d Cir.1979), it nevertheless has the primary responsibility to provide food stamps for the needy who live within its borders. *See Biggs v. Block*, 629 F.Supp. 1574, 1580 (E.D.N.Y 1986) ("New York administers its Food Stamp program through local agencies. Each county (plus the City of New York) has been designated a social services district which is responsible for public assistance programs within its jurisdiction."). Therefore, the City does not enjoy sovereign immunity as a state defendant.

The parties' experts both concluded that the City defendants were in compliance with the five-day period for expedited food stamps under 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a) only 69 percent of the time. (Pls. Ex. 49: Fourth Faust Rep., Table C-2; Pollner Supp. Rep. at 14, Table 13.) Since approximately one-third of eligible applicants do not receive expedited food stamps within the required five-day limit, this Court cannot conclude that the City defendants are meeting their obligations under 18 N.Y.C.R.R. § 387.8(a)(2)(i)(a). FN10

> FN10. Additionally, the percentage of eligible applicants receiving expedited food stamps within the federally mandated seven-day limit is not materially different. (*See* Supp. Pollner Rep. Attach. 16, Query C-5; Pls. Findings ¶ 53.) The City defendants' PERT audits do not undermine that finding. While the City defendants launched an initiative to make expedited food stamps available on the day of application, it was not fully implemented at the time of trial. Accordingly, this Court also concludes that the City defendants have not complied with the federal time limits for expedited food stamps.

Moreover, approximately 65 percent of eligible applicants were denied expedited food stamps. (*See* Fourth Faust Rep., Table C-3, at Pls. Ex. 49; Pollner Rep. at 15 (Table 10).) Error rates of these magnitudes are evidence of a breakdown in the delivery of essential services to New York's neediest population. *See Caswell v. Califano*, 583 F.2d 9, 12-13 (1st Cir.1978) (injunction warranted where government failed to meet obligations for nearly half of eligible claimants); *Peppers v. McKenna*, 81 F.R.D. 361, 366-67, 370 (N.D.Ohio 1977) (time limit satisfied for only 47.4 percent of welfare benefits appeals).

2. *Immediate Needs Grants*

Plaintiffs also invoke this Court's supplemental jurisdiction to assert a claim for violation of New York Social Services Law § 133. This Court finds that its exercise of supplemental jurisdiction is appropriate here. *See supra* note 9. That statute provides public assistance applicants with a right to pre-investigative relief if they are in immediate need.

See *Gonzales*, 486 N.Y.S.2d at 632 (stating that § 133 establishes a right of public assistance recipients to pre-investigative relief). Local social services districts do not enjoy sovereign immunity against plaintiffs' Social Services Law claim because they have a duty to administer public assistance under New York law. Thus, the City can be held liable for failing to comply with the strictures of Social Services Law § 133. *See* *Koster v. Perales*, 903 F.2d 131, 137 (2d Cir.1990) (noting that the "County Commissioner has an independent statutory duty, distinct from his obligation as an agent of the State, to 'administer ... public assistance and care" '); *Holley*, 605 F.2d at 644 (stating that the Supreme Court "has 'consistently refused to construe the [Eleventh] Amendment to afford protection to political subdivisions such as counties and municipalities, even though such entities exercise a "slice of state power" " ' (quoting *Lake County Estates, Inc. v. Tahoe Reg'l Planning Agency*, 440 U.S. 391, 400 (1979))).

***20** While *Beaudoin v. Toia*, 45 N.Y.2d 343, 347-48 (1978) , concluded that local social services districts are agents of the state under Social Services Law § 133, that case focused on a county's role in implementing fair hearing decisions as an agent of the state. That is not the situation presented to this Court. Thus, *Beaudoin* is not determinative.

The City defendants assert that imposing liability on them under § 133 would require a transfer of funds from the state treasury and violate the doctrine of sovereign immunity. That argument lacks merit because "the county's duty to provide assistance is not dependent upon the receipt of equivalent money from the State and the cases have so held." *Jones*, 37 N.Y.2d at 55. Indeed, courts have imposed liability on local government entities for violations of § 133. *See* *Henrietta D. v. Giuliani*, 119 F.Supp.2d 181, 219-20 (E.D.N.Y.2000), *aff'd*, *Henrietta D. v. Bloomberg*, 331 F.3d 261 (2d Cir.2004).

The experts agree that the City defendants were in compliance with the same-day requirement for immediate needs grants 69 percent of the time. (Pls. Findings ¶ 58.) Moreover, the City defendants erroneously denied immediate needs grants to approximately 47 percent of eligible applicants. (Supp. Pollner Rep. Table 5 at 9; Pls. Ex. 49: Fourth Faust Rep., Table B-3.) Those statistics compel the conclusion that the City defendants are not in full compliance with their obligations under New York Social Services Law § 133.

3. *Separate Determinations for Food Stamps and Medicaid*

Although the City defendants implemented remedial measures to assure separate determinations for food stamps and Medicaid, the September 2000 Audit revealed inadequate performance. The credible statistical proof revealed that separate determinations for food stamps and Medicaid were made only about 14 percent of the time. (Fourth Faust Rep. ¶ 64; Supp. Pollner Rep., Table 19 at 20.) Thus, the City defendants are not in strict compliance with their obligation under 7 C.F.R. § 273.2(b)(3).

4. *Application Withdrawals*

Forty-five percent of all food stamp application withdrawals were based on misleading or inaccurate information. With such an error rate, the City defendants are not in full compliance with the applicable federal regulations. *See* 42 C.F.R. § § 435.913 , 435.909; *see also, e.g.*, *Caswell*, 583 F.2d at 12-13.

5. *Provision of Notices*

While the City's performance with respect to the provision of notices is better, non-compliance in the range of 20 percent is not *"de minimus." See* *Withrow*, 942 F.2d at 1388. Moreover, the City defendants failed to provide needed information on the W-145HH and M-3 forms more than 50 percent of the time. *See supra* Section 1.B.5 . ¶ ¶ a, b, c, d, e, f. Because the law requires that the notices be completed correctly, this Court finds that the City defendants have not met their obligations under 7 C.F.R. § 273.10(g)(1) , 42 C.F.R. § § 435.911 , 435.912 and 18 N.Y.C.R.R. § § 351.8(b) and 358-2.2(a).

6. *Access*

***21** HRA has a policy in place emphasizing applicants' right to apply for benefits on their initial contact at a Center. That policy is enforced through the "spot check" program. The evidence does not demonstrate that the City defendants have engaged in a pattern or policy of denying access.

D. *The State Defendants*

States that participate in the food stamp and Medicaid programs can either designate a single state agency to administer the programs or, as New York has done, can implement the programs on a decentralized basis through local agencies. *See* 7 U.S.C. § 2012(n) ; 42

U.S.C. § 1396a(a)(1). While states may delegate administrative responsibility for the day-to-day oversight of these programs, " 'ultimate responsibility' for compliance with [their] requirements nevertheless remains at the state level." *Robertson v. Jackson*, 972 F.2d 529, 533 (4th Cir.1992) (citation omitted); *Woods v. United States*, 724 F.2d 1444, 1447-48 (9th Cir.1984) (State of California could be held responsible for violations of Food Stamp Act committed by San Francisco City government); *Reynolds III*, 118 F.Supp.2d at 385.

For administration of these public welfare programs, local social services districts, including the City of New York, are considered "agents of the state." *See Reynolds III*, 118 F.Supp.2d at 386. The Food Stamp Act expressly defines the term "State agency" as "the agency of State government, including the local offices thereof, which has the responsibility for the administration of the federally aided public assistance programs within such State...." 7 U.S.C. § 2012(n). Similarly, states bear the ultimate responsibility for supervising compliance with the Medicaid Act and state cash assistance programs. *See Hillburn v. Maher*, 795 F .2d 252, 260 (2d Cir.1986) ("single State agency" required to administer Medicaid to avoid lack of accountability); *Beaudoin*, 45 N.Y.2d at 347-48 ("In the administration of public assistance funds, whether they come from Federal, State or local sources ... the local commissions act on behalf of and as agents for the State.").

Thus, as this Court held in *Reynolds III*, the Food Stamp and Medicaid Acts require participating states to administer these programs and actively supervise local agencies to ensure compliance. 118 F.Supp.2d at 385-86; *see also Beaudoin*, 45 N.Y.2d at 347-48 (holding that the same rule applies for state cash assistance programs). Therefore, a violation of plaintiffs' rights under the Food Stamp, Medicaid and cash assistance programs by City defendants can "give[ ] rise to corresponding Section 1983 claims against the State defendants." *Reynolds III*, 118 F.Supp.2d at 386.

The State defendants have taken various measures to foster compliance by the City Defendants. OTDA has used the ME, PA and CAP reviews to monitor performance. In 2000, it began reporting the results of those reviews to the City defendants. (Ptak Decl. ¶ ¶ 52-53.) In addition, OTDA required HRA to submit regular reports for CAP components in each Center until outstanding issues were resolved. (Ptak Supp. ¶ 18.) OTDA also issued directives requiring adherence to mandates such as the need to make separate eligibility determinations. (Ptak Decl. ¶ ¶ 40, 43.) DoH implemented various training programs for the City defendants and has also provided direct supervision for the City's training programs. (Rice Decl. ¶ ¶ 23, 29, 31; McElligot Decl. ¶ ¶ 7-8.) Moreover, the State fair hearing process provides a means to ensure correct determinations for public assistance applications. (Hanks Decl. ¶ ¶ 3-4.)

***22** However, the City defendant's failure to satisfy their obligations under the Food Stamp and Medicaid Acts, as revealed by the low compliance levels, is persuasive evidence that the State defendants have failed in their oversight obligations. Despite the State defendants' remedial measures, only 65 percent of eligible applicants received expedited food stamps within seven days. Moreover, nearly half of all applications for immediate needs grants were improperly denied. More than half of all withdrawn cash assistance applications were withdrawn for improper reasons. By any measure, those results are not within the *de minimus* range required by the Food Stamp and Medicaid Acts. *See Withrow*, 942 F.2d at 1388. They underscore the fact that the State defendants' curative initiatives have not had the desired prophylactic effect. Thus, the State defendants are not fulfilling their "ultimate responsibility" of ensuring compliance. *See Robertson*, 972 F.2d at 533. This conclusion is consistent with the January 1999 USDA Report noting a "lack of effective state agency oversight." (Pls. Ex. 33, at 17.) A contrary holding would ignore New York City's role as an agent of the state, *see* 7 U.S.C. § 2012(n) ; 42 U.S.C. § 1396a(a)(1), and allow the State to avoid its responsibility for overseeing the food stamp and Medicaid programs. *See Hillburn*, 795 F.2d at 260 (holding that the Medicaid Act's single state agency provision is intended to avoid "a lack of accountability for the appropriate operation of the program"); *see also Woods*, 724 F.2d at 1447 ("The Food Stamp Act places responsibility for the administration of the food stamp program on the state."). That would be inconsistent with the State's non-delegable duty to administer the food stamp and Medicaid programs under 7 U.S.C. § 2020 and 42 U.S.C. § 1396a, respectively. Plaintiffs' request for declaratory and injunctive relief as to the State defendants is therefore granted.

CONCLUSION

For the foregoing reasons, the plaintiff class is entitled to a permanent injunction requiring the City defendants and the State defendants to: (i) provide expedited food stamp service to eligible applicants within five days; (ii) provide temporary assistance to

applicants for Medicaid, food stamps or cash assistance who are in immediate need in accord with N.Y. Soc. Serv. Law § 133 ; (iii) separately process applications for food stamps when the applications for cash assistance are denied or withdrawn; (iv) send notices to applicants confirming voluntary withdrawals for Medicaid in accord with 42 C.F.R. § 435.913 and document such withdrawals pursuant to 7 C.F.R. § 273.2(c)(6); and (v) provide adequate and timely notice by correctly completing Forms W-145HH and M-3.

The parties are directed to submit a proposed final judgment consistent with this Amended Memorandum and Opinion by February 17, 2005.

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that this brief was produced in Times New Roman 14 point typeface using Microsoft Word 2003 and contains 6,996 words.

s/ Jonathan S. Franklin
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DIGITAL SUBMISSION CERTIFICATION

Counsel for amici the American Medical Association, the Oklahoma State Medical Association, and the American Academy of Pediatrics hereby certifies that:

1. All required privacy redactions have been made and, with the exception of those redactions, every document submitted in digital form or scanned PDF format is an exact copy of the written document filed with the Clerk; and

2. The digital submissions have been scanned for viruses with the most recent version of a commercial virus scanning program (Symantic Antivirus, Version 9.0.0.338, updated Sept. 11, 2005) and, according to the program, are free of viruses.

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CERTIFICATE OF SERVICE

I hereby certify that on this 12th day of September, 2005, two copies of the foregoing Brief for Amici Curiae the American Academy of Pediatrics, the American Medical Association, and the Oklahoma State Medical Association Supporting Plaintiffs-Appellants and Reversal in No. 05-5100 were served by overnight delivery and by electronic mail upon:

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