UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

W.B., by and through his father and legal guardian, David B., and A.W., by and through her mother and legal guardian, Brittany C., on behalf of themselves and all others similarly situated,

Plaintiffs,

v. Case No.:

SIMONE MARSTILLER, in her official capacity as Secretary for the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendant.

______________________________________/

MOTION FOR CLASS CERTIFICATION

PLEASE TAKE NOTICE upon the annexed declarations of David B. and Brittany C. and upon all the papers filed herein, Plaintiffs move this court, at a time and place to be determined by the United States District Judge for the Middle District of Florida to which this case is assigned for an order granting Plaintiffs' motion pursuant to Fed. R. Civ. P. 23 on behalf of:

> All Florida Medicaid beneficiaries under age 21 who have been or will be required to establish their need for Medicaid services under Defendant's standard for medical necessity set forth in Fla. Admin. Code R. 59G-1.010.

MEMORANDUM OF LAW

I. INTRODUCTION

Defendant, the Florida Agency for Healthcare Administration (AHCA), in evaluating requests for Medicaid services, applies its standard of medical necessity established in Fla. Admin. Code R. 59G-1.010 to all beneficiaries, regardless of age. However, as repeatedly found by Florida state courts, Defendant's standard conflicts with the standard accorded by the Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of federal Medicaid law. Those provisions mandate that states cover all Medicaid services necessary to "correct or ameliorate" health conditions of children under age 21. Defendant requires child Medicaid beneficiaries to meet its medical necessity standard, which is significantly narrower than the broad EPSDT standard. This has resulted in the Defendant's denying necessary health services to the named plaintiffs and thousands of Florida's children like them, even though the children are legally entitled to such services under federal Medicaid law.

Plaintiffs therefore move the Court for an order pursuant to Rules 23(a) and (b)(2) of the Federal Rules of Civil Procedure, certifying a class as follows:

> All Florida Medicaid beneficiaries under age 21 who have been or will be required to establish their need for Medicaid services under Defendant's standard for medical necessity set forth in Fla. Admin. Code R. 59G-1.010.

II. LEGAL BACKGROUND

AHCA, as the single state Medicaid agency must provide certain mandatory services, including EPSDT services for children under the age of 21. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396(a)(43), 1396d(a)(4)(B), and 1396d(r). The EPSDT provisions require states to cover any service listed in 42 U.S.C. § 1396d(a) if those services are "necessary health care, diagnostic services, treatment and other measures…to correct or ameliorate defects and physical and mental illnesses and conditions…regardless of whether or not such services are covered" for adults. 42 U.S.C. § 1396d(r)(5).

EPSDT's scope of coverage is broad. *Smith v. Benson*, 703 F. Supp. 1262, 1269-70 (S.D. Fla. 2010). States must cover all services listed in the Medicaid Act if those services correct, compensate for, improve a condition, or prevent a condition from worsening, even if the condition cannot be prevented or cured. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs. (CMS), *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* at 10 (June 2014) (hereinafter CMS, EPSDT Guide). States may use these prescribed limits to establish parameters when evaluating whether Medicaid services for beneficiaries under age 21 are medically necessary. *Id.* at 23. Paramount, however, is that those parameters do not contradict or act to restrict that which EPSDT mandates. *Id.*

III. FACTUAL BACKGROUND

A. Defendant's Administration of Florida's Medicaid Program and Medical Necessity Standard.

The Florida Medicaid program provides health care services to beneficiaries one of two ways: either on a Fee-For-Service (FFS) basis or through a managed care plan, otherwise known as a managed care organization (MCO). Fla. Stat. §§ 409.966, .967, .968, .971. In addition to federal and state law, the MCOs' obligations in administering Florida's Medicaid program are set forth in AHCA's Statewide Medicaid Managed Care Model Contract (AHCA Model Contract).[1]

Defendant requires that, before any Medicaid service is reimbursed, the requested service be authorized as medically necessary. Fla. Admin. Code. R. 59G-1.035(6). Defendant defines medical necessity or medically necessary in Fla. Admin. Code R. 59G-1.010 as follows:

> "The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
>
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs

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[1] Individual MCO contracts are not publicly available, but a "Model Contract" is published on AHCA's website at: https://ahca.myflorida.com/medicaid/statewide_mc/model_health_FY18-23.shtml.

> ● Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
>
> ● Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
>
> ● Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider
>
> The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

For children enrolled in MCOs, Defendant requires the MCOs to evaluate requested services under Defendant's definition of medical necessity. *See* AHCA Model Contract, Attach. II, pg. 18, 63 & 78. For children in FFS, Defendant contracts with a Quality Improvement Organization (QIO) called eQHealth Solutions, Inc (eQHealth) to evaluate requested Medicaid services using Defendant's medical necessity standard. (Ex. 2, p. 3-4); *see also*, Fla. Admin. Code R. 59G-1.053.

Defendant drafted a memo dated August 5, 2014, entitled "Summary Memorandum: Medical Necessity as a Limitation on Medicaid Services, Including EPSDT." (Ex. 3, p. 27-38). The memo, which contains Defendant's rationale for applying the same medical necessity standard to all Medicaid beneficiaries (adults

and children under 21), asserts that "states may place limits on Medicaid state plan services, including EPSDT services…based on the state's definition of 'medical necessity.'" (*Id.* at 36). The memo also takes the position that "a treating physician's opinion regarding the medical necessity of a services is not dispositive or accorded deference." (*Id.*). Defendant includes this memo as part of its training of hearing officers and in the hearing record for named Plaintiff, A.W. (*Id.*; Ex. 10)

Defendant's medical necessity standard set forth in Fla. Admin. Code R. 59G-1.010, and its memo expounding on that standard, conflicts with EPSDT. (*Id.*) EPSDT requires a state to cover any service necessary to correct or ameliorate a child's health condition; in contrast, Defendant's standard imposes a requirement on beneficiaries to show, regardless of age, that the service is "necessary to protect life, to prevent *significant* illness or *significant* disability, or to alleviate *severe* pain." (emphasis added). *Compare* 42 U.S.C. § 1396d(r)(5) *with* Fla. Admin. Code R. 59G-1.010

Further, Defendant's medical necessity standard incorporates a requirement that the service not be primarily intended for the sake of caregiver, physician, or recipient convenience. Fla. Admin. Code R. 59G.1.010. This requirement is not part of EPSDT's broad definition and states do not have the discretion to impose additional criteria outside what federal guidelines allow. *Jackson v. Millstone*, 801 A.2d 1034, 1049 (Md. 2002); *M.H. v. Berry*, No. 15-CV-1427 TWT, 2021 WL

1192938, *7 (N.D. Ga. March 29, 2021) (finding that the state should determine whether a service is medically necessary…based on whether a service is medically necessary to correct or ameliorate a beneficiary's condition" and not "based upon non-medical criteria.").

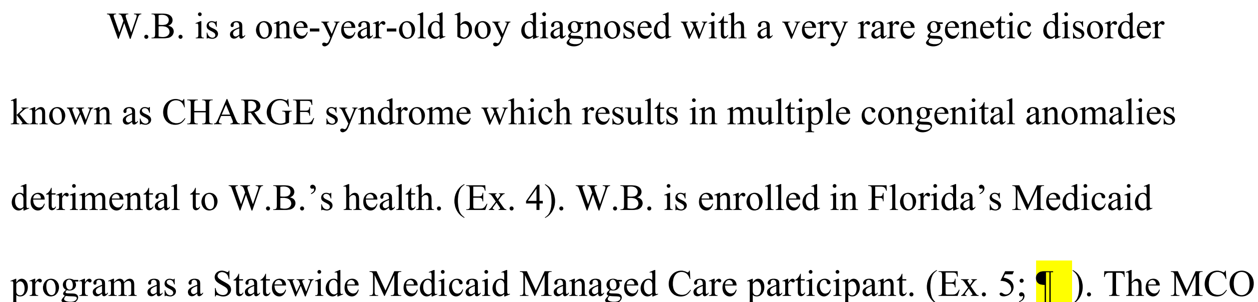
In the memo, Defendant also asserts that it owes no deference to a treating physician's opinion; in comparison, EPSDT prohibits a state from arbitrarily disregarding the opinion of a treating physician. *Compare* (Ex. B, p. 27-38) *with C.F. v. Dep't of Children and Families*, 934 So.2d 1, 7 (Fla. 3d DCA 2005); *M.H.*, 2021 WL 1192938 at *6. Contrary to Defendant's assertion, the state is not the final arbiter of medical necessity in EPSDT service determinations; instead, both the state and the treating professional play "roles in determining what medical measures are necessary to 'correct or ameliorate'" a child's health condition. *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1258-59 (11th Cir. 2011); *Moore ex rel. Moore v. Medows*, 324 F. App'x. 773, 774 (11th Cir. 2009).

Florida state courts have repeatedly found that Defendant's standard violates EPSDT by being more restrictive than the broad federal mandate. *See*, *e.g.*, *C.F.*, 934 So.2d at 1 (reversing the state's decision to deny services to an EPSDT-eligible child finding that the state "improperly applied a more restrictive standard of 'medical necessity' [Fla. Admin. Code R. 59G-1.010] than that outlined by federal Medicaid law."); *see also*, *I.B. v. Agency for Health Care Admin.*, 87 So.3d

6, 8-10 (Fla. 3d DCA 2012) (reversing the Defendant's decision to deny coverage for services needed by an EPSDT-eligible child, finding that the Defendant "relied upon an incorrect and inapplicable rule [Fla. Admin. Code R. 59G-1.010] to determine medical necessity."); *E.B. v. Agency for Health Care Admin*, 94 So.3d 708, 708-09 (Fla. 4th DCA 2012) (Defendant, in evaluating a request for Medicaid services, failed "to consider the federal…[EPSDT]…standard in making its determination as to which services requested by E.B. were covered by the Medicaid…Program."); *Q.H. v. Sunshine State Health Plan*, 307 So.3d 1, 14 (Fla. 4th DCA 2020) (finding that Defendant erroneously applied "the 'overly restrictive' standard of medical necessity set forth in the Florida Administrative Code, rather than the more expansive EPSDT standard of whether the treatment was necessary to 'correct or ameliorate' the child's condition."). Nevertheless, Defendant persists in applying this illegal and restrictive criteria to all requests for Medicaid services for children under 21 in Florida.

B. The Facts of the Named Plaintiffs.

1. W.B.



W.B. is a one-year-old boy diagnosed with a very rare genetic disorder known as CHARGE syndrome which results in multiple congenital anomalies detrimental to W.B.'s health. (Ex. 4). W.B. is enrolled in Florida's Medicaid program as a Statewide Medicaid Managed Care participant. (Ex. 5; ¶_). The MCO

that manages W.B.'s Medicaid benefits is called the Children's Medical Services Health Plan or the "CMS Plan." (*Id.* at ¶_).

Based on his diagnosis and medical needs, W.B.'s primary care physician, Dr. Carlin, prescribed a course of treatment at a specialty clinic in Ohio called the CHARGE Center (the CHARGE Center). (Ex. 4). Dr. Carlin prescribed this care because it is a one-of-a-kind clinic housing multiple specialists who all have specific expertise in CHARGE syndrome. (*Id.*) It is Dr. Carlin's professional opinion that W.B. will experience long-term developmental setbacks if he does not receive treatment at the CHARGE Center. (*Id.*)

Defendant has denied W.B.'s request for Medicaid to cover his treatment at the CHARGE Center. (Ex. 5 at ¶_; Ex. 6). W.B.'s MCO based its denial on Fla. Admin. Code R. 59G-1.010 finding, in part, that W.B. failed to establish that his requested treatment is not meant to "be furnished in a manner not primarily intended for the convenience of the recipient, caretaker, or provider." (Ex. 6). By requiring W.B. to demonstrate this, the MCO (and, thereby, the Defendant) imposed upon W.B. additional criteria that EPSDT does not require or allow. *Jackson*, 369 A.2d at 1049; *M.H.*, 2021 WL 1192938 at *7.

W.B.'s MCO did not evaluate whether the less costly option of in-state care among uncoordinated specialists who do not have CHARGE syndrome expertise is equally effective, or otherwise assess W.B.'s request according to EPSDT's

criteria, that is, whether the service is necessary to correct or ameliorate his condition. (Ex. 6). W.B.'s MCO also did not consider the opinions of W.B.'s treating physician that the service she prescribed was not available locally. (*Id.*)

2. A.W.

A.W. is an 11-year-old child diagnosed with quadriplegic cerebral palsy and multiple other health conditions and disabilities. (Ex. 7, 8 & 9). As a result of her diagnosis, A.W is non-verbal, incontinent of bowel and bladder, uses a gastronomy tube (g-tube), requires either a two-person or Hoyer lift, and uses a wheelchair. (*Id.*) She requires maximum assistance with all activities of daily living, is a high risk for falling out of bed, and her g-tube feeding schedule includes enteral feeds continuously at night. (*Id.*)

Due to these diagnoses, Dr. Carlin prescribed A.W. a specialty medical bed called a Dream Series bed. (Ex. 7). Dr. Carlin prescribed the Dream Series bed to ensure that A.W. has a safe and supportive sleep arrangement at night that fully accounts for her disabilities. (*Id.*) The bed is also specifically designed to mitigate the safety risks posed by alternative sleeping arrangements including a regular bed and a traditional hospital bed. (Ex. 7, 8 & 10). On February 24, 2020, eQHealth, relying on Defendant's medical necessity standard, denied the Dream Series. (Ex. 11).

On March 2, 2020, A.W.'s mother requested an appeal with AHCA's Office of Fair Hearings. (Ex. 10, ¶_). On May 6, 2020, Defendant upheld the February 24th denial on the same basis - that A.W. failed to establish that the Dream Series bed met the criteria in Fla. Admin. Code R. 59G-1.010. (Ex. 2). Defendant did not consider or accord deference to the opinions of A.W.'s treating professionals, evaluate whether the less costly option of a hospital bed was equally effective to meet A.W.'s needs, or otherwise assess A.W.'s request under the broad standard, mandated by EPSDT, of whether the bed is necessary to correct or ameliorate her condition. (*Id.*)

IV. ARGUMENT

A. The Class Representatives Having Standing to Bring this Claim.

Prior to conducting the Rule 23 analysis for class certification, a court must determine that at least one named class representative has Article III standing to bring each claim. *Murray v. Auslander,* 244 F.3d 807, 810-11 (11th Cir. 2001). To satisfy standing, a plaintiff must have suffered an "injury in fact" or "an invasion of a legally protected interest which is...concrete and particularized." *Focus on the Family v. Pinellas Suncoast Transit Authority*, 344 F.3d 1263, 1272 (11th Cir. 2003). Additionally, a plaintiff must "allege and show that he personally suffered injury." *Griffin*, 823 F.2d at 1482).

The class representatives, W.B. and A.W., suffer the concrete and particularized injury of (1) Defendant denying their request to provide a Medicaid service based on an erroneous standard of medical necessity, and (2) because of Defendant's denial, they were denied care necessary to correct or ameliorate their conditions placing their health at risk. (Dkt. #1, ¶¶85-101; 119-131); *Focus on the Family*, 344 F.3d at 1272. W.B. and A.W. seek to challenge Defendant's policy that all requests for Medicaid services, regardless of the beneficiary's age, meet Defendant's medical necessity standard instead of the broader standard guaranteed to children under EPSDT. (Dkt. #1, ¶¶133); *Griffin*, 823 F.2d at 1483. As such, W.B. and A.W. fall within the class of persons concretely affected by Defendant's unlawful actions and have standing to bring this claim. *Murray*, 244 F.3d at 810-811; *Focus on the Family*, 344 F.3d at 1272; *Griffin*, 823 F.2d at 1482-83.

B. The Proposed Class Meets the Requirements of Rule 23 and Should be Certified.

Under Rule 23 of the Federal Rules of Civil Procedure, class certification is appropriate when (1) the threshold requirements of Rule 23(a) are satisfied and (2) one of the three requirements under Rule 23(b) has been met. Fed. R. Civ. P. 23; *see also DWFII Corp. v. State Farm Mut. Auto. Ins. Co.*, 469 F. App'x. 762 (11th Cir. 2012). Additionally, the Eleventh Circuit requires "ascertainability" of class members as "implicit in the analysis" of Rule 23(a). *Bussey v. Macon Cnty.*

Grayhound Park, Inc., 562 F. App'x. 782, 787 (11th Cir. 2014); *Cherry v. Dometic Corp.*, 986 F.3d 1302, 1304 (11th Cir. 2021).

1. The proposed class meets the requirements of Rule 23(a).

Rule 23(a) requires that "(1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a). Plaintiffs readily satisfy these criteria.

a. Numerosity

The numerosity requirement of Rule 23(a)(1) is satisfied when "the class is so numerous that joinder of all of its members is impracticable." Fed. R. Civ. P. 23(a)(1). The numerosity requirement imposes a "generally low hurdle." *Vega v. T-Mobile USA, Inc.*, 564 F.3d 1256, 1267 (11th Cir. 2009). "Although mere allegations of numerosity are insufficient to meet this prerequisite, a plaintiff need not show the precise number of members in the class." *Id.* at 1267 (internal citations omitted). In the Eleventh Circuit, "the general rule of thumb…is that 'less than twenty-one is inadequate, more than forty adequate....'" *Manno v. Healthcare Revenue Recovery Grp., LLC*, 289 F.R.D. 674, 684 (S.D. Fla. 2013) (citing *Cox v. American Cast Iron Pipe Co.*, 784 F.2d 1546, 1553 (11th Cir. 1986)).

As of March 31, 2021, 2,366,388 children under the age of 21 were enrolled in Florida's Medicaid program.[2] In a legal brief Defendant filed on October 27, 2020, it states "AHCA's Office of Fair Hearings…received some 1,317 fair hearing requests regarding services for children under age 21 in fiscal year 2019-2020." (Ex. 12, p. 4). Notably, these denials only encompass those who pursued their appeal all the way to a fair hearing. Many more denials were never appealed or were rejected and abandoned along the way. Accordingly, thousands of low-income children in Florida are subject to Defendant's medically necessity standard resulting in denials of EPSDT services, and the named plaintiffs therefore satisfy the numerosity requirement. *Vega*, 564 F.3d at 1267; *Manno*, 289 F.R.D. at 684.

Plaintiffs also meet the other indicators for numerosity because Defendant's policy affects children statewide, who likely do not have the knowledge of federal and state Medicaid law such that they are aware of potential claims without an attorney's assistance, and - as demonstrated by the individual state court cases finding time and time again that Defendant's standard violates EPSDT - a class action will better preserve judicial economy. *See Walco Investments, Inc. v. Thenen*, 168 F.R.D. 315, 324 (S.D. Fla. 1996) (a determination of numerosity

[2] Archives of AHCA's Medicaid Eligibility Reports, including for March 2021, are posted on its website at: https://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/eligibles_archive.shtml

includes other factors "such as the geographic diversity of the class members, the nature of the action, the size of each plaintiff's claim, judicial economy and the inconvenience of trying individual lawsuits, and the ability of the individual class members to institute individual lawsuits).

b. Commonality

The commonality requirement is satisfied when "questions of law or fact common to the class" are present. Fed. R. Civ. P. 23(a)(2). Rule 23(a)(2) "does not require that all questions of law or fact raised in the litigation be common; indeed, even a single question of law or fact common to the members of the class will satisfy the commonality requirement." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 368-69 (2011); *see also Bussey*, 562 F. App'x. at 788-89. More specifically, to satisfy the commonality requirement, class members' claims must "depend upon a common contention" "capable of classwide resolution" such that "determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart Stores* at 338. The relevant inquiry is whether a class action can "generat[e] common answers apt to drive the resolution of the litigation." *Id*.

The commonality requirement is "generally satisfied when a plaintiff alleges that defendants have engaged in a standardized course of conduct that affects all class members." *In re Checking Account Overdraft Litig.*, 307 F.R.D. 656, 668

(S.D. Fla. 2015) (internal citations omitted); *see also*, *Ioime v. Blanchard, Merriam, Adel & Kirkland, P.A.*, No. 15-CV-130 PRL, 2016 WL 829111, *4 (M.D. Fla. March 3, 2016) (*citing Wal-Mart Stores, Inc.*, 564 U.S. 338); *M.H. v. Berry*, No. 15-CV-1427 TWT, 2017 WL 2570262, at *15-16 (N.D. Ga, June 13, 2017) (finding common questions where Plaintiff "challenge[d] broad policies and practices that apply to each member of [the State's EPSDT Program]").

The proposed class here easily satisfies the commonality requirement. All members of the proposed class have suffered or will suffer the same harms; Defendant is denying class members Medicaid services based on its restrictive medical necessity standard rather than afford them the opportunity to prove medical necessity in accordance with EPSDT's broader criteria. (Dkt. #1, ¶¶37-58). This shared harm stems from the written medical necessity standard in Fla. Admin. Code R. 59G-1.010, and the application of that standard by a central decision maker, the Defendant, to Medicaid beneficiaries under age 21. (*Id.*) Defendant should instead, as EPSDT requires, assess whether a requested service for a Medicaid beneficiary under 21 is necessary to correct or ameliorate a child's health condition. (*Id.*)

There is ample proof that, as the central decision maker, Defendant has "engaged in a standardized course of conduct that affects all class members." *Id.*; *In re Checking Account Overdraft Litig.*, 307 F.R.D. at 656. Defendant adopted its

medical necessity standard in administrative rule. *See* Fla. Admin. Code R. 59G-1.010. Defendant requires Florida MCOs, via its contracts, to evaluate all Medicaid services under its medical necessity standard, regardless of the beneficiary's age. *See* AHCA Model Contract, Attach. II, pg. 18, 63 & 78. W.B.'s health plan has incorporated this requirement into their clinical coverage guidelines for all children under age 21 enrolled in the CMS Health Plan. (Ex. 13). Defendant also relies on a legal memo it drafted to justify its policy of applying the same medical necessity standard to all Medicaid beneficiaries regardless of age. (Ex. 3, p. 27-38).

c. Typicality

The typicality requirement is satisfied when the "claims or defenses of the representative parties are typical of the claims or defenses of the class." Fed. R. Civ. P. 23(a)(3); *see also Williams*, 568 F.3d at 1355. The typicality requirement may be satisfied "despite substantial factual differences" when there exists a "strong similarity of legal theories." *Murray*, 244 F.3d at 811. "'Class members' claims need not be identical...rather, there need only exist 'a sufficient nexus...between the legal claims of the named class representatives and those of individual class members to warrant class certification.'" *Ault v. Walt Disney World Co.*, 692 F.3d 1212, 1216 (11th Cir. 2012) (internal citations omitted); *see also Hines*, 334 F.3d at 1253.

A sufficient nexus "exists 'if the claims or defenses of the class and the class representatives arise from the same event or pattern or practice and are based on the same legal theory.'" *Ault*, 692 F. 3d at 1216 (internal citations omitted); *see also Williams*, 568 F.3d at 1355. In other words, "[a] class representative must possess the same interest and suffer the same injury as the class members in order to be typical under Rule 23(a)(3)." *Id.* at 1357 (internal citations omitted).

Named plaintiffs, W.B. and A.W., satisfy the typicality requirements. Both are Medicaid-eligible children under the age of 21. W.B. has requested that Florida's Medicaid program cover out of state, outpatient hospital services, a category of Medicaid services listed in 42 U.S.C. § 1396d(a) and for which no treatment is readily available in Florida. (Dkt. #1, ¶¶21, 25, 68, 85). Similarly, A.W. has requested that Florida's Medicaid program cover medical equipment, a category found in 42 U.S.C. § 1396d(a). (Dkt. #1, ¶¶25, 109, 119).

W.B. and A.W. share the same interests and suffer the same injuries of those whose rights they seek to vindicate. The claims of the class and the named Plaintiffs all arise from Defendant's policy of subjecting Medicaid enrolled children under age 21 to its medical necessity standard, a policy that inhibits the putative class from accessing Medicaid services because the policy requires children to meet criteria more restrictive than what EPSDT allows. (Dkt. #1, ¶¶37-58); s*ee Ault*, 692 F. 3d at 1216.

Additionally, the remedies sought by the named plaintiffs are the same remedies that would benefit class members: an injunction requiring Defendant to modify its medical necessity standard, as applied to children under age 21, in a manner that comports with EPSDT. (Dkt. #1, Para. VIII). The claims of the class representatives are thus typical because there is not only a sufficient – but strong – nexus between their claims and those of the proposed class. *See Prado-Steiman*, 221 F.3d at 1279.

It should be noted that Defendant's policy results in denials of services different from the specific services W.B. and A.W. requested, i.e., outpatient hospital treatment and a piece of specialty medical equipment. However, all Medicaid enrolled children, regardless of the service for which they seek coverage, are subject to Defendant's unduly restrictive standard that conflicts with EPSDT's broader coverage mandates. Since the putative class members are all subject to the same unlawful policy, the fact that they may be denied a different Medicaid service than the named plaintiffs does not render the claims atypical. *See M.H.*, 2017 WL 2570262 at *6 (finding that representative plaintiffs were typical of the class because they challenged the legality of the Georgia Medicaid agencies general policies and practices rather than the legality of the policies as applied to each individual Medicaid beneficiary).

d. Adequacy of representation

Finally, Plaintiffs must show that "the representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). "The adequacy inquiry under Rule 23(a)(4) serves to uncover conflicts of interest between named parties and the class they seek to represent," and class representatives "must be part of the class and possess the same interest and suffer the same injury as the class members." *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 626 (1997) (internal quotations and citations omitted)); *see also London v. Wal-Mart, Inc.*, 340 F.3d 1246, 1253 (11th Cir. 2003).

The adequacy of representation analysis "encompasses two separate inquiries: (1) whether any substantial conflicts of interest exist between the representatives and the class; and (2) whether the representatives will adequately prosecute the action." *Valley Drug Co. v. Geneva Pharms., Inc.*, 350 F.3d 1181, 1189 (11th Cir. 2003) (citations omitted). The class representatives must "possess the same interest and suffer the same injury as class members." *Amchem Prods., Inc.*, 521 U.S. at 625–26 (internal citations omitted). Additionally, "the adequacy-of-representation requirement 'tends to merge' with the commonality and typicality criteria of Rule 23(a), which 'serve as guideposts for determining whether…maintenance of a class action is economical and whether the named plaintiff's claim and the class claims are so interrelated that the interests of the

class members will be fairly and adequately protected in their absence.'" *Id.* at 626, n.20 (citations omitted).

Rule 23(a) is satisfied here. There is no conflict of interest between the class representatives and the absent class members because the class members' interest in having their rights under federal Medicaid law upheld do not interfere with or oppose one another. *Pickett*, 209 F. 3d at 1280; *Valley Drug Co.*, 350 F. 3d at 1189. Every class member seeks to have their right to EPSDT met – a right that is not contingent on other class members being able to access Medicaid benefits or services to which they are entitled. (Dkt. #1); *Id.*; *see also*, *Amchem Prods., Inc.*, 521 U.S. at 625-26.

Furthermore, as argued *supra* at pages 15-19, the commonality and typicality requirements of Rule 23(a) are satisfied. While the satisfaction of the commonality and typicality requirements are not sufficient on their own to satisfy the separate adequacy or representation requirement, the two other factors provide a strong indication that "the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence." *Amchem Prods., Inc*, 521 U.S. at 626, n.20 (citing *Gen. Tel. Co. of Sw.*, 457 U.S. at 157, n.13).

Adequacy is also met because class counsel is competent to represent the interests of the class. *Id.* at 1189. Undersigned counsel are experienced at litigating

Medicaid class actions in federal court. The National Health Law Program (NHeLP) has litigated dozens of state and federal Medicaid cases around the country to advance access to quality health care for low-income and underserved individuals. Counsel for Florida Health Justice Project has also served as lead counsel on federal Medicaid cases, the most recent a successfully settled class action lawsuit involving Medicaid eligibility. Josh Norris was counsel in *Moore* and is currently class counsel in *M.H.*, discussed *supra*, and has litigated several Medicaid Act cases. Thus, Plaintiffs' counsel will adequately prosecute this action.

2. The proposed class meets the Eleventh Circuit's "ascertainability" requirement.

The Eleventh Circuit imposes the requirement that "the proposed class is adequately defined and clearly ascertainable." *Karhu*, 621 F. App'x. at 946. Ascertainability is established where a proposed class "is adequately defined such that its membership is capable of being determined." *Cherry v. Dometic Corp.*, 986 F.3d at 1296.

The proposed class satisfies the ascertainability requirement. When Defendant, or its contractor, refuses coverage of a Medicaid service, it must ensure the beneficiary receives notice and can appeal the decision. 42 C.F.R. §§ 431.206(b) & (c)(2), 438.404. MCOs must report monthly to Defendant a summary of all Medicaid appeals including whether the appeal is EPSDT related. AHCA

Model Contract, Attach. II at pg. 233-234.[3] Defendant thus has a mechanism to identify every Medicaid beneficiary under age 21 who was refused coverage of a requested benefit due to the application of Defendant's medical necessity standard. Therefore, the putative class is ascertainable because its "member is capable of being determined." *Cherry*, 986 F. Supp. at 1304.

3. The proposed class satisfies Rule 23(b)(2).

A proposed class must also satisfy one of the three conditions listed in Fed. R. Civ. P. 23(b). Rule 23(b)(2) is satisfied when the Defendant "has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). Class certification pursuant to Rule 23(b)(2) is "appropriate only if 'the predominant relief sought is injunctive or declaratory.'" *DWFII Corp.*, 469 F. App'x at 765 (quoting *Murray*, 244 F.3d at 812). In assessing whether Rule 23(b)(2) is met, the court evaluates whether the requested relief "run[s] to the benefit of not only the named plaintiffs, but also to all those similarly situated." *Ault v. Walt Disney World Co.*, 254 F.R.D. 680, 687-88 (M.D. Fla. 2009).

[3] The Enrollee Complaints, Grievance, and Appeals Report Template referenced in the MCO contract can be accessed at: https://ahca.myflorida.com/medicaid/statewide_mc/report_guides/ecgar.shtml

Here, Defendant violates federal Medicaid law by applying a medical necessity standard to Medicaid beneficiaries under age 21 that violates EPSDT. (Dkt. #1, ¶¶37-58). As a result, the class representatives and putative members have suffered from the application of medical necessity criteria that denies them Medicaid services necessary to correct or ameliorate their conditions. (Id. ¶¶85-101, 119-131); *see Ault*, 254 F.R.D. at 687. Plaintiffs seek declaratory and injunctive relief to remedy this harm to the benefit of all similarly situated class members; they do not seek monetary damages. (Dkt. #1, Para. VIII); *see Ault*, 254 F.R.D. at 687-88. Thus, the current action, which can only be resolved through injunctive relief, is precisely the scenario for which Rule 23(b)(2) was intended.

V. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court certify the proposed class, pursuant to Fed. R. Civ. P. 23.

Plaintiffs by their Attorneys,

/s/ Katy DeBriere
Katherine DeBriere
Lead Counsel

Fla. Bar No.: 58506
Florida Health Justice Project
126 W. Adams Street
Jacksonville, FL 32202
Telephone: (904) 356-8371, ext. 333
Facsimile: (904) 356-8780
debriere@floridahealthjustice.org

Joshua H. Norris*
Georgia Bar No. 545854
Law Office of Joshua H. Norris, LLC
One West Court Square, Suite 750
Decatur, Georgia 30030
Telephone: (404)867-6188
Facsimile:(404) 393-9680
josh.norris@childrenshealthlaw.org

Sarah Somers*
NC Bar No.: 33165
Miriam D. Heard*
NC Bar No.: 39747
National Health Law Program
North Carolina Office
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
Telephone: (919) 968-6308
somers@healthlaw.org
heard@healthlaw.org

Counsel for Plaintiffs and Proposed Class Counsel

*Attorneys are appearing provisionally subject to approval to appear pro hac vice.

CERTIFICATE OF SERVICE

I hereby certify that on August 6, 2021, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system. I further certify that I served by processor server the foregoing on the following non-CM/ECF participant:

Simone Marstiller, Secretary
Agency for Health Care Administration
2727 Mahan Dr.
Tallahassee, FL 32308
(888) 419-3456

/s/ Katy DeBriere
Katherine DeBriere

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

W.B., by and through his father and legal guardian, David B., and A.W., by and through her mother and legal guardian, Brittany C., on behalf of themselves and all others similarly situated,

Plaintiffs,

v. Case No.:

SIMONE MARSTILLER, in her official capacity as Secretary for the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendant.
_______________________________________/

EXHIBIT INDEX – PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

Exhibit Number	**Title of Exhibit**
Exhibit 1	Appendix
Exhibit 2	Plaintiff A.W. AHCA Final Order
Exhibit 3	AHCA Hearing Officer Training & EPSDT Memo
Exhibit 4	Dr. Stephanie Carlin – Letter of Medical Necessity & Appeal on behalf of Plaintiff W.B.
Exhibit 5	Declaration of David B.
Exhibit 6	CMS Plan Notices of Adverse Benefit Determination and Notice of Appeal Plan Resolution as to Plaintiff W.B.

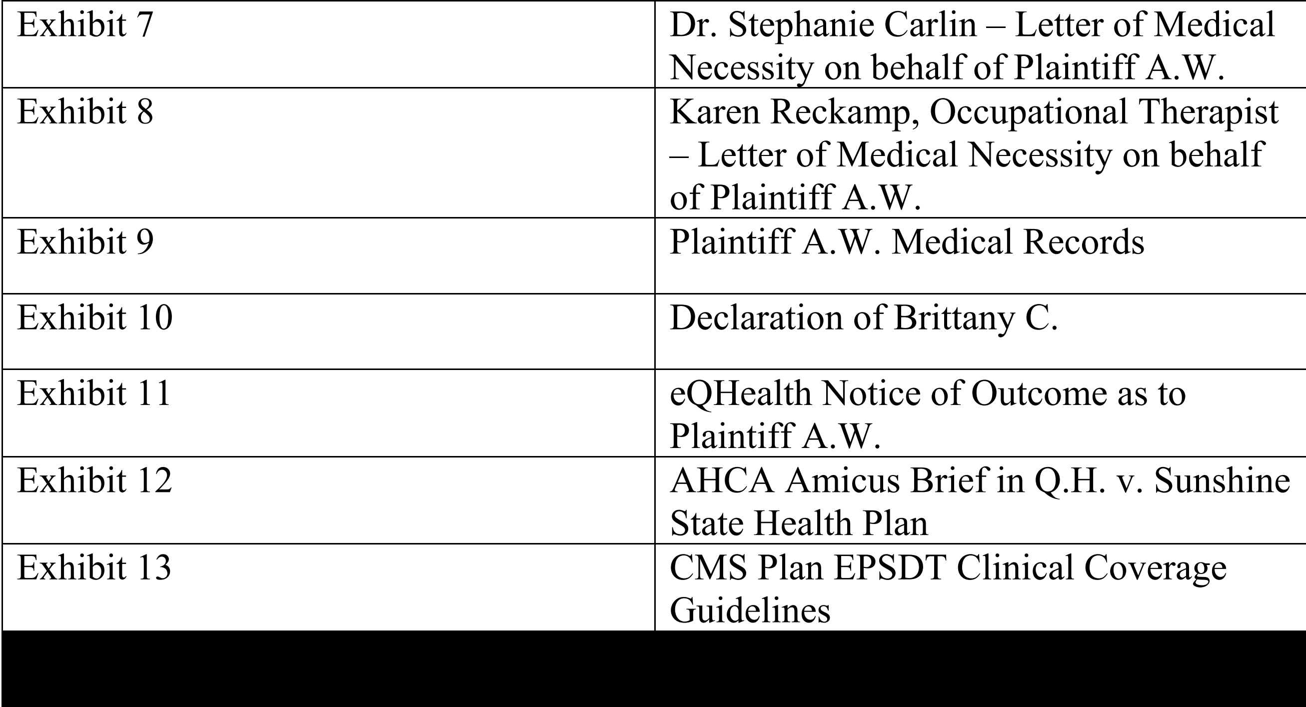


Exhibit 7	Dr. Stephanie Carlin – Letter of Medical Necessity on behalf of Plaintiff A.W.
Exhibit 8	Karen Reckamp, Occupational Therapist – Letter of Medical Necessity on behalf of Plaintiff A.W.
Exhibit 9	Plaintiff A.W. Medical Records
Exhibit 10	Declaration of Brittany C.
Exhibit 11	eQHealth Notice of Outcome as to Plaintiff A.W.
Exhibit 12	AHCA Amicus Brief in Q.H. v. Sunshine State Health Plan
Exhibit 13	CMS Plan EPSDT Clinical Coverage Guidelines

UF Health Jacksonville

BOWER LYMAN CENTER FOR MEDICALLY COMPLEX CHILDREN
841 PRUDENTIAL DR, SUITE 900
JACKSONVILLE FL 32207-8373
Dept Phone: 904-202-8920
Dept Fax: 904-633-0921
UFHealthJax.org

letter of medical necessity

September 9, 2020

Patient: W[redacted] B[redacted]
Date of Birth: [redacted]

To Whom It May Concern:

I am writing on behalf of W[redacted] B[redacted] who attends the Bower Lyman Center for Medically Complex Children for his primary care.

W[redacted] is a 10 month old with a complex medical history of CHARGE Syndrome resulting in multiple congenital anomalies, choanal atresia (S/P repair), right facial palsy, laryngomalacia, coloboma, PV stenosis (S/P balloon valvulotomy), concerns for immunodeficiency, concern for hypoparathyroidism, dysphagia, GERD, and developmental delay. He is dependent on a gastrostomy tube for his nutritional needs.

W[redacted] has been referred to the CHARGE Center run by Cincinnati Children's Hospital. The CHARGE Center is the only center of its kind. It uses a multidisciplinary approach to providing care. The CHARGE Center is able to coordinate medical consultations between the many specialists involved in the care of a child with CHARGE Syndrome. Specialists working with the CHARGE Center include genetics, ophthalmology, cardiology, ENT, plastic surgery, and more.

The CHARGE Center can also provide guidance to local specialists involved in W[redacted] care. Their specialized knowledge of CHARGE syndrome will ensure that specialists involved have the latest recommendations for children with CHARGE Syndrome.

It is essential that the treatment of a child with CHARGE Syndrome be streamlined to avoid long-term developmental setbacks. The coordination of specialists that happens with the CHARGE Clinic also means that visits, testing, and evaluations are done in a sensible sequence, minimizing risk by consolidating anesthesia events and blood draws.

It is medically necessary that W[redacted] be evaluated and treated by the CHARGE Clinic which is an out of network provider. If there are any questions or concerns please feel free to contact our office.

Regards,

Stephanie Carlin, DO, FAAP
Bower Lyman Center for Medically Complex Children

Phone: (904) 202-8920
Fax: (904) 633-0931

UF Health Jacksonville

BOWER LYMAN CENTER FOR MEDICALLY COMPLEX CHILDREN
841 PRUDENTIAL DR, SUITE 900
JACKSONVILLE FL 32207-8373
Dept Phone: 904-202-8920
Dept Fax: 904-633-0931
UFHealthJax.org

Expediated Appeal

Member: [redacted]
Member DOB: [redacted]
Member Medicaid ID: [redacted]
Denial Reference Numbers: PA-7979829; PA-7980409; PA-7979986

To CMS Appeals Department:

I am writing on behalf of W[redacted] B[redacted], who attends the Bower Lyman Center for Medically Complex Children for his primary care.

The prior authorization request for W[redacted] to be treated by the CHARGE Center run by Cincinnati Children's hospital has been denied. This letter is to serve as an appeal to the denials received for ENT (PA-7979986), GI (PA-7979829), and Pulmonology (PA-7980409).

Catherine Hart, MD (NPI 1346451655) has been identified by the CHARGE Center as the lead physician most appropriate for W[redacted] specific case. She is an ENT doctor specializing in CHARGE Syndrome. Dr. Hart will be working closely with the Pulmonologist, Dr. Monica Vielkind, and Gastroenterologist, Dr. Philip Putnam, who also specialize in CHARGE Syndrome.

The denial letters state that this patient was denied treatment due to "in network providers" being able to provide services. Unfortunately, there are no CHARGE centers in network that have a multidisciplinary team of providers who specialize in CHARGE. W[redacted] has had a complicated clinical course and his care would benefit from a multidisciplinary team approach to ensure that we are maximizing his care locally.

To review his clinical status- W[redacted] is a 10 month old with a complex medical history of CHARGE Syndrome resulting in multiple congenital anomalies, choanal atresia (S/P repair), right facial palsy, laryngomalacia, coloboma, PV stenosis (S/P balloon valvulotomy), concerns for immunodeficiency, concern for hypoparathyroidism, dysphagia, GERD, and developmental delay. He is dependent on a gastrostomy tube for his nutritional needs.

Based on the medical history and ongoing issues outlined above, please reconsider the denial decision for this patient as it would be detrimental to W[redacted] health for him to be excluded from the CHARGE Center. Please feel free to contact my office should you have further questions or concerns regarding my request for approval.

Regards,

[signature]

Stephanie Carlin, DO, FAAP Bower Lyman Center for Medically Complex Children
904-383-1864

DECLARATION OF DAVID B.

1. My name is David B.

2. I am forty-two years old and live in St. Augustine, Florida with my wife, Stacy B. and our three children: W.B. (almost two years old), J.D.B. (eight years old) and C.B. (six years old).

3. My son, W.B., is enrolled in Medicaid. His managed care plan is the Children's Medical Services Health Plan (the CMS Plan) administered by WellCare of Florida, Inc. This managed care plan is designed for Medicaid enrolled children who have special health care needs.

4. Within the first month of his life, W.B. was diagnosed with a rare genetic condition known as CHARGE Syndrome. It was identified early on because he presented with so many of the CHARGE markers including coloboma (his right eye has limited vision), a heart defect, choanal atresia (blocked nasal passages), misshapen ears, and problems swallowing.

5. Due to his CHARGE diagnosis, at birth, W.B. was admitted to the Newborn Intensive Care Unit for forty-three days. He was discharged right before December 25, 2019 but the, in the first week of January 2020, got very sick again. He was readmitted to the hospital and spent between two to three weeks in the Pediatric Intensive Care Unit and then another three weeks in non-intensive care before being discharged.

6. The CHARGE Syndrome impacts my son's medical and developmental condition. Some examples of how his development is impacted includes that he cannot swallow, he is mostly deaf, and he has low muscle tone (at almost two years old, he cannot sit up unassisted for longer than thirty seconds).

7. Since he is unable to swallow, my son uses a gastronomy tube for all of his nutrition.

8. My son also attends a Prescribed Pediatric Extended Care center Monday through Friday. At the PPEC, he receives nursing services, personal care, and developmental therapies including speech, occupational, and physical therapy.

9. Since birth, due to the medical and developmental complications of his diagnosis, my son has been followed by multiple specialists.

10. My son's pulmonologist is Dr. Gerardo A. Vazquez Garcia, M.D. who works at Nemours Children's Specialty Care clinic located in Jacksonville, Florida

11. W.B. also sees an Ear, Nose, and Throat (ENT) Specialist, Dr. Andrew R. Simonsen, D.O., who is in private practice in Jacksonville, Florida.

12. My son's pediatrician is Dr. Stephanie Carlin, D.O., who practices at UFHealth's Bower Lyman Center for Medically Complex Children.

13. The above-named physicians recommend that W.B. attend the CHARGE Center at Cincinnati Children's Hospital in Ohio.

14. They make this recommendation because W.B.'s diagnosis is so rare that only the providers at the CHARGE Center have the expertise necessary to evaluate and develop a plan of care that promises the best possible clinical outcomes for W.B. They have explained to me that without care at the CHARGE Center, my son will likely experience developmental setbacks and may continue to present with poor clinical outcomes, including continued hospitalizations.

15. From the months of January 2021 to April 2021, I had to take W.B. to the emergency room on five separate occasions due to respiratory distress. For all but one of these occasions, he was admitted to the hospital. The admissions ranged from two to three days each time.

16. To prevent ongoing hospitalizations, my son's physicians discussed whether to my son should undergo a tracheostomy. Fortunately, the physicians decided that, for now, the procedure is unnecessary. Again, however, they emphasized that the specialists at the CHARGE Center have the requisite expertise to determine the best method for avoiding further respiratory distress and subsequent hospitalizations.

17. W.B. also recently failed his swallow study. W.B.'s ENT, Dr. Simonsen, states that the experts at the CHARGE Center would best be able to evaluate W.B.'s swallowing and develop a treatment plan to correct the problem.

18. I speak regularly with the CHARGE Center about their willingness to provide care to W.B. They are always available to answer my emails and telephone calls with questions I have about his care locally. In response to our questions, the staff at the CHARGE Center have expressed the importance of W.B. being approved for their services. They have developed a preliminary evaluation and treatment plan he would undergo at the CHARGE Center if his insurance were to authorize the service.

19. As stated above, my wife and I have three young children. We also work full time. Although it would be a significant disruption to our daily lives, we are committed to traveling to Ohio so that my son can secure the care he needs to mitigate what has otherwise been a complex course of treatment in his short life.

20. We are also hopeful that, as represented by his physicians here in Florida and by the CHARGE Center, that the plan of care developed by the CHARGE Center and implemented locally will result in the best possible clinical outcomes for W.B.

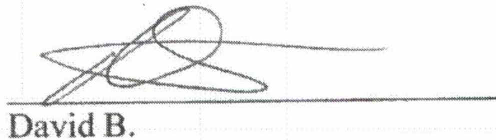
21. It is incredibly frustrating to watch my young child be repeatedly hospitalized, be considered for invasive medical procedures, like a tracheostomy, without his providers, as amazing as they are, being certain about the medical necessity of the intervention, and otherwise try to manage and coordinate his care

when I know these concerns could be directly addressed by the expertise available only at the CHARGE Center.

22. For these reasons, I ask that the Court grant our request for preliminary relief on behalf of W.B. and order that the Agency for Health Care Administration evaluate Dr. Carlin's request for W.B. to attend the CHARGE Center under the correct standard; that is whether care at the CHARGE Center is necessary to correct or ameliorate the impact of CHARGE Syndrome on my son's health condition.

23. I greatly appreciate the Court's consideration of this matter.

Dated: 8/4/21



David B.

PO Box 31370
Tampa, FL 33631-3370

PLAN ID: [redacted]

09/18/2020

W[redacted] B[redacted]
[redacted]
ST AUGUSTINE, FL [redacted]

0107122826300

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear W[redacted] B[redacted] and/or DAVID B[redacted]:

Children's Medical Services Health Plan has reviewed a request for Outpatient Hospital Services and 2 Units/Visits, which we received on 09/11/2020. After our review, this service has been:

Denied as of 09/18/2020

We made our decision because:
We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

* Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
* Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. (The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The facts that we used to make our decision are:
On 7/22/2020, we received a request to authorize treatment for your child with an out of network provider, Dr. Monica Vielkind at Cincinnati Children's Hospital. We did not approve the request for authorization because out of network services are not a covered benefit when services are available within your plan. This service can be provided by one of the following in network providers:

1. Pediatric pulmonology

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UF Health
2000 SW Archer Rd
Gainesville, FL 32608
352-265-8408

2. Pediatric Pulmonology
Nemours Children's Hospital
1717 Orange Ave S, #100
Orlando, FL
(407) 650-7715

Please contact your Primary Care Provider for assistance with a referral to an in network providers, and feel free to contact the WellCare Customer Service Department if you wish their assistance.
Criteria referenced: Children's Medical Services Health Plan Florida Medicaid Member Handbook, Section 10: Accessing Services

020712282630

You, or someone legally authorized to do so, can ask us for a complete copy of your child's file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge

You may request these documents by contacting: Children's Medical Services Health Plan toll-free at **1-866-799-5321** (TTY **711**) Monday–Friday, 8 a.m. to 7 p.m.

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from Children's Medical Services Health Plan. When you ask for a plan appeal, Children's Medical Services Health Plan has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your child's case manager can help you with this. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your child's services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your child's Services to Continue" section below for details.) Here is where to call or send your request:

Mail: Children's Medical Services
Attn: Appeals Department

PO Box 31370
Tampa, FL 33631-3370

PLAN ID: [redacted]

09/14/2020

W[redacted] B[redacted]
[redacted]
ST AUGUSTINE, FL [redacted]

01079332980

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear W[redacted] B[redacted] and/or DAVID B[redacted]

Children's Medical Services Health Plan has reviewed a request for Outpatient Hospital Services and 10 Units/Visits, which we received on 09/11/2020. After our review, this service has been:

Denied as of 09/13/2020

We made our decision because:
We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

* Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
* Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. (The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The facts that we used to make our decision are:
On 9/11/2020, we received a request to authorize treatment for your child with an out of network provider, Dr. Catherine Hart at Cincinnati Children's Hospital. We did not approve the request for authorization because out of network services are not a covered benefit when services are available within your plan. This service can be provided by one of the following in network providers:

1. Pediatric ENT

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UF Health
6201 W Newberry Rd
Gainesville, FL 32605
(352) 265-9465

2. Pediatric ENT
Nemours Children's Hospital
1717 Orange Ave S, #100
Orlando, FL
(407) 650-7000

Please contact your Primary Care Provider for assistance with a referral to an in network providers, and feel free to contact the WellCare Customer Service Department if you wish their assistance.
Criteria referenced: Children's Medical Services Health Plan Florida Medicaid Member Handbook, Section 10: Accessing Services

02079332980

You, or someone legally authorized to do so, can ask us for a complete copy of your child's file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge

You may request these documents by contacting: Children's Medical Services Health Plan toll-free at **1-866-799-5321** (TTY **711**) Monday–Friday, 8 a.m. to 7 p.m.

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from Children's Medical Services Health Plan. When you ask for a plan appeal, Children's Medical Services Health Plan has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your child's case manager can help you with this. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your child's services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your child's Services to Continue" section below for details.) Here is where to call or send your request:

Mail: Children's Medical Services
Attn: Appeals Department

© WellCare 2018

PLAN ID:

PO Box 31370
Tampa, FL 33631-3370

09/18/2020

W B

ST AUGUSTINE, FL

01071228264O

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear W B and/or DAVID B

Children's Medical Services Health Plan has reviewed a request for Consult and Treat and 2 Units/Visits, which we received on 09/11/2020. After our review, this service has been:

Denied as of 09/18/2020

We made our decision because:
We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

* Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
* Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. (The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The facts that we used to make our decision are:
On 9/11/2020, we received a request to authorize treatment for your child with an out of network provider, Dr. Putnam at Cincinnati Children's Hospital. We did not approve the request for authorization because out of network services are not a covered benefit when services are available within your plan. This service can be provided by one of the following in network providers:

1. Pediatric Gastroenterology

UF Health
2000 SW Archer Rd
Second floor
Gainesville, FL 32608
352-273-9350

2. Pediatric Gastroenterology
Nemours Children's Hospital
1717 Orange Ave S, #100
Orlando, FL
(407) 650-7715

Please contact your Primary Care Provider for assistance with a referral to an in network providers, and feel free to contact the WellCare Customer Service Department if you wish their assistance.
Criteria referenced: Children's Medical Services Health Plan Florida Medicaid Member Handbook, Section 10: Accessing Services

020712282640

You, or someone legally authorized to do so, can ask us for a complete copy of your child's file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge

You may request these documents by contacting: Children's Medical Services Health Plan toll-free at **1-866-799-5321** (TTY **711**) Monday–Friday, 8 a.m. to 7 p.m.

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from Children's Medical Services Health Plan. When you ask for a plan appeal, Children's Medical Services Health Plan has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your child's case manager can help you with this. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your child's services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your child's Services to Continue" section below for details.) Here is where to call or send your request:

Mail: Children's Medical Services

© WellCare 2018

P.O. Box 31368
Tampa, FL 33631-3365

PLAN ID: [redacted]

November 13, 2020

Kelsey Bell/ Dr. Stephanie Carlin
841 Prudential Dr. Suite 900
Jacksonville, FL 32207

Re: W[redacted] B[redacted]
ID#: [redacted]
File #: [redacted]
Request: Treatment With OON Provider Dr. Putnam
Date of Service: Pending

NOTICE OF PLAN APPEAL RESOLUTION

Dear Parent/Legal Guardian of W[redacted] B[redacted]

On 10/15/2020 we received your timely plan appeal request regarding Children's Medical Services Health Plan Notice of Adverse Benefit Determination dated 9/18/2020, NABD Number ACME-16-000156 denying the service provided to you.

The request has been reviewed. The review was completed by a licensed doctor. The doctor was not a part of the first review or the findings from that review.

The Medical Director involved is Board Certified MD with a specialty in Pediatrics.

On 11/11/2020, after consideration of the information you provided to Children's Medical Services Health Plan in support of your plan appeal, Children's Medical Services Health Plan hereby Denies your plan appeal. As a result, you will not receive service, effective 11/11/2020.

The facts that we used to make our decision are: We have doctor's who can see and manage your condition. The reasons for this decision are based on a set of standards. This included Wellcare Health Plans, Inc. Find A Provider Website-Member Benefit.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information considered during the plan appeal process. These will be provided free of charge.

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Right to Request a State Medicaid Fair Hearing

If you do not agree with this decision, you have the right to request a Medicaid fair hearing from the state. When you ask for a fair hearing, a hearing officer who works for the state reviews the decision made during the plan appeal.

How to Ask for a Fair Hearing:
You may ask for a fair hearing any time up to 120 days after you get this Notice of Plan Appeal Resolution. Your child's case manager can help you with this, if he/she has one.

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

(877) 254-1055 *(toll-free)*
239-338-2642 *(fax)*
MedicaidHearingUnit@ahca.myflorida.com

Your written request for a Medicaid fair hearing must include the following information:
- Your child's name
- Your child's member number
- Your child's Medicaid ID number
- A phone number where we can reach you or your authorized representative

You may also include the following information if you have it:
- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency for Health Care Administration (Agency) will tell you in writing that they got your fair hearing request.

How to Ask for Your Child's Services to Continue During a Fair Hearing:

If your child was receiving services during your plan appeal, file the request for your child's services to continue with the Agency **no later than 10 days** from the date on this Notice of Plan Appeal Resolution OR on or before the first day that your child's services are scheduled to be reduced, suspended, or terminated, *whichever is later.*

If your child's services are continued and our decision is upheld in a fair hearing, we may ask that you pay for the cost of those services. We will not take away your child's

Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

If you have questions, call us at **1-866-799-5321** (TTY **711**) Monday–Friday 8 a.m. to 7 p.m.

For more information on your rights, review the Grievance and Appeal section in your child's Member Handbook. It can be found online at: www.wellcare.com/florida

Sincerely,

Melissa Thomas, MD

Corporate Medical Director
Children's Medical Services Health Plan

Cc: Parent/Legal Guardian of W[redacted] B[redacted]

The Children's Medical Services Health Plan has partnered with WellCare of Florida, Inc. (WellCare) to provide managed care services to our members. WellCare is a licensed Florida health plan.

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Discrimination is Against the Law

Children's Medical Services Health Plan, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Children's Medical Services Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Children's Medical Services Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, Braille, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Children's Medical Services Health Plan at 1-866-799-5321 (TTY: 711), Monday–Friday from 8 a.m. to 7 p.m., for help or you can ask Customer Service to put you in touch with a Civil Rights Coordinator who works for Children's Medical Services Health Plan.

If you believe that Children's Medical Services Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Children's Medical Services Health Plan, Grievance Department, P.O. Box 31384, Tampa, FL 33631-3384; Telephone 1-866-530-9491; TTY number 711; Fax: 1-866-388-1769; OperationalGrievance@wellcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Childrens Medical Services Health Plan Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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UF Health Jacksonville

BOWER LYMAN CENTER FOR MEDICALLY COMPLEX CHILDREN
841 PRUDENTIAL DR, SUITE 900
JACKSONVILLE FL 32207-8373
Dept Phone: 904-202-8920
Dept Fax: 904-633-0921
UFHealthJax.org

January 16, 2020

RE: A W
DOB:

To Whom It May Concern:

I am writing this letter on behalf of my patient, A W who attends the Bower Lyman Center for Medically Complex Children for her primary care.

A is a 9 year old female who has multiple medical complexities including spastic cerebral palsy, cortical visual impairment, seizures, and developmental delay. A is nonverbal and nonambulatory. A was a premature infant born at 24 weeks gestation and remained in the NICU at Wolfson Children's Hospital for 6 months. She had several surgeries including placement of a gastrostomy tube and has undergone bowel resection. A had her tonsils and adenoids removed in 2013, underwent dorsal rhizotomy for spasticity in 2014 and then had osteotomies completed by Dr. Loveless in 2015. A required her gallbladder to be removed in 2016. A receives Physical Therapy, Occupational Therapy, Speech Therapy, and Vision Therapy. A is completely dependent upon her caregiver for all activities of daily living (ADLs). Patient relies on her custom wheelchair for all mobility purposes.

As a matter of medical necessity, I would request the full size Beds By George DREAM Bed 2500 with clear view windows with air flow panel, casters, 30 inch transfer height, 5 ½ clearance for floor lift, IV pole and mounting bracket, storage drawers under bed rail, and access port for feeding tubes. Due to A progressing scoliosis she needs to be in a bed that has a supportive mattress and bed frame. A medical history includes seizures and spasticity which place her at risk for falling out of bed or becoming entrapped between a bed and side rails. Alternative beds such as a hospital bed with side rails or a Pedicraft canopy bed do not adequately meet patient's needs. With a hospital bed, A runs the risk of becoming entrapped between the mattress and side rails which can lead to injuries. This can also happen with the Pedicraft Canopy bed as over time the netting will loosen and can lead to a slope in the side netting. The DREAM bed style is designed to prevent entrapment and will protect the patient from falling out of the bed due to her developmental delay, seizures, and spasticity. The manual adjustable head of the DREAM bed will allow for A to be positioned during gastrostomy tube feedings to help prevent aspiration. It is imperative that A receives the Beds By George DREAM Bed in order to reduce the risk of injuries at bedtime.

If you have any further questions, please feel free to contact our office.

Sincerely,

Stephanie Carlin, DO, FAAP
Bower Lyman Center for Medically Complex Children
841 Prudential Drive Suite 1900
Jacksonville, FL 32207
Phone: (904) 202-8920
Fax: (904) 633-0931

Changing Health Care for Good.

W[redacted], A[redacted] DOB: [redacted]

LETTER OF MEDICAL NECESSITY
BEDS BY GEORGE DREAM BED

W[redacted], A[redacted] DOB: [redacted]

Past Medical History, Problems, Diagnoses
A[redacted] is a 10 year old child accompanied to the evaluation by her mother who provided pertinent medical and developmental history. Caregiver expressed the following concerns: A[redacted] has been denied a special needs bed x 2 and cannot be safely positioned in a standard bed. Mom would like assistance with finding a solution

Past Medical History, Problems, Diagnoses
Birth History:
Birth Weight: 0.55 kg (1 lb 3.4 oz)
Delivery Method: C-Section, Unspecified
Gestation Age: 24 wks
Pregnancy complications: none.
Birth complications: none.
Perinatal complications: In the NICU for 6 months, ventilator for 3-4 months. Home with g-tube but no oxygen. Brain bleed- grade 1 per Nemours records.

MRI findings from April 10, 2012 showed "markedly thin corpus callosum and markedly diminished white matter throughout the cerebral hemispheres, compatible with periventricular leukomalacia."

MRI of the brain done on March 21, 2018 showed "Unchanged periventricular leukomalacia."

MRI of the spine done on March 21, 2018 showed "No evidence of spinal cord abnormality. Clumped appearance of proximal cauda equina nerve roots, suggestive of arachnoid adhesions."

CURRENT MEDICAL SERVICES: Ophthalmology, GI, Nutrition, Orthopedics, Endocrinology, Neurology

SURGICAL HISTORY:
CHOLECYSTECTOMY 01/18/2016n-Open lysis of intestinal adhesions and cholecystectomy; GASTROSTOMY; HIP SURGERY 05/08/2015 - varus derotational osteotomy proximal femur, with blade plate; OSTEOTOMY, HIP 9/18/2015 San Diego pelvic osteotomy, left hip, Removal proximal orthopedic proximal femoral blade plate, bilateral ; RHIZOTOMY 12/09/2014; TONSILLECTOMY AND ADENOIDECTOMY

Patient Identified Fall Risk Factors : Dependent for all transfers and mobility
Fall Preventative Safeguards : Ensure wheelchair brakes are locked and seat belts are secure, Use lift device to transfer patient > 30lbs.

<u>Diagnoses(Active)</u>

Congenital quadriplegia	*Ranking:*	Primary ;	*Diagnosis Code:*	G80.8
Delayed developmental milestone	*Ranking:*	Tertiary ;	*Diagnosis Code:*	R62.0
Neuromuscular scoliosis	*Ranking:*	Secondary ;	*Diagnosis Code:*	M41.40

Changing Health Care for Good.

W█████, A█████ DOB: ████████

General Information

Reason for Referral : Wheelchair modifications; Patient Lift, Vehicle Lift, Bed
Individuals Present at Evaluation : Patient, Caregiver, Supplier, Therapist
Supplier : National Seating and Mobility (David Wix)

Impairments/Limitations : Abnormal Tone, Ambulation Deficits, Balance Deficits, Cognitive Deficits, ROM Deficits, Strength Deficits, Gross Motor Impairment/Delay, Neurodevelopmental Impairment/Delay

Home Environment

Living Situation : Lives with Family
Lives In : Single level home
Lives With : Parent(s)/Guardian

Functional

School Mobility Requirements : Wheelchair needed throughout the day at school

Integumentary Assessment

Skin Integrity : Intact

ADL

Basic ADL W/C Status Grid

	Bathing Upper Extremity	Bathing Lower Extremity	Dressing Upper Extremity	Dressing Lower Extremity
Assist Level :	Dependent	Dependent	Dependent	Dependent

	Self Feeding	Toileting
Assist Level :	Dependent	Dependent

Bowel Management : Incontinent
Bladder Management : Incontinent
Pt Has Limitations Without Wheelchair : Entirely limited

Current Seating and Mobility

Current Mobility Base : Dependent with tilt
Current Mobility Manufacturer : Freedom NXT
Current Condition of Mobility Base : Need repairs
Posture in Current Seating System : Poor head position, Trunk leans to the side

Wheelchair Skills

Bed To and From Chair : Dependent
Wheelchair To and From Commode : Dependent
Manual Wheelchair Propulsion : Dependent

Balance and Transfers

Sitting Balance : Does not sit
Standing Balance : Does not stand
Transfer Type : 2 person lift, Hoyer lift

Changing Health Care for Good.

W[redacted], A[redacted] DOB: [redacted]

Ambulation : Unable

Measurements
Shoulder Width : 17 inches
Chest Width : 10 inches
Hip Width : 11 inches
Top of Head : 26 inches
Seat to Top Left Shoulder : 17 inches
Seat to Top Right Shoulder : 17 inches
Left Upper Leg Length : 14 inches
Right Upper Leg Length : 14 inches
Left Lower Leg Length : 12 inches
Right Lower Leg Length : 12 inches
.

Neuro-Motor Assessment
Upper Extremity Tone
Left Upper Extremity : Spastic, Hypertonic
Right Upper Extremity : Spastic, Hypertonic

Lower Extremity Tone
Left Lower Extremity : Hypertonic, Spastic
Right Lower Extremity : Hypertonic, Spastic
Trunk : Hypotonic

Head/Neck Position
Position : Flexed
Head Control : Absent
Tone/Movement : strong forward pull of head into flexion, has trialed a chin prompt system but does not work per mom

Trunk and Upper Body Position
Anterior/Posterior : Increased thoracic kyphosis
Position Flexibility : Partly flexible
Left/Right : Convex left
Curvature : C-Curve
Left Flexibility : Partly flexible
Elbows ROM : Left Elbow Flexed, Right Elbow Flexed
Shoulders/Elbows Strength Concerns : right arm is getting caught between wheelchair armrest and the tray

UE ROM
Left Upper Extremity Active Range : Impaired
Left Upper Extremity Passive Range : Impaired
Right Upper Extremity Active Range : Impaired
Right Upper Extremity Passive Range : Impaired

Left Wrist and Hand Strength/Dexterity : Impaired
Right Wrist and Hand Strength/Dexterity : Impaired

Hip and Pelvis Position
Anterior/Posterior : Posterior tilt

Changing Health Care for Good.

W█████, A█████ DOB: ██████

Position Flexibility : Partly flexible
Obliquity : Right side low
Obliquity Flexibility : Partly flexible
Position : Adduct
Position Flexibility : Partly flexible

LE ROM
Left Lower Extremity Active Range : Impaired
Left Lower Extremity Passive Range : Impaired
Right Lower Extremity Active Range : Impaired
Right Lower Extremity Passive Range : Impaired

RECOMMENDED SPECIAL NEEDS BED

Beds by George Dream Series
https://bedsbygeorge.com/safety/our_beds/models/2500.php

1. 30" transfer
2. Lift kit
3. Full Size
4. Casters
5. Clear view windows with air flow panel
6. Access port for tubing
7. Manual adjust head and foot board – due to history of
8. Full articulation

This bed will accommodate A█████ for a lifetime with only minor maintenance and mattress replacement. She is a very involved young lady with minimal expectations for significant improvement in her current functional status. A█████ is completely dependent upon her mother for all care and positioning. This is extremely challenging for a parent and the ability to acquire required medical equipment and positioning devices is critical for the well-being of both the child and the caregiver.

A█████ cannot participate in typical childhood activities and her world is limited to therapy, medical appointments and school. She has no independent mobility and is completely reliant on her caregivers for position changes throughout the night. A█████ mother does not have nursing or respite care. A seemingly benign request for a bed that looks like a bed and not a hospital room is emotionally necessary for families and children with complex medical needs in order to lend a sense of normalcy to their daily lives. Unfortunately, funding sources do not consider this and view items such as beds as "not medically necessary." This is extremely unfortunate as children with special needs spend nearly half of their day in a bed. The ability of a bed to provide comfort, support and positioning is important for their quality of life.

Karen Reckamp, OTR/L, ATP, SMS OT4378

_______________________________________ _______________________________________

Karen Reckamp, OTR/L, ATP, SMS 1/16/2019

Member Number:	Patient:	DOB:
[redacted]	A[redacted] W[redacted]	[redacted]
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

Introduction :		
Question Number	**Question**	**Response**
1	The recipient and or caregiver are aware that this questionnaire and answers are covered under the HIPAA act.	Yes
2	(Coordinator discussed program with caregiver)Parent/caregiver agrees to participate in Care Coordination program	Yes

Health Literacy :		
Question Number	**Question**	**Response**
1	What is the primary language used in the home?	English
2	Are you comfortable speaking with me in English?	Speaks English
3	Do you have any cultural, religious or social practices that may affect your child's medical treatment?	No
4	I would like to talk to you about any difficulties that you may have in dealing with your child's healthcare needs. How often do you need to have someone help you read instructions, pamphlets, or other written materials from you child's doctor or pharmacist?	Never
5	Do you have problems learning about your child's medical condition because of understanding written materials that you get from your child's doctor, hospital or pharmacist?	No
6	Can you fill out medical forms without help from others?	Yes
7	Care Coordinator to answer based on observation/answers: Does the caregiver need assistance reading educational materials, understanding educational materials or filling out forms on the child's behalf?	No

Healthcare Team :		
Question Number	**Question**	**Response**
1	What is the current payment sources for your child's care?	Medicaid - Traditional FFS
2	What type of services are being requested (check all that apply)	PPEC services PCS Services
3	Does your child have a primary care physician?	Yes

Member Number:	Patient:	DOB:
[redacted]	A[redacted] W[redacted]	[redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

Healthcare Team :

Question Number	Question	Response
4	What is the name of your child's primary care physician?	KOMATZ
5	When was the last time your child was seen by their Primary Care Physician?	7/2019
6	Are you maintaining a regular schedule of well child visits to your primary care physician?	Yes
7	Are your child's immunizations up to date?	Yes
8	If the recipient is under age 2, has he/she been screen for exposure to lead?	NA Recipient is over age 2
9	When is your child's next appointment with the primary care physician?	12/2019
10	What type of specialty physicians does your child see?	Orthopedics, Endocrine,Ophthalmology, GI.Nutrition,Neurology, Spasticity Clinic
11	When was the last time the recipient was seen by their specialty physician(s)?	11/2019
12	When is the next scheduled appointment with the specialist(s)?	TBD
13	Is transportation a problem to go to MD appointments or pick up prescriptions?	No
14	Does the parent/caregiver have all of the medical equipment that they need in order to care for their child?	Yes
15	What home equipment is currently in use (check all that apply)?	Wheelchair dependent Bath chair Stander Feeding equipment Splints Hoyer Lift Other Nebulizer TLSO brace, hip brace medical carseat and activity chair
16	Are there issues with or repairs needed for any equipment that is already in the home?	No
17	Does the recipient have a preferred DME provider?	Yes ALL ABOUT PEDS & Numotion
18	If the recipient is receiving any medical supplies, have there been any issues with timely receipt?	NA, does not need supplies or no issues
19	Does the recipient have an established pharmacy that they use regularly?	Yes

Member Number:	Patient: A W	DOB:
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

Healthcare Team :

Question Number	Question	Response
20	What was the outcome of the most recent inpatient discharge?	Recipient not hospitalized in the last 6 months
21	Has the recipient gone to the Emergency Department in the last 6 months?	No
22	Overall status Which description best fits the recipient's overall status?	Stable with no heightened risks for serious complications and death
23	Tell me about your child's health status in your own words.	she's doing well
24	Does the parent/caregiver appear to understand the child's diagnosis?	Yes
25	Tell me about the treatment plan that the physician has prescribed for your child in your own words	continue specialty visits

MEDICATION :

Question Number	Question	Response
1	Do you understand the purpose and proper administration of each of the medications you give your child?	Yes
2	Are there medications that have been ordered that are not being given?	No
3	Are there reason (financial or other) that you have been unable to obtain the medications that are ordered for your child?	No
4	Medication list was reviewed and updated in Medication profile in Care Coordination system	Yes, Medication profile was updated

ADMINISTRATION OF INTRAVENOUS FLUIDS/ANTIBIOTICS :

Question Number	Question	Response
1	Does the recipient receive IV/Infusion therapy (excludes TPN)?	No
2	Does the recipient get parenteral nutrition (TPN or lipids)?	No
3	What type of vascular access device does the recipient have?	None
4	Does the recipient have scheduled IV medications (other than IV pain medications)?	None
5	Does the recipient receive IV PRN pain medications?	None
6	Does the intravenous catheter require routine flushing?	None

Member Number: [redacted]	Patient: A[redacted] W[redacted]	DOB: [redacted]
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

LIVING ARRANGEMENTS :		
Question Number	**Question**	**Response**
1	What is the number of competent adults living in the home?	Two
2	What is the number of adults who work outside of the home?	All
3	What is the number of children, 0-10 years of age, living in the home other than the recipient?	One
4	What is the number of physically or mentally disabled children/adults living in the home, other than the recipient?	Zero
SCHOOL :		
Question Number	**Question**	**Response**
1	Does the recipient attend school or PPEC? Select all that apply.	PPEC School
2	Name and location of PPEC?	FLETCHER'S TC SOUTH
3	What is the PPEC schedule?	after school and non school days
4	Are skilled services needed during school hours?	Yes
5	Does the school provide a nurse for the recipient's skilled needs?	No
6	Does the school provide an aide for recipient's ADL needs?	No
SKILLED NURSING SERVICES: RESPIRATORY :		
Question Number	**Question**	**Response**
1	Which best describes the recipient's airway status?	Normal
2	Which best describes the recipient's airway/tracheostomy care needs?	No suctioning required
3	Does the recipient use a ventilator?	Does not use a ventilator
4	If recipient does not have tracheostomy, what are the suctioning needs?	Requires no suctioning
5	What are the recipient's nebulizer needs?	PRN or BID nebulizers, Chest physiotherapy or Cough assist
6	What are the recipient's BIPAP/CPAP needs?	Does not use BiPAP/CPAP
7	Does the recipient receive chest percussive therapy?	No chest percussive therapy

Member Number:	Patient:	DOB:
[redacted]	A[redacted] W[redacted]	[redacted]
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

SKILLED NURSING SERVICES: RESPIRATORY :

Question Number	Question	Response
8	What are the recipient's oxygen therapy needs?	Does not use oxygen
9	What type of monitors are used in the home?	No monitors used
10	Has the recipient had sleep apnea or bradycardia requiring intervention within the last year?	No
11	Is the parent/caregiver certified in CPR?	Yes

GI/NUTRITION STATUS :

Question Number	Question	Response
1	What is the enteral G-Tube/J-Tube feeding schedule? Choose all that apply.	Enteral feeds QID or less Enteral feeds continuously at night only Enteral feeds over 30 minutes or less Enteral feeds via pump runs longer than 30 minutes/feed
2	In addition to feeds, are there boluses of water?	Yes
3	Oral feeding or eating - Current ability to feed self meals and snacks safely. Select those that apply.	Unable to feed self and must be assisted or supervised throughout the meal/snack
4	Does the recipient require aspiration precautions beyond routine positioning?	Yes

ELIMINATION STATUS :

Question Number	Question	Response
1	Urinary continence status:	Is incontinent at night only, or only occasionally, not appropriate for age
2	Bowel incontinence?	Occasionally incontinent of bowel, not appropriate for age
3	Does the recipient have an ostomy for bowel elimination?	No
4	Toilet transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	Incontinent and does not do toilet transfers
5	Toilet Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and or incontinence pads before and after using toilet, commode. If managing ostomy, includes cleaning area around stoma but not managing equipment.	Depends entirely upon another person to maintain toileting hygiene, not appropriate for age

Member Number:	Patient:	DOB:
[redacted]	A[redacted] W[redacted]	[redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

RENAL/UROLOGY :

Question Number	Question	Response
1	Is peritoneal dialysis done at home?	No
2	Does the recipient have a urinary catheter?	None
3	Does the recipient use external catheters?	No

NEUROLOGY :

Question Number	Question	Response
1	Which best describes the recipient's history of seizures?	Has seizures once to twice per month
2	Does the recipient have a Baclofen pump?	No

NEURO/EMOTIONAL/BEHAVIORAL STATUS :

Question Number	Question	Response
1	Cognitive functioning: Recipient's current (day of the assessment) level of alertness, orientation, comprehensive, concentration and immediate memory for simple commands.	Requires considerable assitance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half of the time, not appropriate for age
2	Has the physician or other care provider discussed ordering behavioral therapy or other evaluations to address behavioral issues?	No
3	Does the recipient currently receive or need a prescription for behavioral therapy services?	No

INTEGUMENTARY STATUS AND WOUND/STOMA CARE :

Question Number	Question	Response
1	Does the recipient have a risk of developing pressure ulcers? (Select all that apply)	Wheelchair dependent Incontinent of bowel/bladder
2	Wound Care? (Select one)	No wounds or stomas
3	Are the parents/guardian/caregiver receiving medical supplies for the recipient and have there been any issues or complications? List supplies needed and issues that need follow-up in the box below.	No

Member Number:	**Patient:** A[redacted] W[redacted]	**DOB:** [redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	
GROWTH AND DEVELOPMENT :		
Question Number	**Question**	**Response**
1	Gross motor skills (best estimate of assessment or most recent evaluation done)? (Select one)	Child is at 1-3 years
SENSORY STATUS :		
Question Number	**Question**	**Response**
1	Vision with corrective lenses if the recipient usually wears them.	Severly impaired; cannot locate objects without hearing or touching or the recipient is nonresponsive
2	Is the recipient affiliated or receiving services from Lighthouse for the Blind?	No
3	What is the recipient's ability to hear (with hearing aid or hearing appliance if normally used)?	Adequate: hears normal conversation without difficulty
4	What is the recipient's understanding of verbal content in the recipient's own language (with hearing aid or device if used)?	Sometimes understands: understands only basic conversation or simple direct phrases. Frequently requires cues to understand.
5	Speech and oral (verbal)expression of language in recipient's own language.	Unable to express basic needs even with maximal promting or assistance, or recipient is unresponsive, not appropriate for age
6	Use of augmentative device (select one)	NA does not use augmentive devices
7	Does the recipient currently receive speech therapy? If yes, please specify services.	Yes BROOKS REHAB
8	Does the recipient have or need a prescription for speech therapy evaluation or has a physician discussed ordering speech therapy?	Yes
ACTIVITIES OF DAILY LIVING :		
Question Number	**Question**	**Response**
1	Grooming: Current ability to tend safely to personal hygiene needs (ie washing face and hands, hair care, shaving or makeup, teeth care and fingernail care)	Depends entirely upon someone else for grooming needs, not appropriate for age.
2	Current ability to dress safely: Including undergarments, pullovers, front opening shirts and blouses, managing zippers, buttons and snaps (with or without dressing aids)	Depends entirely upon another person to dress, not appropriate for age
3	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face and hands and shampooing hair)	Depends entirely upon another person to be bathed, not appropriate for age

Member Number:	Patient:	DOB:
[redacted]	A[redacted] W[redacted]	[redacted]
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

ACTIVITIES OF DAILY LIVING :		
Question Number	Question	Response
4	Does the recipient receive occupational therapy?	If yes, list provider name and phone number. List frequency of services BROOKS REHAB
5	Does the recipient have or need a prescription for an occupational therapy evaluation or has a physician discussed ordering occupational therapy?	Yes

AMBULATION/LOCOMOTION :		
Question Number	Question	Response
1	Positioning	Requires total assistance with repositioning
2	Transferring: Current ability to move from bed to chair	Bedfast, unable to participate in transfers (this includes requiring single lift, two person lift or mechanical lift)
3	Ambulation/Locomotion: Current ability to walk safely, once in a standing position or use of a wheelchair, once in a seated position, on a variety of surfaces	Dependent upon others for locomotion/wheelchair operation, not appropriate for age
4	Exercise	Requires assistance with a PT or MD ordered exercise plan including passive or active range of motion, use of standers, gait trainers, or other similar equipment meant to improve development and muscle tone or stretching
5	Does the recipient currently receive physical therapy?	If yes, list provider name and phone number. List frequency of services
6	Does the recipient currently have or need a prescription for physical therapy evaluation or has a physician discussed physical therapy?	Yes

ADDITIONAL RESOURCES :		
Question Number	Question	Response
1	Is the recipient/family currently involved with a local support group?	No
2	Does the recipient need referral to local support groups?	No
3	Is the recipient receiving hospice services?	No
4	Is the recipient receiving respite services?	No

5	Receiving CDC+ and/or PCS services?	Authorized for PCS services up to 12 hours per day, 7 days per week but not receiving at this time
6	PPEC services: List the number of days/week authorized	5
7	If enrolled in an MMA, list the name and phone number of the Coordinator from the MMA.	NA
Goal Setting :		
Question Number	**Question**	**Response**
1	What is the member/member caregiver's short term personal health goal (SMART format: Specific, Measureable, Actionable, Realistic, Time limited)?	A[redacted] WILL HAVE LESS G-TUBE FEEDS AND EAT MORE ORALLY
2	What is the member/member caregiver's long term personal health goal (SMART format: Specific, Measureable, Actionable, Realistic, Time limited)?	A[redacted] WILL EAT HALF HER MEALS BY MOUTH, MAYBE HAVE A COMMUNICATION DEVICE
AGING OUT :		
Question Number	**Question**	**Response**
1	Is the recipient age 17 or older?	No
2	Is the recipient age 20?	No

DECLARATION OF BRITTANY C.

1. My name is Brittany C.

2. I am 31 years old and live in Jacksonville, Florida with my husband, Antonio W., and our two children: A.W. (11 years old); and A.W. (7 years old). I am also pregnant with our third child.

3. My daughter, A.W., is enrolled in Medicaid. She does not have a managed care plan but, instead, is enrolled in Fee For Service Medicaid. eQHealth Solutions, Inc. (eQHealth) is the entity that determines whether Medicaid will provide a requested service to A.W.

4. A.W. was born premature at 24 weeks. As a result, she has multiple medical complexities including spastic cerebral palsy, cortical visual impairment, seizures, and developmental delay.

5. A.W. is at a high risk for falling out of her bed because of her seizure disorder and because she has extreme spasticity.

6. A.W. cannot talk. She uses a Tobii Dynavox to communicate. If she is in danger or if she is hurt, she cannot call out for assistance.

7. A.W. is unable to walk and uses a wheelchair. When she is at home, we use a Hoyer lift which is a piece of durable medical equipment that enables one person to lift and transfer A.W. Without the Hoyer lift, it takes two people to lift her.

8. My daughter's ability to eat solid foods is very limited so she uses a gastronomy tube (g-tube) for supplemental nutrition.

9. My daughter is fully dependent on her caregivers for all activities of daily living.

10. My daughter's pediatrician is Dr. Stephanie Carlin, D.O., who practices at UFHealth's Bower Lyman Center for Medically Complex Children located in Jacksonville, Florida.

11. My daughter's occupational therapist who conducts evaluations for her durable medical equipment is Karen Reckamp. Ms. Reckamp works at Wolfson Children's Hospital – Rehabilitation Center also located in Jacksonville, Florida.

12. In winter 2019, Dr. Carlin, Ms. Reckamp, and I discussed the specialty medical bed that would best support A.W.'s needs. My concerns included that the bed needed to be enclosed to prevent falls, that it needed a special outlet to route the excess tubing from A.W.'s g-tube (because previously, A.W. has been found with the g-tube wrapped around her neck), and the bed should allow A.W.'s caregivers to access A.W. quickly and easily.

13. Dr. Carlin's concerns included A.W.'s worsening scoliosis necessitating a supportive mattress, the need to prevent A.W. from falling out of bed necessitating an enclosed bed structure, and the likelihood that A.W. could

become entrapped in a traditional hospital bed. Dr. Carlin also stated that A.W.'s specialty medical bed should have an adjustable head because A.W. risks aspiration due to her g-tube.

14. Ms. Reckamp's concerns were the same as mine and Dr. Carlin's but, in addition, Ms. Reckamp wanted to ensure that the prescribed bed took into consideration A.W.'s quality of life since A.W. spends most of her time in bed.

15. After those conversations, Dr. Carlin and Ms. Reckamp prescribed the Dream Series bed for A.W.

16. On February 24, 2020, in response to the request, eQHealth denied the Dream Series bed.

17. Frustrated and concerned about A.W.'s health and safety, I pursued the denial diligently and filed appeal with the Office of Fair Hearings – Agency for Health Care Administration (AHCA) on March 2, 2020.

18. The hearing was held on April 7, 2020. It lasted from 9:30am to 10:19am.

19. During the hearing, eQHealth insisted that a hospital bed with rails would be sufficient to meet A.W.'s needs. I tried to emphasize the safety concerns posed by a traditional hospital bed including the risk of g-tube entanglement as well as entrapment in the hospital bed rails and gaps between the frame and

mattress. It did not seem like the hearing officer took my concerns, or more importantly, the concerns of A.W.'s treating professionals into account.

20. The hearing officer sent me a final order upholding eQHealth's denial of the Dream Series bed. I also received a copy of the entire record on appeal which included an AHCA document entitled "Summary Memorandum: Medical Necessity as a Limitation on Medicaid Services, Including EPSDT" dated August 5, 2014. It had handwritten page numbers on the bottom right-hand corner beginning at 183 and ending at 194. I gave the record on appeal to my daughter's attorney, Katy DeBriere.

21. Since AHCA will not provide the Dream Series bed, I do not know what next steps I should take to ensure A.W.'s is safe when she is in bed. Given that Dr. Carlin and Ms. Reckamp emphasized the dangers of entrapment posed by a traditional hospital bed with rails, I do not want to choose that sleeping arrangement.

22. At the same time, I know A.W.'s current sleeping arrangement in a regular bed is also not safe. For example, on May 6, 2021, she fell out of bed and was found hanging by her foot with her head stuck between the wall and bed.

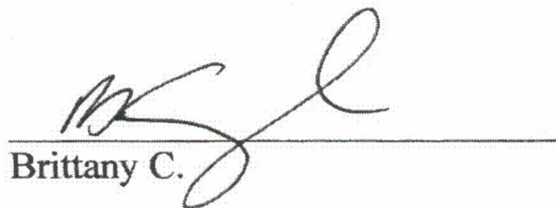
23. Like the scenario on May 6, 2021, there are moments when I do not even realize the potential risks that A.W. sleeping in a regular bed pose until they happen. This brings me great anxiety.

24. Due to AHCA's denial of the Dream Series bed, I have been placed in an untenable position where I must pick between two unsafe sleeping situations for my daughter. A.W. is non-verbal and because she cannot call out to us for help, I am constantly concerned about her safety at night. This interrupts my sleep significantly and impacts everyone in our home.

25. As a parent, my daughter's safety, well-being, and quality of life are at the forefront of my mind. For these reasons, I ask that the Court grant our request for preliminary relief on behalf of A.W. and order that AHCA evaluate A.W.'s need for the Dream Series bed under the correct standard - that is whether the bed is necessary to correct or ameliorate A.W.'s disabling conditions.

26. I greatly appreciate the Court's consideration of this matter.

Dated: 8/4/2021



Brittany C.

eQHealth Solutions – Florida Division
5802 Benjamin Center Drive
Suite 105
Tampa, FL 33634

Date of Notice: 2/24/2020
Review Complete Date: 2/20/2020
Review Request Date: 2/18/2020
Billing Provider Name & Number: 003207800
ALL ABOUT PEDIATRICS,LLC
Setting: DME
Doctor's Name & Number:
STEPHANIE CARLIN
Recipient Name: A[redacted] W[redacted]
Recipient's Medicaid Number: [redacted]
Admit Date: 3/15/2020

Brittany C[redacted]
[redacted]
JACKSONVILLE, FL [redacted]

NOTICE OF OUTCOME

Dear Brittany C[redacted]

eQHealth Solutions reviews requests for DME services under the Florida Medicaid program. Nurses and physicians with experience in DME review the information from your provider in order to determine medical necessity.

Your provider submitted a request for services. A physician reviewed the request and based on the information provided to us our findings are below.

Our decision includes the number of units approved or denied in the "Total Units" column.

Code	Description	From	Thru	Total Units		Rental Type If Rented
E1399	Specialized Medical Equipment/Supplies	3/15/20	5/14/20	Approved	0	
				Denied	1	

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010(166), Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standard(s):

> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The rationale for our decision is as follows:

> PR Principal Reason - Denial:
>
> The clinical information provided does not support Medicaid's medical necessity definition.
>
> The patient is a 10 year old with CP who is non-ambulatory, non-verbal, and has a GT and the request is for a specialty bed. The request is excessive because a hospital bed should suffice. A specialy bed was previously denied last November.

Date of action is 2/21/2020

Brittany C
Page 2
2/24/2020 DME OP Outcome-Denial

Right to Reconsideration

If you do not agree with this decision, you, your doctor, or your provider can ask eQHealth to reconsider and have another physician review the case. A request for reconsideration must be submitted to eQHealth before 3/6/2020.

eQHealth Solutions – Florida Division
Attention: Reconsideration
5802 Benjamin Center Drive
Suite 105
Tampa, Florida 33634
(855) 444-3747

If you ask for reconsideration, A W still has a right to a fair hearing.

You do not have to ask for reconsideration. If you do not, A W can ask for a fair hearing as follows.

Right to Fair Hearing

You may ask for a fair hearing within 90 calendar days from the date this notice was mailed by contacting AHCA by telephone at (877)-254-1055, by fax at (239)-338- 2642, by email at MedicaidHearingUnit@ahca.myflorida.com, or in writing at:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

You may represent yourself at the hearing or use legal counsel, a relative, a friend, or another person you authorize to represent you.

Sincerely,

Medical Director
Chris Kunis, MD

650 DME OP Outcome-Denial

47144890

Notice: This notice is only for the persons it was sent to and should not be used by anyone else. If it was sent to you by mistake you should not use it in any way. If it should not have been sent to you, please call us right away at 855-444-3747. Please destroy the letter.

Filing # 115714289 E-Filed 10/27/2020 06:45:41 PM

RECEIVED, 10/27/2020 06:46:32 PM, Clerk, Fourth District Court of Appeal

IN THE DISTRICT COURT OF APPEAL
FOURTH DISTRICT
STATE OF FLORIDA

Q.H. c/o A.H.,

Appellant,

v.

CASE NOS.: 4D20-0741
L.T. No. AHCA 20-FH0016

SUNSHINE STATE HEALTH PLAN, INC.,

Appellee.
________________________________/

AMICUS BRIEF IN SUPPORT OF APPELLEE, SUNSHINE STATE HEALTH PLAN, INC.'S MOTION FOR REHEARING, REHEARING EN BANC, CLARIFICATION AND/OR CERTIFICATION OF CERTAIN QUESTIONS TO THE FLORIDA SUPREME COURT AS MATTERS OF GREAT PUBLIC IMPORTANCE

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Counsel for Amicus Curiae

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IDENTITY AND INTEREST OF AMICUS CURIAE

The State of Florida, Agency for Health Care Administration ("AHCA" or "the Agency") is the "single state agency" responsible for administering Florida Medicaid and ensuring compliance with state and federal law and policies. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(b); § 409.902, Fla. Stat. The Majority Opinion significantly curtails AHCA's ability to effectively serve children in the program while at the same time making decisions for the good stewardship of the program and of taxpayer dollars. And it conflicts with the Eleventh Circuit's precedent, such that AHCA (and its Hearing Officers and contracted Medicaid Managed Care plans) will be subject to different standards depending on where suit is brought.

SUMMARY OF THE ARGUMENT

The Majority Opinion uses different standards from the Eleventh Circuit to decide whether Florida Medicaid should cover and pay for services for a child under the Early and Periodic Screening, Diagnosis, and Testing ("EPSDT") requirement, and whether a treating physician's opinion of medical necessity is entitled to deference? It also significantly curtails AHCA's ability to effectively serve children in program while at the same time making decisions for the good stewardship of the program and of taxpayer dollars. AHCA supports Appellee, Sunshine State Health Plan, Inc. ("Sunshine") in requesting rehearing, rehearing en banc, clarification, and/or certification of one or more questions of great public importance.

ARGUMENT

The Eleventh Circuit has held States may define "medical necessity" and apply their definitions to limit Medicaid coverage of EPSDT services and a treating physician's discretion, so long as a definition "reasonable" and "'**consistent with the objectives of' the Medicaid Act, specifically its EPSDT Program.**" The Majority Opinion says it agrees but, when actually determining if AHCA's medical necessity definition is permissible, it surreptitiously **substitutes a different standard: whether it is "consistent with the EPSDT's 'necessary to correct or ameliorate' standard**[?]" Also, United States Supreme Court and Eleventh Circuit precedent hold a treating physician's opinion of medically necessary **should not be pre-assigned specific weight or deference**, but the Majority says **a treating physician's opinion should be given "considerable and substantial weight."**

The Majority leaves AHCA no room to adopt and apply a definition of medical necessity in an EPSDT case unless it merely regurgitates the service definition at § 1396d(r)(5). Such a definition would be pointless, as it clearly would not help AHCA to "refuse to fund unnecessary—though perhaps desirable—medical services." And it leaves AHCA no discretion to deny Medicaid coverage and payment for services that are unlikely to be effective, are experimental or unsafe, are more aggressive or more costly than other services that could effectively treat a condition, are purely cosmetic, are primarily for the recipient's or their caretaker's

convenience, and/or where it has not been shown the child would suffer any adverse consequence if the treatment were withheld or provided later on (i.e. when the child is older). Thus, the Majority significantly curtails AHCA's ability to effectively serve children in the Medicaid program while at the same time making decisions for the good stewardship of the program and of taxpayer dollars.

While the Eleventh Circuit's standards are in line with how the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") interprets the federal Medicaid Act and regulations (as set forth in CMS policy statements that are binding on AHCA), the Majority's standards are not. The Eleventh Circuit's precedent is binding on AHCA, as the State Medicaid agency, and will be used to adjudge its action whenever it is sued or sues in federal court. The Fourth District's precedent is likewise binding on AHCA in any case brought in the Fourth District, will be used to adjudge its actions whenever it is sued/sues in the Fourth District, and is persuasive to other Florida Courts. AHCA seldom has a choice as to where it will be sued, and disputes arising from AHCA's fair hearing final orders are most often heard by Florida's District Courts of Appeal.

The question of what standards and analyses should apply to determine Medicaid coverage for children under age 21 under EPSDT is of great public importance. As of October 20, 2020, there were 2,455,674 children under age 21 enrolled in Florida Medicaid, including 78,777 children receiving services on a fee-

for-service basis and 2,376,897 children enrolled in Managed Care Plans under SMMC. All these children are eligible to receive services under the EPSDT benefit.[1] During fiscal year 2019-2020, Florida Medicaid spent $7,710,035,725.44, on services for children under age 21. This figure includes $1,474,995,336.97, in fee-for-service payments made directly to health care providers (an average of $4,525.14 per child), plus $6,235,040,389.47 in capitation payments made to Managed Care Plans AHCA has contracted with to provide services recipients under Statewide Medicaid Managed Care (an average of $2,373.15 per child). The cost of such services is borne by federal and state taxpayers.

Also, AHCA's Office of Fair Hearings – which hears recipient appeals from any adverse service authorization decisions made by AHCA's Quality Improvement Organization (fee-for-service) and AHCA's contracted Managed Care Plans (SMMC) – received some 1,317 fair hearing requests regarding services for children under age 21 in fiscal year 2019-2020. If AHCA and its hearing officers cannot apply a uniform medical necessity definition to all EPSDT cases, and if this Court adopts a different standard and analysis for deciding Medicaid coverage of services than the Eleventh Circuit, the amount of litigation and number of hearing requests regarding children's services is expected to increase significantly.

---

[1] The same EPSDT service requirements apply to children under age 21 who are enrolled in a Medicaid Managed Care Plan under SMMC, pursuant to federally approved waivers and AHCA's contracts with the Managed Care Plans.

In summary, the Majority Opinion places AHCA in an untenable position regarding the choices it must make for the Florida Medicaid program generally, and its vulnerability to state and federal lawsuits. Florida Courts and the Eleventh Circuit need to use the same standards and analyses, and those standards and analyses needs to comport with the federal regulatory scheme. That so many children and so many of the State's resources will be affected makes the question of what standard and analysis should apply one of great public importance.

AHCA believes the relief that would be most appropriate and helpful is for this Court to grant rehearing or rehearing en banc and issue a new Opinion that: 1) is consistent with Eleventh Circuit precedent; 2) finds AHCA may adopt and apply a definition of medical necessity that is "reasonable" and "consistent with the objectives of" the EPSDT requirement; 3) does not require deference to a treating physician's opinion; and 4) recognizes AHCA has discretion to deny coverage and payment for unnecessary services. AHCA requests this Court limit any Opinion to deciding if the first prong of its medical necessity definition – the only prong the Hearing Officer applied – is "inconsistent with the objectives of" EPSDT, under the facts of this case. The Eleventh Circuit precedent espouses a case-by-case analysis, and whether the various prongs of AHCA's medical necessity definition are "reasonable" and "consistent with the objectives of" EPSDT cannot accurately be determined without reference to the facts and evidence presented in a particular case.

A. Background Law

The Medicaid Act requires states to cover under their State Plans all 29 services listed at 42 U.S.C. §§ 1396d(a)(1)-(29), for an eligible child under age 21 when requested an "EPSDT service." 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4), (a)(16); CMS State Medicaid Manual[2] at § 5110. 42 U.S.C. § 1396d(r)(1)-(5) defines ESPDT services, stating "[t]he term [EPSDT] means the following items and services:" screening, vision, dental, and hearing services, including at "medically necessary" intervals, and:

> (5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. . . .

Federal Medicaid law authorizes states to impose "amount, duration, and scope limitations," "utilization controls," and a state-adopted definition of "medical necessity" to limit all of the services listed in §§ 1396d(a)(1)-(29), including EPSDT. Specifically, 42 U.S.C. § 1396a(a)(17)(A) (emphasis added), states:

> 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 Medicaid Act] ...

---

[2] Sections 5010 through 5360 of the CMS State Medicaid Manual are binding state Medicaid programs and describe how states must provide EPSDT services to meet federal requirements. CMS State Medicaid Manual ch.1, § B.1, ch. 5 §§ 5010-5360 (available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html).

42 U.S.C. § 1396a(a)(30)(A) (emphasis added), states Medicaid plans must:

> 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 42 U.S.C. § 1396a(a)(19) indicates states have discretion to determine the "amount, duration, and scope" of the services they provide, but the provision of services must be consistent with "the best interests of recipients."

42 C.F.R. § 440.230(a)-(d) (emphasis added) provides:

> (a) The [State] plan must specify the amount, duration, and scope of each service that it provides ...
> **(b)** Each service must be **sufficient in amount, duration, and scope to reasonably achieve its purpose.**
> **(c)** The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible beneficiary **solely because of the diagnosis, type of illness, or condition.**
> **(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.**

Also, the CMS State Medicaid Manual at §§ 5110 and 5122.F. instructs States that (emphasis added):

> **Appropriate limits may be placed on EPSDT services based on medical necessity.**
>
> * * *
>
> **You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.**

> 42 CFR 440.230 allows you to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). …

Florida has expressly incorporated "medical necessity" as a requirement for all Medicaid services, including EPSDT services, and made AHCA the "final arbiter of medical necessity." §§ 409.905(introduction), (2), 409.906(introduction), 409.913(1)(d), Fla. Stat. The Florida Medicaid Definitions Policy (Aug. 2017), incorporated into law at Florida Administrative Code Rule 59G-1.010 (available at https://www.flrules.org/gateway/reference.asp?No=Ref-08567, provides at § 2.83:

> **2.83 Medically Necessary or Medical Necessity**
> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
> - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
> - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
> - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider
>
> The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. . . .

Compare to former Fla. Admin. Code R. 59G-1.010(166)(a), (c).

In Beal v. Doe, 432 U.S. 438, 441-42, 444-45 (1977), the US Supreme Court found: § 1396a(a)(17) "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that they be "'reasonable' and 'consistent with the objectives' of the Act"; upheld a State's refusal to pay for abortions unless they met its definition of "medically necessary"; and reasoned "it is hardly inconsistent with the objective of the Act for a state to refuse to fund unnecessary though perhaps desirable medical services."

In 1980 in Rush v. Parham, 625 F.2d 1150, 1155 (5th Cir. 1980), the old Fifth Circuit[3] found: "the Medicaid statutes and regulations permit a state to define medical necessity in a way tailored to the requirements of its own Medicaid program"; a state can reasonably define "medically necessary" to exclude unproven, experimental treatments; and such an exclusion is "fully consonant with a requirement that all medically necessary services be funded," and rejected the idea that states must pay for any treatment a doctor finds to be medically necessary.

In Moore ex rel. Moore v. Medows, 324 Fed. Appx. 773, 774 (11th Cir. 2009) (unpublished opinion), the Eleventh Circuit held:

> [A]fter the 1989 amendments to the Medicaid Act, the state must fund any medically necessary treatment that [a child Medicaid recipient] requires… **[B]oth the state and [treating] physician have roles in determining what medical measures are necessary to "correct or ameliorate" [a child Medicaid recipient's] medical conditions. A**

[3] Old Fifth Circuit cases are binding on the Eleventh Circuit. E.g., Bonner v. City of Prichard, 661 F.2d 1206, 1209 (11th Cir.1981) (en banc).

private physician's word on medical necessity is not dispositive.

324 Fed. Appx. at 774 (emphasis added, internal citations omitted).

In Moore ex rel. Moore v. Reese, 637 F.3d 1220, 1255 (2011), the Eleventh Circuit conducted a thorough review of the federal Medicaid statutes, regulations, manuals, and precedents, and summarized them in six (6) "guiding principles."

(1) [A Medicaid-participating state] is required to provide [the 29 services listed at 42 U.S.C. § 1396d(a)] to [a child Medicaid recipient], who meets the EPSDT eligibility requirements **when such services are medically necessary to correct or ameliorate [his or her] illness and condition.**

(2) A state Medicaid plan must include **reasonable standards** . . . for determining such eligibility for and the extent of medical assistance . . . and **such standards must be "consistent with the objectives of the Medicaid Act, specifically, its EPSDT program.**

(3) **A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."**

(4) The treating physician assumes the primary responsibility of determining what treatment should be made available to his patients. **Both the treating physician and the state have roles to play, however, and [a] private physician's word on medical necessity is not dispositive.**

(5) A state may establish the amount, duration, and scope of [medical services] provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing

services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) **A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis," and may present its own evidence of medical necessity in disputes between the state and Medicaid patients.**

(Emphasis added, internal citations omitted).

Most recently, in Garrido v. Dudek, 731 F.3d 1152, 1153-54 (11th Cir. 2013), the Eleventh Circuit reiterated:

> [U]nder § 1396d(r)(5), a state must provide a service listed in § 1396d(a) to a Medicaid-eligible minor—even if the state does not provide that service to Medicaid-eligible adults—if the service is necessary to "correct or ameliorate" a condition or defect discovered during an EPSDT screen.
>
> * * *
>
> However, federal regulations provide that …the state Medicaid agency **"may place appropriate limits on a service based on ... medical necessity." Although neither the Medicaid Act nor its implementing regulations explicitly define the standard of "medical necessity," "it has become a judicially accepted component of the federal legislative scheme." The Medicaid Act and its implementing regulations grant the authority to the states to set reasonable standards for the terms "necessary" and "medical necessity**." ...

(Emphasis added, internal citations omitted). Garrido noted AHCA could apply its medical necessity definition to limit EPSDT on a case-by-case basis. Id. at 1154-61.

B. Disparities Between the Eleventh Circuit and Majority Opinion Regarding AHCA's Authority and Discretion to Adopt and Apply a Definition of Medical Necessity to Limit ESPDT Coverage and A Treating Physician's Discretion.

The Eleventh Circuit has held a State may define "medical necessity" "in a way tailored to the requirements of its Medicaid program" and apply that definition to "limit" coverage of ESDPT services, as defined at § 1396d(r)(1)-(5), so long as the Agency's definition is "reasonable" and "'**consistent with the objectives of' the Medicaid Act, specifically, its EPSDT program**." Reese 637 F.3d at 1248, 1255, 1258. See 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 440.230(d); CMS State Medicaid Manual at § 5122F. A state may "establish criteria, including its medical necessity definition, for physicians to use in determining what services are appropriate in a particular case" and a treating physician "is required to operate within such reasonable limitations as the state may impose." Reese, 637 F.3d at 1248-49, 1255 (quoting and discussing Rush, 625 F.2d at 1154, 1156). A state's medical necessity definition may reasonably exclude experimental or risky treatments from coverage. Reese, 637 F.3d at 1249 (discussing Rush, 625 F.2d at 1155-56). And "[a] state may limit required Medicaid services based upon its judgment of degree of medical necessity [if] such limitations do not discriminate on the basis of the kinds of medical condition." Reese, 635 F.3d at 1255 (citing 42 C.F.R. § 440.230(c)).

The Majority Opinion says it agrees with the Eleventh Circuit at *5-*6, *9, and *11. But when **actually applying** a standard to determine if AHCA's definition of medical necessity is permissible, it surreptitiously **substitutes a different one:**

> While we agree with Moore that a state may adopt a reasonable definition of medical necessity, **any such definition must be**

> **consistent with the EPSDT's "necessary to correct or ameliorate" standard**. See Collins v. Hamilton, 349 F.3d 371, 376 n.8 (7th Cir. 2003) (**"[A] state's discretion to exclude services deemed 'medically necessary' by an EPSDT provider has been circumscribed by the express mandate of the statute."**). And Florida courts have held that the AHCA's definition of medical necessity applicable to adult Medicaid recipients is narrower than the EPSDT standard. See C.F.[v. Dep't of Child. & Fams.], 934 So. 2d [1,] 6 [(Fla. 3d DCA 2005)]; E.B.[v. AHCA], 94 So. 3d [708,] 708–09 [(Fla. 4th DCA 2012)].

Majority Opinion at *11 (all emphasis added).

The Majority's Opinion is wrong for all of the following reasons. First, it relies on Seventh Circuit and Florida cases, that predate Medows, Reese, and Garrido to reach these holdings. And these two lines of cases directly conflict.

Second, the Majority's and C.F's construction of § 1396d(r) is illogical. Section 1396d(r) cannot be a "federal definition of medical necessity" **because it is a service definition, and a service definition merely describes the services that Medicaid can cover;** the first sentence of § 1396d(r) states "[t]he term '[EPSDT]' means the following items and services . . ." Contra Majority Opinion at *8; C.F., 934 So. 2d at *6. And § 1396d(r)(1)-(4) use "medically necessary" to describe screening intervals, while § 1396d(r)(5) uses "necessary" to describe "such other services … to correct or ameliorate . . . a condition …"; thus, the terms must have different meanings and it is possible, reasonable, and consistent with the Medicaid Act's framework for States to adopt and impose a medical necessity definition to limit services that does not just reiterate § 1396(r)(5)'s language. See C.F. at *6

("necessary" in § 1396(r)(5) is sufficiently broad to permit coverage of services that "sustain or support, as opposed to actually treating" a medical condition).

Importantly, AHCA does not contend its definition may be applied to reduce "necessary" in § 1396d(r)(5) to mean "medically necessary" **only**. Florida Medicaid must provide the 29 services listed at § 1396(a)(1)-(29) under the EPSDT mandate per §§ 1396a(a)(43) and 1396d(a)(4), (a)(16) and (r)(1)-(5). In each instance in which a service is requested for a child, AHCA applies (and its Managed Care Plans and Hearing Officers should apply) 1) the individual service definition, as well all federal and state laws, regulations, rules, and policies specific to that service type, 2) the medical necessity definition, and 3) the ESDPT definition and requirements, in concert, to determine if the service should be covered. Significantly, AHCA's service-specific policies are carefully crafted to provide coverage of services for children that may not be strictly medically necessary or even strictly within the service definition for adults to satisfy ESPDT requirements. To the extent this Court determines all three prongs of the required analysis were not correctly applied in this case, it should not construe the error as program-wide.

Third, the Majority's holding that AHCA's medical necessity definition is impermissibly narrow depends on its dubious finding that "Florida courts,[specifically, C.F. and E.B,] have held that the AHCA's definition of medical necessity applicable to adult Medicaid recipients is narrower than the EPSDT

standard." Id. at *8-*9, *11. Yes, C.F. found "the hearing officer erred when he applied definitions of medical necessity and personal care assistance that are overly restrictive." Id. at *1-*6. But, as Reese pointed out, "the EPSDT-required service at issue in C.F.—'personal care services'—contained a statutory qualifier that does not similarly apply to "[other] services.'" 637 F.3d at 1261 n.66." Thus, one cannot know if C.F. would have reached the same conclusion if the personal care service definition itself had not been "overly restrictive." The C.F. case is distinguishable, too, in that it appears to have focused on (what are now) the second and fourth bullets of AHCA's medical necessity definition, rather than the first prong (which the Hearing Officer applied in this case). See Majority Opinion at *10; C.F., 934 So. 2d at 6. And contrary to the Majority's claim, E.B. did not hold AHCA's definition of medical necessity was "overly restrictive" or "too narrow" when applied to EPSDT services, but remanded because the Hearing Officer had **failed to consider the ESDPT requirement at all**. Majority Opinion at *8-9, *11; E.B., 94 So. 3d at 708.

Fifth, the federal and state Medicaid laws, regulations, rules, and policies set forth in the Summary of the Law section of this Brief clearly permit AHCA to adopt a medical necessity definition and apply it to limit all services, including ESPDT services. But, again, the Majority leaves AHCA no room to adopt and apply a medical necessity definition for EPSDT cases that does not just reiterate § 1396d(r)(5)'s language. Such a definition would be pointless, as it would not help

AHCA to "refuse to fund unnecessary—though perhaps desirable—medical services." Beal, 432 U.S. at 444–45; Reese, 637 F.3d at 1255; Dissent at *14; CMS Manual § 5010.B. The Majority also leaves AHCA no discretion to deny coverage and payment for services that are unlikely to be effective, are experimental or unsafe, are more aggressive or more costly than other services that could effectively treat a condition, are purely cosmetic, are primarily for the recipient's or their caretaker's convenience, and/or where it has not been shown the child would suffer any adverse consequence if the treatment were withheld or provided later on (i.e. when the child is older), even though such a result is clearly inconsistent with the federal and state law and case law. Reese, 637 F.3d at 1236-37, 1247-52 (noting CMS has told States they could exclude services that are not medically necessary, unsafe, experimental, or not generally recognized as an accepted method of treatment or practice, from coverage); Rush, 625 F.2d at 1152-53, 156-58 (concluding a State may "shape its own definition of medical necessity" and "reasonably exclude" sexual reassignment surgery for a child as experimental); Lorenzo v. AHCA, 985 So.2d 703 (Fla. 4th DCA 2008) (Mem.) (affirming AHCA's denial of hyperbaric oxygen treatment as "experimental or investigational" because there was evidence that it was effective for the child's condition); C.F., 934 So. 2d at *7 (reversing another agency's coverage denial in-part because the number of personal care hours was "not in excess of [the child's] needs" and was "reflective of the level of service that can be safely

furnished and for which no equally effective and more conservative or less costly treatment is available."); Dissent at *14-*15 (discussing Beal, Rush, and C.F.).

Sixth, the Hearing Officer only applied the first prong of AHCA's medical necessity definition below to determine the services at issue should not be covered under Florida Medicaid and EPSDT. If this Court finds the first bullet point is impermissibly narrow, either generally or as applied to the facts of this case, it should say so expressly. The Agency might not like such a holding. But it could live with it much better than the Majority Opinion's current amorphous holding, which could be construed – and certainly will be construed by plaintiffs – as saying AHCA's entire definition is impermissibly narrow when applied to EPSDT services.

Finally, the Eleventh Circuit has said the purpose of the EPSDT requirement is to "provide low-income children with comprehensive health care. Reese, 637 F.3d at 1233. The Majority says the purpose of the EPSDT requirement is "to ensure that underserved children receive preventative health care and follow up treatment," quoting a case from the Middle District of Tennessee. Id. at *6. The difference is significant; the Eleventh Circuit's focus is on the wholistic aspects of ESDPT, instead of just the preventative aspects or specific treatments. This Court should align its description of ESPDT's purpose with the Eleventh Circuit.

C. Disparities Between the Eleventh Circuit Precedent and Majority Opinions Regarding the Weight of A Treating Physician's Opinion.

The Majority Opinion holds "a state must give considerable and substantial

weight to the opinions of treating physicians" in determining whether a service is medically necessary for a child in the context of EPSDT. Id. at *10-*11. The Majority takes this holding from C.F., 934 So. 2d at 7, which relies on Snyder v. Department of Children and Families, 705 So.2d 1067, 1068-69 (Fla. 1st DCA 1998). All of these cases are incorrect and should be expressly overruled.

Neither federal Medicaid Act and regulations nor Florida law expressly requires states to give deference or any particular weight to a treating physician's opinion as to whether services are "necessary" or "medically necessary." In 2003, the United States Supreme Court held a requirement that deference be accorded a treating physician's opinion **should not be inferred into a federal regulatory scheme when, as here, it is not expressly stated therein.** Black & Decker Disab. Plan v. Nord, 538 U.S. 822, 828-34 (2003) (finding a court should not infer a requirement of deference to a treating physician under another Social Security program – the Employee Retirement Income Security Act of 1974 – as the federal regulatory scheme did not express include the requirement).

Further, the Eleventh Circuit precedents confirm that a treating physician's opinion as to medical necessity should not be preassigned weight or deference. The Eleventh Circuit has held: "a state may adopt a definition of medical necessity that places reasonable limits on a physician's discretion," "a treating physician maintains primarily responsibility over a patient's treatment needs but must operate within

such reasonable limitations as the state may impose," "both the treating physician and the state have roles to play" and "a private physician's word on medical necessity is not dispositive," "a state can review the medical necessity of a treatment prescribed by a doctor on a case-by-case basis and may present its own evidence of medical necessity in disputes between the state and Medicaid patients." Reese, 637 F.3d at 1253, 1255 (quoting Rush, 625 F.2d at 1152, 1154-56; Medows, 324 Fed. Appx. at 774) (internal quotations omitted). Also in Reese, the Eleventh Circuit said:

> **Moore contends that the state, and the courts as well, should defer to her treating physician's judgment of how many hours are medically necessary for Moore, so long as the treating physician's nursing hours recommendation is within the reasonable standards of medical care and is not tainted with fraud or abuse … Congress could have said that … but it did not.** Instead, the Supreme Court has instructed that the Medicaid Act "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." … A state is obligated to provide EPSDT- eligible children with private duty nursing services, **but only to the extent that they are medically necessary. It is unclear how a state Medicaid agency could effectively discharge its § 440.230(d) authority if the treating physician were the only actor effectively placing a "medical necessity" limitation on a required service.**
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> * * *
>
> **[T]he Medicaid Act does not give the treating physician unilateral discretion to define[4] medical necessity so long as the physician does not violate the law or breach ethical duties** … It is a false dichotomy

[4] When the Reese Court said "define" here, it appears it meant "determine" or "decide." The intransitive verb "define" can mean "to determine or identify the essential qualities or meaning of." Define definition, Merriam-Webster.com, https://www.merriam-webster.com/dictionary/define at 1.a. (last visited Oct.23, 2020).

> to say that one or the other, the state's medical expert or the treating physician, must have complete control, or must be deferred to, when assessing whether a service or treatment is medically necessary …

Reese, 637 F.3d at 1258-60 (emphasis added, internal citations omitted).

CONCLUSION AND PRAYER FOR RELIEF

For the above-stated reasons, this Court should grant relief via rehearing, rehearing en banc, or clarification, and/or should certify the following questions the Florida Supreme Court as matters of great public importance:

1. Whether AHCA may adopt a definition of "medical necessity" that is more restrictive than the language in ESDPT service definition at § 1396(r)(5), so long it is "reasonable," "consistent with the objectives of" the Medicaid Act and EPSDT, and is applied on a case-by-case basis?; and

2. Whether the Agency's definition of medical necessity may reasonably exclude services that are experimental or unsafe, are more aggressive or more costly than other services that could effectively treat a condition, are purely cosmetic, are primarily for the recipient's or their caretaker's convenience, and/or where it has not been shown the child would suffer any adverse consequence if the treatment were withheld or provided later on (i.e. when the child is older)?; and

3. Whether the Medicaid law requires the opinion of treating physician as to whether a service is medically necessary for a recipient be given deference?

Respectfully submitted and served,

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CERTIFICATE OF SERVICE

I CERTIFY that the foregoing document has been furnished by Electronic Mail to counsel for Appellee, Craig H. Smith, Esquire, craig.smith@hoganlovells.com, and Paige Comparato, Esquire, paige.comparato@hoganlovells.com, Gladys.cata@hoganlovells.com, 215 South Monroe Street, Tallahassee, Florida 32301 (counsel for Sunshine); and to counsel for Appellant, Maria T. Santi, Esquire, msanti@healthandmedicinelawfirm.com,

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CERTIFICATE OF COMPLIANCE

I CERTIFY that the foregoing Answer Brief complies with the font requirements of Florida Rule of Appellate Procedure 9.210(a)(2).

/S/ *Tracy Lee Cooper George*
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