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I. INTRODUCTION

1. Plaintiffs are a certified class of children (collectively, the "Children") who are Cook County, Illinois, residents under 18 years of age, eligible for medical benefits under the Medicaid program administered by the defendant Illinois state officials (collectively, the "State"). The Children claim that the State, in violation of the federal Medicaid law, has failed to administer the Medicaid program so that the Children are served by a comprehensive health system that ensures receipt of timely well-child examinations and health screens, timely immunizations, diagnosis of health problems and treatment (the "EPSDT Claim"). The Children also claim that the State, in violation of the federal Medicaid law, has failed to administer the Medicaid program so that the Children have access to medical care that is equal to that of children in Cook County who are covered by other private or public health care programs (the "Equal Access Claim"). The Children seek declaratory and injunctive relief.

II. LEGAL STANDARDS

A. Jurisdiction And Cause Of Action

2. This Court has jurisdiction over this case under 28 U.S.C. §§ 1331 and 1343(3).

3. Plaintiffs have a cause of action under 42 U.S.C. § 1983 to enforce rights secured to them under the federal Medicaid program, 42 U.S.C. §§ 1396a(a)(30), 1396a(a)(43), 1396d(r) and related statutory provisions and implementing regulations (collectively, "Medicaid law"). See Wilder v. Virginia Hospital Ass'n, 496 U.S. 498, 509 (1990). As this Court has previously held, the laws under which the Children assert rights were intended by Congress to benefit the Children and provide them with rights; those laws are stated in mandatory terms and were intended by Congress to bind defendants; those laws are not "vague and amorphous" and the judiciary is competent to enforce them; and Congress has not explicitly or implicitly

foreclosed private enforcement of those laws. Memorandum Opinion and Order (October 17, 2001) at 11-13.¹ See also Methodist Hospitals v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996) (analyzing § 1396a(a)(30)); Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 924 (5th Cir. 2000) (analyzing § 1396a(a)(30)); Miller by Miller v. Whitburn, 10 F.3d 1315, 1316 (7th Cir. 1993) (analyzing § 1396a(a)(43)); Westside Mothers et al. v. Haveman, 289 F.3d 852, 862-63 (6th Cir. 2002), *cert. denied*, 537 U.S. 1045 (2002) (analyzing § 1396a(a)(43) and 1396d(r)); Bond v. Stanton, 655 F.2d 766, 767-768 (7th Cir. 1981) (enforcing predecessor provision to § 1396a(a)(43)); and Maine v. Thiboutot, 448 U.S. 1, 4 (1980) ("[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act² on the part of participating States.") (quoting Rosado v. Wyman, 397 U.S. 397 (1970)).

4. Medicaid beneficiaries may seek declaratory and injunctive relief to compel the State to comply with the Act. See Bond, 655 F.2d at 768 ("Declaratory and injunctive relief at the behest of 'those individuals most directly affected by the administration of [a] program' are available 'should the State not develop a conforming plan within a reasonable period of time....' Congress knows how to deprive a court of broad equitable power when it chooses to do so. It did not choose to do so in this instance.") (quoting Rosado, 397 U.S. at 420-21); see also, 42 U.S.C. § 1320a-2.

B. The Federal Medicaid Program

5. Created in 1965, the Medicaid program provides federal funds to states that choose to provide medical services to low-income people. 42 U.S.C. § 1396 et seq.

¹ These rulings are law of the case, entitled to continuing force unless there is "a strong conviction that the earlier ruling was wrong and the party that benefitted from the earlier ruling would not be unduly harmed." White v. Godinez, 301 F.3d 796, 803 (7th Cir. 2002). No such factors exist here.

² The Medicaid Act is part of the Social Security Act.

(originally enacted as Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286) (the "Medicaid Act" or the "Act"); Harris v. McRae, 448 U.S. 297, 308 (1980). Participation in the program is voluntary, but once a state opts to participate, it must comply with the Act and with the regulations promulgated by the federal Centers for Medicare and Medicaid Services ("CMS")³, a part of the United States Department of Health and Human Services ("HHS"). Id. at 301; Wilder, 496 U.S. at 502. To qualify for federal reimbursement, the Act requires each state to submit its Medicaid plan to the federal government. 42 U.S.C. § 1396a. This plan "is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in ... Chapter IV [of the Code of Federal Regulations], and other applicable official issuances of the Department." 42 C.F.R. § 430.10.

6. Since 1967, Illinois has opted to participate in the Medicaid program. See 305 ILCS §§ 5/5-1 et seq. (originally adopted at Laws 1967, p. 122, § 5-1, eff. April 11, 1967).

7. CMS, as the federal agency that administers Medicaid, has expertise in administering the Medicaid Act. CMS has promulgated a State Medicaid Manual that is an authoritative explanation of what the Medicaid statute and regulations require the states to do in implementing the Medicaid program. See State Medicaid Manual (relevant provisions reproduced in the Appendix hereto) (available at http://cms.hhs.gov/manuals/45_smm). See Indiana Family and Social Services Admin. v. Thompson, 286 F.3d 476, 482 (7th Cir. 2002) (State Medicaid Manual warranted deference); Stanton v. Bond, 504 F.2d 1246, 1249 (7th Cir. 1974) (Manual's provisions describe "what is required"). Likewise, letters written by the

³ CMS was formerly known as the Health Care Financing Administration ("HCFA"). HCFA was renamed CMS effective July 1, 2001; historical references to HCFA should be construed as references to CMS.

Director of CMS, commonly referred to as "State Medicaid Letters", provide states with direction and interpretive guidance in the provision of state Medicaid programs. Slekis v. Thomas, 525 U.S. 1098 (1999) ("vacating Second Circuit's ruling that state was not obligated to cover medically necessary equipment items under its Medicaid plan, and remanding for further consideration in light of the interpretive guidance issued by [HCFA] on September 4, 1998."); T.L. v. Colo. Dep't. of Health Care Policy and Fin., 42 P.3d 63, 67 (Colo. Ct. App. 2001) (state regulation held invalid under federal law and objectives of Medicaid Act based, in part, on HCFA interpretive guidance letter).

8. Although states may contract with private and public health care providers to deliver the panoply of services guaranteed under the Medicaid program, states retain ultimate responsibility to ensure compliance with the Medicaid Act in providing adequate health care. See Carr v. Wilson-Coker, 203 F.R.D. 66, 75 (D. Conn. 2001) ("[The State's] duties relative to ensuring that the plaintiffs receive medical services with reasonable promptness are non-delegable."); Salazar v. District of Columbia, No. CA-93-452, 1997 WL 306876, *11 (D.D.C. Jan 17, 1997) ("Defendants may enter into contracts with providers delegating the requirements of this paragraph but, if they do so, Defendants shall monitor these activities and enforce these contractual provisions in order to assure that they are fully carried out."); J.K. By and Through R.K. v. Dillenberg, 836 F. Supp. 694, 699-700 (D.Ariz. 1993). ("It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity. The law demands that the designated single state Medicaid agency must oversee and remain accountable for uniform statewide utilization review procedures conforming to bona fide standards of medical necessity.") (internal citations omitted).

C. Legal Requirements For The Provision Of Early And Periodic Screening, Diagnosis And Treatment (EPSDT)

1. Background On EPSDT

9. The Medicaid Act and its implementing regulations set forth a detailed list of services that a state program must provide. See 42 U.S.C. § 1396 et seq.; 42 C.F.R. § 430 et seq. Specifically, the Medicaid Act mandates that a state program provide that children receive: (i) regular healthcare screening services (i.e., well-child exams and immunizations); (ii) effective diagnosis of any conditions that need treatment; and (iii) treatment for any such conditions. 42 U.S.C. § 1396a(a)(10). The statute refers to these services as "early and periodic screening, diagnostic, and treatment services", and they are commonly known by their acronym, EPSDT services.⁴

10. The Medicaid Act defines EPSDT services in detail at 42 U.S.C. § 1396d(r). See also 42 C.F.R. § 441.56 (relevant portions of the statute and regulation are set forth in Appendix.) Screening services include comprehensive medical and developmental histories of both physical and mental health, comprehensive unclothed examinations, immunizations, laboratory tests (including lead blood level tests), and health education. 42 U.S.C. § 1396d(r)(1). See also IDPA Handbook for Providers of Healthy Kids Services.

11. EPSDT also includes vision, dental, and hearing screens and diagnosis. The Children are entitled to age appropriate vision and hearing screening; risk assessment (such as mental health and substance abuse screening), as appropriate; developmental screening and

⁴ 42 U.S.C. § 1396a(a)(10) mandates that: "a state plan for medical assistance must ... provide for making medical assistance available [to eligible persons], including at least the care and services listed in paragraphs (1) through (5) ... of section 1396d(a) of this title... ." In turn, 42 U.S.C. § 1396d(a)(4)(B) says that "medical assistance means ... early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21".

assessment as needed; and oral health screenings and referrals for dental care and other needed medical services. IDPA Handbook for Providers of Healthy Kids Services, § HK-203.11. See 42 U.S.C. § 1396d(r)(2)-(4); 42 C.F.R. § 441.56(b)-(c).

2. **EPSDT Services Must Be Provided On A Timely Basis**

12. EPSDT services are to be performed at intervals that meet reasonable standards of medical and dental practice. 42 U.S.C. § 1396d(r)(1)-(4). The Medicaid regulations refer to this required schedule of periodic examinations, tests and services as a "periodicity schedule", and they instruct the states to implement one in consultation with medical provider groups that specialize in providing healthcare to children. 42 C.F.R. § 441.58. The periodicity schedule must specify the screening services applicable "at each stage of the recipient's life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services." 42 C.F.R. § 441.58(b); see also State Medicaid Manual § 5140 (relevant portions of which are set forth in Appendix). Services must be provided more frequently as may be medically necessary for any individual child. 42 U.S.C. § 1396d(r)(1)(A)(ii).

13. Illinois has adopted a periodicity schedule that tracks the recommendations of the American Academy of Pediatricians and incorporates the nationally recognized schedule for immunizations. 89 Ill. Admin. Code § 140.488. The Illinois periodicity schedule calls for seven appointments for health screening services in the first year of life, four appointments in the second year of life, and a decreasing number of annual appointments as a child becomes older. Id. Under the periodicity schedule, a child should receive additional examinations if medically necessary. Illinois also calls for annual vision, hearing, and dental screens, and two blood lead screens (at 12 and 24 months of age).

14. To comply with its EPSDT obligations, the Illinois Department of Public Aid ("IDPA"), which is the Illinois agency that implements the Medicaid Act, requires that children receive immunizations appropriate for a child's age and health history as set forth in the Recommended Childhood Immunization Schedule, as approved by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). 89 Ill. Admin. Code § 140.488.

15. To comply with EPSDT obligations, § HK-203.31 of IDPA's Handbook for Providers of Healthy Kids Services states that:

"Federal mandates and Department policy recommend that all children enrolled in the Department's Medical Programs be considered at risk for lead poisoning, and receive a screening blood lead test at 12 and 24 months. Children over the age of 24 months, up to 72 months of age, for whom no record of a previous screening blood lead test exists, should also receive a screening blood lead test. All children enrolled in the Department's Medical Programs are expected to receive a blood lead test regardless of where they live."

3. The Children Are Entitled To Follow-Up Services

16. A state program must ensure that children get follow-up corrective services, 42 U.S.C. § 1396a(a)(43)(C) (states are required to "arrange[] for (directly or through referral to appropriate agencies, organizations or individuals) corrective treatment, the need for which is disclosed by . . . child health screening services.") See Bond, 655 F.2d at 770. The states also must provide all care, treatment, services or other measures that are medically necessary to address any conditions that are discovered through the screening and diagnostic services under EPSDT. 42 U.S.C. § 1396d(r)(2)-(5).

17. Congress conferred the right to EPSDT services on every recipient child, and reinforced this intent with the extraordinary step of expressly instructing the Secretary of

HHS to "develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services." 42 U.S.C. § 1396d(r)(5). The Secretary established a schedule of goals in the State Medicaid Manual in 1990, directing the states to show by 1995 a "participant ratio" and a "screening ratio" of 80% each. State Medicaid Manual § 5360(B) and (C). The "participant ratio" measures how many of the children eligible for EPSDT services in a particular year received at least one service. The "screening ratio" measures the extent to which eligible children scheduled to receive at least one service in a given year actually receive services (as noted above, young children are scheduled to receive many more than one per year). These goals indicate that the Secretary, charged with and expert in the implementation of the statute, interprets the statute to entitle every eligible child to the full EPSDT comprehensive health program. Further, the Secretary requires, as a matter of federal-state accountability, that states evidence compliance with this entitlement by producing success in 80% of the cases. See Salazar v. District of Columbia, 954 F. Supp. 278, 304-06 (D.D.C. 1996) (district's failure to achieve participation goals constituted evidence of district's failure to deliver EPSDT services to eligible poor children). In setting an 80% goal for actual success in the delivery of EPSDT services, CMS was construing the statute to require that the state make the full effort for every single child. The Secretary, as a matter of federal oversight, was telling the states that producing a success rate of 80% would be adequate proof that the State had complied with its obligation to deliver to every child the statutory entitlement of services.

18. The states also must ensure that providers of EPSDT services are "qualified and willing to provide EPSDT services." 42 CFR § 441.61(b); see also Bond, 655 F.2d at 770 (addressing 45 CFR § 205.146(c)(2), the predecessor to § 441.61(b)).

4. **Illinois Must Actively Advance The Children's Use Of EPSDT Services**

19. The Medicaid Act requires that the states provide information to recipients that effectively promotes the use of EPSDT services. 42 U.S.C. § 1396a(a)(43), relevant portions of which are set forth in Appendix.

20. The Medicaid regulations require that the state inform recipients about the EPSDT program and its benefits using both written and oral methods. 42 C.F.R. § 441.56(a)(1). States must not just perfunctorily provide information about the program; the state's efforts must be "effective" – they must sell the plan in a way that gets children to participate in what the Act intends to be a comprehensive child health program.⁵ Id.; see also Salazar, 954 F. Supp. at 318-323, 333 (district violated EPSDT statute by failing to provide effective notice of EPSDT to children who are eligible for those services, failing to monitor whether social services staff inform patients about EPSDT services or take other appropriate action to ensure that eligible families are informed about EPSDT); Stanton, 504 F.2d at 1250 (7th Cir. 1974) ("The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the 1967 act and by the interpretative regulations and guidelines.").

21. Consistently, the regulations instruct the states to sell the program to its intended beneficiaries in various ways: they must use "clear, non-technical language", inform people of the services available and where and how to obtain them, and of "the benefits of preventive health care", and invite them to request transportation services and help with

⁵ Pursuant to 42 C.F.R. § 441.56(a)(1): "The [state] agency must – (1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program." (emphasis added).

scheduling medical appointments. See 42 C.F.R. § 441.56(a)(2); 42 C.F.R. § 441.62 (requiring the provision of transportation and scheduling services); State Medicaid Manual § 5150 ("To ensure that recipients obtain needed Medicaid services, offer and provide, if requested and necessary, assistance with transportation and scheduling appointments.... Offer both transportation and scheduling assistance prior to each due date of a child's periodic examination. Provide this assistance if requested and necessary."). States must "effectively inform" those who are blind or deaf or who cannot read or understand the English language. 42 C.F.R. § 441.56(a)(3); see also Salazar, 954 F. Supp. at 320 (written forms available only in English were inadequate notice to illiterate and non-English speaking recipients). States must act promptly and monitor their caseloads regarding EPSDT; and they must provide assurance to CMS that "processes are in place to effectively inform individuals...." 42 C.F.R. § 441.56(a)(4).

22. The State Medicaid Manual provides further prescriptions about the "informing" requirement in 42 U.S.C. § 1396a(a)(43)(A). It instructs the states to "use methods of communication that recipients can clearly and easily understand to ensure that they have the information they need to utilize services to which they are entitled." State Medicaid Manual § 5121(A). Oral methods are expressly required by the Medicaid Act, and these methods include face-to-face communications from eligibility workers, health aides, and providers, plus public service announcements, community awareness campaigns and audio and visual methods. See id.; 42 U.S.C § 1396a(a)(43)(A). It is "effective and efficient" to tailor these methods to particular at risk groups. Id.

23. The State Medicaid Manual sums up its result-oriented set of "informing" duties in this way: "[States] have the flexibility to determine how information may be given most appropriately while assuring that every EPSDT eligible receives the basic information

necessary to gain access to EPSDT services." State Medicaid Manual at 5121(c) (emphasis added).

24. Whether the informational strategies a state employs comply with the practical, result-oriented "informing" requirements of the EPSDT scheme is properly measured not only by the objective reasonableness of each strategy but ultimately by the overall results. Eligible children are not being "effectively" informed -- even if they receive a few flyers in the mail -- if significant numbers of them are not accessing services according to the periodicity schedule (or at all). See Salazar, 954 F. Supp. at 320 (low percentage of recipients who expressed desire for EPSDT services was evidence that District's use of recertification form was an ineffective tool for informing Medicaid recipients about EPSDT).

5. **Illinois Must Follow-Up With Those Children Who Are Not Receiving Care**

25. The states are obligated to increase their efforts for any children that "have not used services." 42 C.F.R. § 441.56(a)(4). This necessarily requires that the states monitor the healthcare provided to each child and that the states follow-up with every child that does not receive services. The states have an obligation to monitor the level of healthcare actually provided to help them improve their performance. See Salazar, 1997 WL 306876, *10-11 (District required to establish a tracking system to assure that all Medicaid-eligible children receive all age-appropriate screens, services and follow-up treatment).

26. If states do not know how the program is performing with respect to individual recipients of EPSDT services, the failure to monitor the program is itself a violation of the EPSDT requirements. See Bond, 655 F.2d at 770-771 (state violated EPSDT statute in failing to monitor whether complete screening services are being performed on EPSDT-eligible children); Salazar, 954 F. Supp. at 329 (agency's failure to respond to parental requests for

EPSDT services for their children, failure to conduct site visits to monitor providers serving EPSDT-eligible children, and lack of data collection requirements or organized system for receiving feedback from providers and for enforcing those requirements evidenced district's failure to monitor whether EPSDT-eligible children receive complete screening services).

27. The states must take the same result-oriented approach to comply with the statute's requirement to provide the full panoply of screening services in the periodicity schedule to "eligible EPSDT recipients who request it." 42 C.F.R. § 441.56(b); see also 42 U.S.C. § 1396a(a)(43)(B). From the earliest enactment of the EPSDT provisions, Congress has intended that states engage in "vigorous efforts" to provide health screens to children. 1967 U.S. Code Cong. & Admin. News 2834, 3032.

28. The state agency must "make available a variety of individual and group providers qualified and willing to provide EPSDT services", and it must "make appropriate use" of all other agencies and programs dealing with public health, mental health, education and related programs "to ensure an effective child health program." 42 C.F.R. § 441.61(b) and (c).

29. To achieve an "effective child health program" the states are required to take a practical, pro-active and result-oriented approach to the screening requirements of the EPSDT program. According to the State Medicaid Manual, the initial EPSDT examination:

may be requested at any time, and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Sound medical practice requires that when children first enter the EPSDT program you [the state] encourage and promote that they receive the full panoply of screening services available under EPSDT. It is desirable that a parent or other responsible adult accompany the child to the examination. When this is not possible or practical, arrange for a follow-up worker, social worker, health aide, or neighborhood worker to discuss the results in a visit to the home or in contacts with the family elsewhere.

State Medicaid Manual § 5123.1(B).

30. The Seventh Circuit has held that a technical and bureaucratic approach to the concept of a "request" for services is inconsistent with the result-oriented and practical approach embodied in the Medicaid Act. See Stanton, 504 F.2d at 1251 ("Indiana's somewhat casual approach to EPSDT hardly conforms to the aggressive search for early detection of child health problems envisaged by Congress. It is difficult enough to activate the average affluent adult to seek medical assistance until he is virtually laid low. It is utterly beyond belief to expect that children of needy parents will volunteer themselves or that their parents will voluntarily deliver them to the providers of health services for early medical screenings and diagnosis. By the time an Indiana child is brought for treatment it may too often be on a stretcher. This is hardly the goal of 'early and periodic screening and diagnosis.'"); Frew v. Gilbert, 109 F. Supp. 2d 579, 606-612 (E.D. Tex. 2000), *vacated on other grounds sub nom. Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *cert. granted in part sub nom. Frew ex rel. Frew v. Hawkins*, 123 S.Ct. 1481 (U.S. 2003) (rejecting state's argument that state is responsible for providing EPSDT services to only those Medicaid recipients' who technically request them; recipients' entitlement to services is not dependent upon a formalized type of request).⁶

31. The language in § 1396a(a)(43)(B) is closely linked to the requirement that the state "effectively inform" children and their families of the services available -- if the information is effective, the children will request services. If significant numbers of children do

⁶ The Fifth Circuit vacated the district court's order on grounds that are irrelevant to this case. Specifically, the parties entered into a consent decree. The State violated the consent decree, and the district court directed the state to submit a proposed corrective action plan to remedy each violation of that decree. The circuit court reversed, holding that the district court was without authority to enforce a consent decree against the state "except to vindicate a federal right granted in the federal Constitution or a federal statute, since 'the consent decree does not enlarge the courts' jurisdiction.'" Frazar, 300 F.3d at 542 (internal citations omitted).

not request or receive services according to the periodicity schedule or at all, then they are either not effectively informed or they are not being provided the required services in spite of a "request". See Frew, 109 F. Supp. 2d at 609 ("Whatever might be discerned about the goals of the founders of EPSDT, one may fairly assume that they did not intend to create a means by which states that fail to inform poor and unhealthy children about the program might turn around and use this as a defense to their failure to provide services.") The State Medicaid Manual explains: "Once you [the state] know that a recipient is participating, *assure* that the recipient receives timely delivery of services for the next encounter under the periodicity schedule." State Medicaid Manual § 5510(a) (emphasis provided).⁷

32. In this context, case management services are a key strategy states should employ to achieve the results required in EPSDT. Case management "centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment loop." State Medicaid Manual § 5310(D). It "provides the difference" in achieving the goal of the program: instead of fragmentation and children falling through cracks, there is "a comprehensive program based on the concept of getting children into the existing mainstream system of health care delivery." Id.; see also Frew, 109 F. Supp. 2d at 646 ("Case management helps indigent families to develop coherent plans to take care of their children's healthcare and related needs. Case managers also work to help empower families to request healthcare services on their own. Their support can often be crucial for ... [Medicaid recipients] and their families, who are largely uneducated and unfamiliar with the state's healthcare system in general.... Thus, case

⁷ Importantly, the states are to "consider an initial examination of a newborn determined eligible for Medicaid as an initial examination for purposes of identifying a child as participating in the program." Id.

management plays a vital role in facilitating recipients' access to needed medical, social and educational services.").

33. Case management is particularly effective in helping the state to accomplish the "integral responsibility" of notifying recipients each time they are due to receive an EPSDT screening. State Medicaid Manual § 5310(D). While case management is not in itself specifically mandated by the statute, its absence or underuse in a state that has significant numbers of children not receiving EPSDT services according to the periodicity schedule or at all is powerful evidence of a program that does not comply with the result-oriented requirements of the statute. See State Medicaid Manual § 5010(B) ("Although 'case management' does not appear in statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided."); Bond, 655 F.2d at 771 ("The state must assure that arrangements are made for treating detected health problems. Without feedback from the Medicaid provider who performs the screen, the caseworker cannot know who needs treatment and who is getting it. Monitoring of this aspect of the program is mandatory in order to prevent future health problems as Congress intended."); John B. v. Menke, 176 F. Supp. 2d 786, 802-803 (M.D. Tenn. 2001) (state's laissez faire attitude toward EPSDT outreach procedures of their contractors constituted inadequate oversight in violation of EPSDT statute; "without proper outreach, EPSDT is worthless.").

34. The "arranging for treatment" component of the EPSDT program in 42 U.S.C. § 1396a(a)(43)(C) is also result-oriented. The states must provide any and all diagnostic and treatment services allowed under the federal Medicaid scheme to address needs indicated by the screens, regardless of whether the state has opted to provide those services to adult Medicaid

recipients. 42 C.F.R. § 441.56(c). To ensure that treatment is provided according to this requirement, states are instructed to "[t]ake advantage of all resources available. Make arrangements with providers, including physicians practicing in individual or group settings, for the delivery of EPSDT services." State Medicaid Manual § 5220(A). There is no limitation with respect to specialists. If treatment services are indicated based on the screens and among those provided for in the federal Medicaid scheme, the state must provide them to children.

35. States may contract with MCOs to provide EPSDT services to eligible children enrolled with the organization. 42 U.S.C. § 1396b(m)(1)(A)(i). To the extent a state contracts with an MCO, the contract must provide for certain quality assurance measures including "maintenance of sufficient patient encounter data to identify the physician who delivers services to patients." 42 U.S.C. § 1396b(m)(1)(A)(xi). States also must ensure through their contracts that each MCO maintain a "health information system" that collects data on enrollee and provider characteristics and on "services furnished to enrollees through an encounter data system" 42 C.F.R. § 438.242(a) and (b)(1). Ultimately, however, the states remain accountable for the provision of EPSDT services, and must monitor these activities and enforce these contractual provisions in order to assure that they are fully carried out. See John B., 176 F. Supp. 2d at 801-802 (state contractors' failure to follow federal EPSDT requirements did not relieve State of its responsibilities; "EPSDT cannot be simply relinquished to the MCOs, as the State remains ultimately bound by the EPSDT regulations."); see discussion supra Paragraph 8.

6. ***Illinois Must Create A Health Care System That Results In Care Being Provided To The Children***

36. The State Medicaid Manual sums up the statutory and regulatory requirements of EPSDT as creating two mutually supportive operational components: "assuring

the availability and accessibility of required health care resources; and helping Medicaid recipients and their parents or guardians effectively use them." State Medicaid Manual § 5010(B). See Stanton, 504 F.2d at 1251 ("EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose."). The following components enable state Medicaid agencies to manage a "comprehensive child health program of prevention and treatment to systematically:"

- Seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- Help them and their families use health resources ... effectively and efficiently,
- Assess the child's health needs through initial and periodic examinations and evaluation, and
- Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

State Medicaid Manual § 5010(B) (emphasis added). These are active verbs describing a proactive and result-oriented program. The compliance of a state with such a program can be weighed by scrutinizing its parts, but also by examining its overall outcomes. A program with significant numbers of children not receiving services called for in the periodicity schedule or not receiving services at all cannot be in compliance with the overall statutory and regulatory scheme. See Bond, 655 F.2d at 769 ("The special emphasis placed by Congress on a large scale preventive screening and treatment program indicates that Congress believed this health program would produce meaningful results."); Chisholm v. Hood, 110 F. Supp. 2d 499, 508 (E.D. La. 2000) (low utilization rate of EPSDT services was evidence of failure of state's health care system to comply with federal law).

D. Legal Requirements For Medicaid Patients' Equal Access To Medical Care

1. Legal Requirement For "Equal Access"

37. The Medicaid Act requires that children on Medicaid have access to care that is "equal" to the care available to children who have other forms of health insurance. Specifically, the Medicaid Act provides that each state's Medicaid Plan must:

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

42 U.S.C. § 1396a(a)(30)(A).

38. This is commonly referred to as the "equal access" provision. Originally, the latter part of this provision was not in the statute, but rather was (and still is) the CMS regulatory interpretation of the first part of the provision calling for "payments ... consistent with efficiency, economy and quality of care."⁸ Congress endorsed CMS' interpretation by importing it into the statute in 1989. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a) (adding the requirement that payments are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area".) Congress explained that it wanted to endorse the CMS interpretation of the Medicaid Act's original intent, because states at the time were improperly limiting provider reimbursement rates as "one method of controlling program

⁸ The CMS interpretation, codified at 42 C.F.R. § 447.204, is still in effect: "The [state] agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."

costs." Report of the House Budget Committee on H.R. 3299 (Sept. 20, 1989) *reprinted in Medicare & Medicaid Guide (CCH), Extra Edition No. 596 (Oct. 5, 1990) at 390.* Congress concluded that, "[W]ithout adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." *Id.*

2. **The Equal Access Provision Requires That Children On Medicaid Have The Same Access To Care As Insured Children**

39. The proper analysis of "equal access" involves a comparison of the access to care of Medicaid beneficiaries "to the access of other individuals in the same geographic area with private or public coverage." H.R.Rep. No. 1010-247, 101st Cong., 1st Sess. 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. The uninsured are not part of the analysis. See Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519, 527 (8th Cir. 1993) ("to construe the language "general population" to include the uninsured members of the population would be directly contrary to the intent of the Medicaid statute....To suggest that Congress appropriated vast sums of money and enacted a huge bureaucratic structure to ensure that recipients of the federal Medicaid program have equivalent access to medical services as their uninsured neighbors (i.e. close to none) is ridiculous. Congress must have meant that Medicaid recipients are entitled to access equal to that of the insured population."); Clark v. Kizer, 758 F. Supp. 572, 576 (E.D. Cal. 1990), *aff'd in relevant part sub nom.*, Clark v. Coye, 967 F.2d 585 (1992) ("According to the House Budget Committee report, the test for evaluating access is to compare the access of Medicaid recipients living in a specific geographic area with the access of individuals in the same area who have private or public insurance coverage.").

40. The legislative purpose behind the "equal access" provision is to produce a level of access to care for Cook County children who are Medicaid beneficiaries equal to the access to care enjoyed by Cook County children who are insured. The "equal access" provision,

"requires each state to produce a result." Methodist Hospitals, 91 F.3d at 1030. "Under [the equal access provision]... states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears." Id. (emphasis added).

3. ***The Equal Access Provision Requires An Analysis Of Rates And Access***

41. The key to a state's compliance with the equal access provision is "to check predictions against reality" by monitoring the rates and the resulting access to care and making the necessary adjustments if the care is insufficient. Id. at 1029-30; see also American Society of Consultant Pharmacies v. Garner, 180 F. Supp. 2d 953, 973 (N.D. Ill. 2001) ("Methodist Hospitals makes plain that the IDPA has a duty to monitor the supply that results from the new rates, and must raise the price if experience shows that the supply is not adequate under Section 30(A)"); id. at 974 (the Methodist Hospitals reading of the statute "imposes on a state the post-implementation requirement of monitoring and adjusting the rate as necessary to prevent unequal access").

42. Under Methodist Hospitals, the statute requires the monitoring of access after rates are set; it notes with approval that Indiana, the defendant state, did this with "studies" and with rate-revisions to address problems with access that the studies revealed, and it suggests that evidence of the withdrawal of providers from the system and of complaints by those affected would also be persuasive. Methodist Hospitals, 91 F.3d at 1029-30. Thus, Methodist Hospitals mandates that states monitor and adjust rates according to the level of access being produced; it suggests ways of doing this and affirms that assessing the efficacy of the state's methods and results is properly within the competence of a court. Id.

43. In cases where, as here, there is a challenge by recipients to the adequacy of the state's monitoring of access to care under existing rates, there are several factors a court may consider to evaluate whether a state has complied with the "equal access" provision: (a) the level of reimbursement to participating physicians in the context of the market and the cost of providing services; (b) the level of physician participation in the Medicaid program and whether providers are opting out of or restricting their Medicaid caseloads; (c) whether there is a stream of reports that recipients are having difficulty obtaining care; (d) whether the rate at which Medicaid recipients utilize healthcare services is lower than the rate at which the generally insured population uses those services; and (e) whether defendants have admitted that reimbursement rates are inadequate. See Clark, 758 F. Supp. at 575-78; see also Methodist Hospitals, 91 F.3d 1029-1030 (mandating studies to determine impact of rates on access and recommending physician participation and consumer or recipient complaints as two factors for such studies).⁹

44. In analyzing the adequacy of reimbursement levels, a court should consider the state's rate compared to what practitioners actually charge, and the adequacy of the rate to cover overhead or the cost of rendering services plus some marginal profit. Id. at 577; see also Rite Aid of Pennsylvania, Inc. v. Houston, 171 F.3d 842, 854-855 (3rd Cir. 1999) (evaluation of reimbursement rate levels should include consideration of whether the rate the state arrived at "would allow [providers] to maintain provision of care and earn a profit."). As

⁹ Both Methodist Hospitals and American Society involved challenges by health care providers to proposed rate decreases. See Methodist Hospitals, 91 F.3d at 1027; American Society, 180 F. Supp. 2d at 956, 962-963. In those cases, the courts were presented with only the providers' predictions of adverse impact on recipients' access to care. Neither case presented the circumstances found in the instant action: a challenge by recipients to the adequacy of the access to care under existing rates -- that is, the question of whether current rates have produced the requisite equal access.

recognized by the Clark Court, "the focus of the law is on the State's ability to encourage participation by setting adequate reimbursement rates. Although other factors may affect provider participation, the statute directs the State's attention to reimbursement levels. Regardless of the interplay of other factors, if the reimbursement levels are not enough to ensure equal access to ... care, then the State has failed in its statutory duty." Id. at 578 (internal citations omitted).

45. In measuring the level of physician participation, a court may consider: (i) the extent to which participating practitioners serve Medicaid patients; and (ii) the percentage of licensed practitioners who see every Medicaid patient who present themselves for treatment ("full participation"). See Clark, 758 F. Supp. at 576-577.

46. Separate from a showing that reimbursement rate levels are insufficient to ensure equal access, a violation of equal access can also be established where the reimbursement rates for physicians for pediatric care in the Medicaid program are arbitrary and capricious based on how they were adopted or their level compared to objective benchmarks. Indeed, where a state's methodology for adopting rates is found to be arbitrary and capricious, the resulting rates may be held invalid under equal access. See Rite Aid, 171 F.3d at 853.

47. Established rules of conduct by government agencies require that administrative actions not be "arbitrary and capricious". See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 40-41 (1983). An agency's action is arbitrary and capricious if, "the agency relied on factors other than those intended by Congress, did not consider an important aspect of the issue confronting the agency, provided an explanation for its decision which runs counter to the evidence before the agency or is entirely implausible." Rite Aid, 171 F.3d 842, 853 (3rd Cir. 1999).

48. Under the equal access provision, no particular rate-setting method or rate is mandated. Methodist Hospitals, 91 F.3d at 1030. But whatever method the state employs or rate it arrives at must comply with the general obligation not to be arbitrary and capricious. Rite Aid, 171 F.3d at 853; see also American Society, 180 F. Supp. 2d at 976 (acknowledging that an arbitrary and capricious rate could run afoul of Methodist Hospitals).

49. Specifically with respect to Medicaid rate-setting, factors identified by the court in Rite Aid appropriate for determining whether the rate is arbitrary and capricious include: (i) whether, "by considering [a] study and other sources of information, [the state] made a reasonable effort to anticipate the effects of its action"; and (ii) whether the rate the state arrived at "would allow [providers] to maintain provision of care and earn a profit." Id. at 854-855.

III. PROPOSED FINDINGS OF FACT

A. Description Of The Parties

1. The Plaintiff Class

50. There are approximately 800,000 children on Medicaid in Illinois, and approximately 600,000 of those children are in Cook County.

51. The plaintiff class (previously defined as the "Children") is as:

All children (persons under the age of 18) in Cook County, Illinois, who, on or after July 1, 1990, have been, are or will be eligible for the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act.¹⁰

2. The Defendant State Agencies

52. Defendant Barry S. Maram is sued in his official capacity as the Director of the Illinois Department of Public Aid ("IDPA"), which is primarily responsible for

¹⁰ This Court certified the Class in a Memorandum and Order entered on October 8, 1992.

implementing the Medicaid program. Defendant Maram was substituted for his predecessors in office by operation of Fed. R. Civ. P. 25(d)(1).

53. Defendant Carol L. Adams is sued in her official capacity as the Secretary of the Illinois Department of Human Services ("IDHS"). IDPA delegated to IDHS the responsibility of carrying out some personal interactions with the Children and their families under the Medicaid program. Defendant Adams was substituted for her predecessors in office by operation of Fed. R. Civ. P. 25(d)(1).

B. The Original Impetus For This Lawsuit

54. This case was originally filed in 1992 after the Health Care Financing Administration (now CMS) disapproved the Illinois State Medicaid Plan, concluding that in violation of federal law Illinois failed to show that its payment rates were sufficient to enlist enough providers to secure for the Children equal access to health care. CMS particularly criticized Illinois for not accurately counting physicians and stated that equal access had not been shown.

55. In response, Illinois proposed a mandatory managed care plan to address barriers to access for children on Medicaid. Illinois acknowledged in its program proposal to HCFA that there was a critical need for a change in the healthcare delivery system for children and that access to quality medical care was a severe problem, especially in urban areas in the state such as Cook County. The State, in its request, stated that unnecessary childhood deaths and incidence of preventable diseases were on an upsurge and that cases of measles, mumps and pertussis were increasing. In addition, the State acknowledged that Medicaid caseloads were increasing with a disproportionate number of Medicaid recipients concentrated in urban areas while available physicians had moved their practices into areas accessible to privately insured

patients. This case was stayed for years to accommodate the State's efforts at reform. Despite the admitted problems with access for children, the State never implemented its proposed solutions to remove barriers to access.

56. For example, IDPA had originally proposed to improve access to necessary medical care for children through activities such as case management services and transportation services. Today, the State provides case management only to approximately 30,000 infants, approximately 5% of the children on Medicaid in Cook County. IDPA also stated that increasing provider participation would be a major focus of the proposed program and would be accomplished by providing incentives for participation such as increased reimbursement rates. IDPA currently pays reimbursement rates that are less than or equal to 50% of any appropriate benchmark. This reimbursement rate is no better than the circumstances which prompted this case.

C. The Existing Illinois EPSDT Program

57. All children who receive Medicaid are entitled to all of the covered services available under the Illinois EPSDT program. States frequently give their EPSDT programs more user-friendly names. The panoply of EPSDT services for children on Medicaid in Illinois and the system used to inform them of those services is generally called the "Healthy Kids Program."

58. IDPA has developed the policies for the Healthy Kids Program. The program is supposed to deliver scheduled preventive health care and early diagnosis and treatment for the Children.

D. Separation Of Responsibility Between IDHS And IDPA

1. IDPA Has Ultimate Responsibility For Implementing The Medicaid Act

59. Illinois has designated IDPA as the "single state agency" that has responsibility for ensuring that the Medicaid program in Illinois complies with the Medicaid Act's requirements. See 42 U.S.C. § 1396a(a)(5) (requiring single responsible state agency).

60. IDPA operates offices in Chicago and Springfield. IDPA does not operate a local office system in the communities it serves to provide services or interactions with individual recipients. Recipients of the Medicaid program have very little in-person or phone contact with IDPA or its staff regarding the Medicaid program.

61. IDPA sets the qualifications for medical providers to participate in the Medicaid program and sets reimbursement rates for providers of pediatric services.

2. IDHS Responsibilities For Medicaid Implementations

62. Although IDPA has ultimate responsibility for administering the Medicaid program, IDPA has delegated some of its responsibilities to IDHS. IDHS administers local offices throughout the state where applicants can apply for Medicaid, and IDHS local office staff are the primary personal contact with Medicaid applicants and recipients. IDHS local offices determine whether applicants are eligible for the Medicaid program. These Medicaid eligibility determinations are the primary activity of the local office staff with regard to their involvement in the Medicaid program.

63. IDHS also has primary responsibility for issuing computer-generated eligibility and recipient information, such as recipient ID cards (known as "Mediplan" cards) and various notices, which it generates through its central office.

64. IDPA has not given the IDHS local office caseworkers the role of encouraging recipients to receive immunizations for their children or to bring their children to physicians, but rather only to accept and process eligibility applications.

65. IDPA imposes "policies" on IDHS staff regarding the Healthy Kids Program, but IDPA does not have any methods for monitoring, supervising or enforcing the activities of the IDHS local office staff with regard to their provision of any Healthy Kids services. IDPA takes the position that IDHS knows what to do from two pages in manuals that describe IDHS's responsibilities.

66. Other state agencies and sub-agencies, such as the Department of Children and Family Services, also have some responsibility to jointly administer limited aspects of the Medicaid program to special recipient populations such as foster children.

E. Description And Provision Of EPSDT

1. Well Child Visits Are Critical To The Development And Health Of A Child.

67. Timely screening for general medical, lead toxicity in blood, vision, hearing, dental conditions and providing immunizations, are critical parts of a child's health care plan. The importance and cost-effectiveness of primary and preventive health care are well documented by the medical community. Preventive health care, early treatment of acute illnesses, and amelioration of chronic illnesses early in life may prevent more costly and personally challenging health problems later. For example, a child who is not screened for hearing loss at an early opportunity is at significant risk for speech and language deficiencies. Similarly, a child who does not receive early blood lead tests to detect lead poisoning is at risk for inpatient hospitalization, invasive chelation treatment, and subsequent developmental delays or permanent harm.

2. *The State Has Provided Care To An Abysmally Low Percentage Of The Class – The Dr. Darling Analysis.*

68. The only records that IDPA maintains on the level of care provided to the individual Children are claims data from providers. In other words, IDPA keeps a child's health history by recording which medical services IDPA has reimbursed. Each reimbursed physician service is called an "encounter." This data is maintained in the Medicaid Management Information System ("MMIS"), which contains information on all services and associated payments, as well as information pertaining to the providers and recipients of each service.

69. There is another computer system that collates information about certain tests and immunizations provided to the Children. This system is called Cornerstone, and it is run by IDHS. The Cornerstone system purports to compile data from IDPA's MMIS as well as the Cook County Department of Health, the City of Chicago Department of Health, and not-for-profit community health agencies. Because the Cornerstone system compiles disparate information from so many different organizations, and performs little quality assurance of that data, the information in Cornerstone is not inherently reliable.

70. The Children Class retained Dr. Thomas Darling to analyze the MMIS encounter data to determine the level of well-child services, blood lead screens, vision screens, and hearing screens, that have been provided to the Children for the period of July 1, 1998 through December 31, 2001 (the "Data Period"). He also analyzed the Cornerstone data as well as the MMIS data for this same period to determine the level of immunizations provided to the Children.

71. Dr. Darling received his Ph.D. in 1994 from Rockefeller College of Public Affairs and Policy, State University of New York at Albany. He is on the faculty of The School of Public Affairs at the University of Baltimore in Baltimore, Maryland. Dr. Darling has

extensive professional and academic experience in conducting sophisticated analyses of large amounts of data, including working with a variety of state agencies on developing outcome-based performance measures regarding the provision of social services to children.

72. Dr. Darling put all of the MMIS and Cornerstone encounter data into a computerized database using the Microsoft Access computer program. He then analyzed the services provided to the Children during the Data Period across a broad set of defined age ranges corresponding to the age categories in the EPDST periodicity schedule to determine the level of services that each child received. For example, an infant after leaving the hospital of birth should receive well-child exams at two weeks, one month, two months, four months, six months and nine months. Dr. Darling analyzed the number of well-child examinations that were received by each child who was between the ages of ten days and eleven months of age during the Data Period to capture these exams. He began this age category at ten days of age in order to factor out any services received in the hospital as part of the birth and postpartum services and he ended at eleven months of age to allow a window of two months to catch the sixth and last scheduled well-child exam (i.e., the exam that should be done at nine months). Dr. Darling performed similar analyses of children, for example, in the following age groups: children who were 11 to 23 months of age (to capture the exams that should be given at 12 months, 15 months and 18 months); children who were 23 to 35 months of age (to capture the exams that should be given at age two); children who were 35 to 47 months of age (to capture the exams that should be given at age three); children who were 47 to 59 months of age (to capture the exams that should be given at age four); and children who were 59 to 71 months of age (to capture the exams that should be given at age five) during the Data Period.

73. Dr. Darling also analyzed the number of Children who received blood lead screenings, vision screenings, hearing screenings, Haemophilus B (HIB) immunizations, Polio (IPV) immunizations, Diphtheria and Tetanus (DtaP) immunizations, and Measles, Mumps, and Rubella (MMR) immunizations. These are some key indicators among the full set of EPSDT services and his analyses show the percentage of children who received the appropriate level of these services and those that did not. Dr Darling also analyzed some key age specific services among the full set of required EPDST services. For example, Dr. Darling analyzed the number of Children who received the appropriate number of blood-lead level screens between the ages of 11 and 37 months; and also the number of Children who received HIB immunizations between 10 days and 11 months of age.

74. Dr. Darling's analysis shows that *a majority* of Medicaid-enrolled children in Cook County did not receive sufficient medically necessary preventive health care, and a significant number – one-third or higher – did not receive *any* preventive health care at all.

75. In performing his analysis of the number of children that received appropriate well-child examinations, Dr. Darling looked at two categories of examinations. The first category consists of those examinations in which doctors are required to provide all components of an EPSDT screening (Dr. Darling described these services as "Healthy Moms Healthy Kids examinations" or "HMHK examinations" because these services satisfy the requirements of the EPSDT program, which is sometimes referred to as "Healthy Moms Healthy Kids"). The second category includes those services that IDPA counts as "well-child" examinations when responding to CMS-Form 416, which includes "HMHK examinations" as well as other services such as prenatal examinations for pregnant teenagers and exams that last five minutes. This category includes examinations that do not satisfy the requirements of an

EPSDT screen, although IDPA has characterized them as meeting the EPSDT screen requirements. Dr. Darling referred to these as "IDPA well-child examinations."

76. Dr. Darling omitted from his analysis services provided in the first ten days of life. His analysis assumes that virtually every baby born in Illinois receives a well-child checkup before being discharged from the hospital. Including those visits in the analysis would not provide an accurate picture of the number of children who receive preventive health care after they leave the hospital postpartum.

77. Dr. Darling also analyzed a set of examinations that was broader than well-child examinations. This third category includes "sick kid" visits. Dr. Darling referred to this category of visits as "any child" exams. Thus, "HMHK examinations" are a subset of "IDPA well-child examinations," which in turn are a subset of "any child examinations."

78. Dr. Darling's results show that the State has failed to provide EPSDT screening examinations to many of the Children. A few examples are illustrative. After discharge from the hospital (postpartum), children between the age of 10 days and 11 months should receive six screening examinations--at 2 weeks, 1 month, 2 months, 4 months, 6 months, and 9 months. Of the Medicaid-eligible children who should have received 6 screening examinations during this time period, 60.6% received two screening examinations or less, with 43% not receiving a single screening examination. Only 8.2% received the proper level of services.

79. Children between the age of 11 months and 23 months should receive three screening examinations—at 12 months, 15 months, and 18 months. Of the Medicaid-eligible children who should have received three screening examinations during this time period,

65.3% received one screening examination or less, with 49.7% not receiving a single screening examination.

80. Children between the age of 10 days and 11 months should receive three Haemophilus B (HIB) immunizations—at 2 months, at 4 months, and at 6 months (a fourth is due between 12 and 18 months). In assessing immunization rates, Professor Darling utilized all data made available—MMIS data and Cornerstone data. Based on that combined data, 48.0% of Medicaid-eligible children in Cook County did not receive even one HIB immunization between the age of 10 days and 11 months. Another 9.6% received only one HIB immunization and 15.2% received only 2 HIB immunizations. Only 27.2% of all Medicaid-eligible children between 10 days and 11 months received the requisite three HIB immunizations.

81. Dr. Darling's analysis shows that despite the fact that the Children should receive a blood-lead screening test at 12 months, 77.9% of Medicaid-eligible children in Cook County between the ages of 11 months and 23 months did not receive a blood lead screening test. The results of these failures are predictable. Medicaid-enrolled children are more likely than young children not on Medicaid to have elevated blood lead levels.

82. Beginning at age three, an objective vision screening, using a standard testing method, is recommended annually for children between the ages of 3 and 20. 89 Ill. Admin. Code § 140.488(b). Thus, children should receive one of their vision examinations at 36 months. However, the State's data shows, for example, that of the Medicaid-eligible children between the ages of 35 months and 47 months who should have received a vision examination during this time period, 97.3% did not receive one. Other periods demonstrate similar results.

83. Objective hearing screening, using a standard testing method, is recommended annually for children between the ages of 3 and 20. 89 Ill. Admin. Code

§ 140.488(c). Thus, children should receive one of their hearing examinations at 48 months. Of the Medicaid-eligible children between the ages of 47 months and 59 months who should have received a hearing examination during this time period, 93.6% did not receive one. Again, other periods demonstrate similar results.

84. Dr. Darling's analysis is credible and reliable. His reports are incorporated herein as findings of fact by this Court.

85. IDPA has never performed (even in response to this case) an analysis similar to Dr. Darling's that looks at the number of services that each child received and then aggregates those results to show the number of children who received, for example, no services, one service, two services, etc. in a given time period. The State has not attempted to argue that Dr. Darling's analysis is inaccurate. Dr. Darling's analysis demonstrates conclusively that IDPA is not providing screening examinations, screening tests or immunizations (or arranging for them to be provided) to the Children consistent with the mandates of the EPSDT requirements.

3. ***The State's Own Reports Confirm That The State Is Failing To Comply With Its Obligations Under EPSDT***

(a) **Cornerstone**

86. A standard measure of appropriate immunizations for 19-35 month old children is a vaccination series termed 4-3-1-3 (4 doses DTP, 3 doses polio, 1 dose measles, mumps, and rubella; and 3 doses Haemophilus B (HIB)).

87. Cornerstone immunization data from August 2003 for Cook County children enrolled in Medicaid shows that more than 60% of these children have not completed the 4-3-1-3 (4 DtaP, 3 IPV, 1 MMR, and 3 HIB) vaccination series by 36 months of age.

88. Based on data from the National Immunization Program of the United States Centers for Disease Control, all children in Illinois and all children in Chicago between 19-35 month of age have a much higher immunization rate for the 4-3-1-3 vaccination series than do children enrolled in Medicaid.

(b) CMS-416's Generally

89. Pursuant to 42 U.S.C. § 1396d(r), IDPA is required to prepare a form known as CMS-416 to report the level of care that children on Medicaid receive. IDPA submits this form annually to CMS. CMS-416 Reporting requirements are set forth at State Medicaid Manual § 2700.4.A, 4.B and 4.E. The CMS-416 serves a dual purpose: (a) to demonstrate a state's success or failure in attaining participation and screening goals; and (b) to show trend patterns and projections "from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care." CMS State Medicaid Manual § 2700.4.A.

90. The CMS-416 shows the number of EPSDT encounters for certain age groups, which include (i) birth to attainment of age one; (ii) age one to attainment of age three; (iii) age three to attainment of age six; (iv) age six to attainment of age 10; (v) age 10 to attainment of age 15; and (vi) age 15 to attainment of age 18.

91. The EPSDT encounters that are measured by IDPA as part of its CMS-416 reporting are: (i) total number of initial and periodic screening services received by children, adjusted by the proportion of the year for which they are Medicaid eligible; (ii) number of unique children receiving at least one well-child examination; (iii) number of unique children receiving blood-lead screenings; (iv) number of children receiving preventive dental care; (v) number of

unique children receiving vision screening; and (vi) number of unique children receiving hearing screening.

92. IDPA has prepared instructions on how its staff should compile data to complete the CMS-416 form. The instructions used by IDPA skew the reported data to make it appear as though IDPA's performance is better than it actually is.

93. IDPA also overcounts the number of screening examinations for Medicaid-eligible children. It counts many types of doctor visits that do not and cannot comply with the EPSDT well-child screening criteria, including prenatal visits and brief visits with a doctor lasting only a few minutes.

94. Although the CMS-416 data that IDPA reports to CMS is statewide, IDPA also breaks out the CMS-416 data for Cook County, and for managed care organizations ("MCOs") operating in Cook County. As described below, even under the State's overly favorable reporting methodology, the CMS-416 reports for Cook County and the Cook County MCOs show that IDPA provides an insufficient level of care to the Children.

(c) Results Of Cook County-Specific CMS-416 Data

95. Based upon Illinois' own internally prepared (and overstated) CMS-416 Reports for children in Cook County in federal fiscal years 2002, 2001 and 2000, one-third of children in Cook County enrolled in Medicaid did not receive *any* well-child screening services that are necessary to discover conditions that need corrective treatment.

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

a. Over one-half of Medicaid-enrolled children ages 1-5 in Cook County did not receive blood lead screenings.

b. Approximately 90% of Medicaid-enrolled children in Cook County, Illinois did not receive a vision screening.

c. Approximately 80% of Medicaid-enrolled children in Cook County, Illinois did not receive a hearing screening.

d. Approximately 75% of Medicaid-enrolled children in Cook County, Illinois did not receive a dental screening.

(d) CMS-416 And Cornerstone Results For MCOs

97. Less than 15% of children received care from MCOs. The rates for receiving EPSDT services for those MCO participants are no better.

98. On October 2, 2002, Nelly Ryan, IDPA Division of Medical Programs, wrote the five MCOs that provide services to Medicaid-enrolled children in Cook County and outlined each MCO's malperformance in providing well-child exams (based on CMS-416 data) and immunizations (based on Cornerstone data) to MCO-enrolled Medicaid-eligible children. Ms. Ryan indicated to each of the five MCOs that "[f]rom an analysis of the administrative data set and from the [MCO's] report of HEDIS measurements¹¹ and analysis of focused studies, [the MCO] is not yet achieving the participation goals set forth in the MCO contract at, Article 5.13 Required Minimum Standards of Care."¹²

¹¹ HEDIS is a report, discussed below, measuring the provision of services.

¹² Section 5.13(a) of each MCO's contract with IDPA provides in relevant part for children: "All beneficiaries under twenty-one (21) year of age should receive screening examinations including appropriate childhood immunizations at intervals specified by the Healthy Kids/EPSDT program.... At a minimum, the Contractor shall provide or arrange to provide all appropriate screening and vaccinations in accordance with OBRA 1989 guidelines to eighty percent (80%) of Beneficiaries younger than twenty-one (21) years of age."

99. Cornerstone immunization data from August 2003 for each MCO covering children on Medicaid in Cook County shows that 60-70% of children have not completed the 4-3-1-3 vaccination series by 36 months of age.

100. For example, a run of Cornerstone on August 12, 2003 data for Medicaid-enrolled children in Cook County, Illinois enrolled in United Healthcare shows the following:

Shot Group	Completed by 24 Months	Completed by 36 Months
4-3-1-3	236 [21.95%]	315 [27.08%]
Clients reviewed	1,075	1,163

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

- a. Only 13% of children received a screening examination;
- b. Only 27% of children ages 3-20 received a dental screen;
- c. Only 22% of children ages 1-5 received a blood lead screen;
- d. Only 38% of children ages 3-20 received a hearing screen; and
- e. Only 40% of children ages 3-20 received a vision screen.

102. Medicaid-enrolled children in Cook County enrolled in MCOs received less preventive health care (e.g. screening examinations, blood lead screens, dental screens, hearing screens, and vision screens) than required by federal EPSDT guidelines.

4. **The MCO's "HEDIS" Reports Confirm That MCOs Are Not Providing EPSDT Services**

103. Annually, many of the MCOs prepare reports under the aegis of the National Committee on Quality Assurance ("NCQA"), the MCO credentialing organization. These are commonly known as HEDIS reports. These reports also show that the MCOs provide an inadequate level of screening examinations. For example, in United Healthcare's 2002 HEDIS report, United Healthcare reported to the NCQA, in response to the "Children's Access to Primary Care Practitioners," that the following percentages of enrolled MCO child members had a visit to a Primary Care Practitioner in 2002:

12-24 mos.	49.01%
25 mos.-6 yrs.	34.92%
7yrs.-11 yrs.	29.16%

104. These HEDIS percentages show that the great majority of children enrolled with United Healthcare to receive EPSDT services never saw a doctor in 2002.

5. **The State Has Acquiesced To The MCO's Failures**

105. Five MCOs cover Medicaid-enrolled children in Cook County: Amerigroup Illinois, Inc.; Family Health Network; Harmony Health Plan of Illinois, Inc.; Humana Health Plan, Inc.; and United Healthcare of Illinois, Inc.

106. Each of the five MCO contracts with the State provides that the MCO shall ensure that all of the children enrolled receive all EPSDT services and, at a minimum, that 80% of all children enrolled received EPSDT services. The State is entitled to sanction MCOs for contractual noncompliance. Despite the fact that the data demonstrated that the MCOs were out of compliance, the State has chosen not to enforce these provisions of the five MCO contracts through available sanctions.

107. No MCO that has ever contracted with IDPA to provide services to the Medicaid population in Cook County has met the EPSDT requirements in the MCO Contract.

6. **The State Does Not Effectively Inform The Children Of The EPSDT Program**

(a) **Description Of The State's Notice Program**

108. The State uses two documents to describe its Healthy Kids (EPSDT) program to families enrolling in Medicaid. The first is a four-page form, and is called Healthy Kids: Good Health for Children and Teens (DPA Form 1123). The second document is the KidCare Member Handbook, which is 89 pages long and explains benefits, coverage, responsibilities such as co-pays, premiums, periodicity schedule for examinations and immunizations, grievance and appeal forms. As described below, the State's distribution of these documents is haphazard.

(i) **Notice At The Time Of Application**

109. Children and their families can apply for Medicaid coverage and be enrolled in three different ways. The documents describing the Healthy Kids Program that the Children receive vary depending on which method they happen to choose. The three application methods are: (1) applying for Medicaid benefits through a local IDHS office either in person or by mail; (2) mailing a KidCare application to the IDPA KidCare central processing unit; or (3) completing a KidCare application with a KidCare application agent (KCAA) who then sends the KidCare application to the IDPA KidCare central processing unit.¹³

110. Children who apply for Medicaid through the local IDHS office are supposed to be informed by local IDHS staff about the Healthy Kids Program when they apply

¹³ IDPA uses KidCare Application Agents to assist applicants for KidCare in applying. There are approximately 1400 KidCare application agents throughout the state.

and given the four-page form 1123 entitled Healthy Kids: Good Health for Children and Teens. The State does not provide the KidCare Member Handbook to any of the children and their families who apply at local IDHS offices. Moreover, neither IDHS nor IDPA tracks or otherwise monitors whether these children and their families are actually told about the Healthy Kids program or receive Form 1123.

111. There is much confusion about what IDHS caseworkers must do in giving "frontline" service, including whether they must orally advise children and their families of the EPSDT program and the benefit of preventative health services when they are applying for Medicaid. There are: (a) no policies or procedures in place to govern how such oral notice is to be given (content and manner); (b) no training manual relating to advising recipients as to Healthy Kids program; and (c) no accountability system to assure that IDHS caseworkers actually give oral notice of EPSDT services/availability.

112. Children who apply for KidCare through the IDPA KidCare central processing unit are provided with a copy of the KidCare Member Handbook, but not a copy of the form entitled Healthy Kids: Good Health for Children and Teens. The staff at the IDPA KidCare central processing unit do not have any duty to call persons they enroll in the Medicaid program to orally explain the EPSDT program. In fact, IDPA has no written policy on how it orally informs children and families of the EPSDT program and the benefits of preventative health care when they are applying for Medicaid through the mail.

113. KidCare application agents are neither instructed nor required to inform applicants about the specifics of the Healthy Kids program. Thus, there is no reason to believe that children and their families who apply for KidCare through KidCare application agents

uniformly receive any appropriate oral information about the EPSDT program and the benefits of preventative health care.

(ii) **Other Notices Of EPSDT Services Sent To The Children And Their Families Are Inadequate**

114. IDPA Form 1802 is a one-page document sent by the IDHS Central Office annually to all children enrolled in Medicaid to inform them about the EPSDT program.

115. IDPA Form 2286 is sent to children prior to the due date of each periodic examination, as set by the EPSDT periodicity schedule for well-child exams. The notice only mentions well-child examinations, not blood lead screens, or immunizations. The form advises the Children that they "may" be due for an exam.

116. IDPA does not track how many notices are returned by the United States Postal Service as undeliverable or follow up with families whose Form 2286 notices were not delivered.

117. There are no other forms that IDPA or IDHS use to disseminate information to children and families applying for Medicaid about the EPSDT or the Healthy Kids program.

118. IDPA does not routinely send any EPSDT or Healthy Kids notices to children receiving Medicaid through a subsidized adoption agreement with the Illinois Department of Children and Family Services (DCFS).

119. IDPA has not and does not survey or study whether recipients receive automated periodicity notices or whether these notices are an effective way of notifying parents to take their children to medical providers.

(b) The State's Written Information Is Ineffective

120. IDPA does not evaluate the effectiveness of its notices or brochures as to particular recipients based on those recipients' individual Medicaid usage and history.

121. IDPA develops its written EPSDT notices—Forms 1123, 1802, and 2286--in-house. IDPA does not field test these forms with focus groups or other Medicaid recipient audiences. IDPA also does not use outside linguists in developing or evaluating these materials to ensure that they are readable by persons with limited education, nor does IDPA use cultural experts to develop or evaluate them for people who are illiterate, have limited English proficiency, or limited American cultural literacy.

122. IDPA has not studied the most effective mix of oral and written material for informing recipients about EPSDT.

123. IDPA information about EPSDT is not tailored in any way to account for different circumstances or "at risk" populations, e.g., new moms, new recipients, recipients for less than 2 years, victims of sexual abuse, foster children.

124. IDPA has not done any geographic, cultural, or demographic studies as to Medicaid recipients who do not participate in or receive EPSDT services to determine if a lack of understandable information is causing that lack of participation.

125. The readability of documents used for public health purposes should have difficulty levels of approximately grade four to six. The State's written methods for informing families about EPSDT services are ineffective because they are too difficult to read for many parents and children. Parts of IDPA Form 1123, used to inform families who are enrolling in Medicaid about the Healthy Kids program, are geared to grade seven to nine. The child

screening examination and immunization forms included in IDPA Form 1123 are difficult to read. The IDPA Form 2286, a letter sent to parents informing them that their child is due for a check-up, is geared to an eighth-grade reading level and too difficult to read for many families enrolled in Medicaid. The 89-page manual is even more complex.

(c) The State Does Not Properly Inform Recipients Who Are Blind, Deaf Or Cannot Understand English.

126. IDPA and IDHS do not have written policies regarding how to inform applicants or recipients who are blind or deaf about EPSDT, and it has no materials or people to effectively provide the necessary information to these recipients.

127. IDPA and IDHS do not have EPSDT notices in any languages other than English or Spanish.

128. IDPA and IDHS do not have any written policies regarding how to inform applicants who do not speak English or Spanish about EPSDT. The State does not translate IDPA Forms 1123, 1802, and 2286 into any languages other than English and Spanish. IDPA and IDHS have not employed any other methods for publicizing the EPSDT program to non-English or non-Spanish speaking populations.

(d) The State Does Not Use Appropriate Oral Or Other Notice Methods.

129. IDPA has recognized that in order to get recipients' attention with respect to health care issues, "you have to have multiple methods multiple times". Accordingly, when IDPA has attempted to increase the number of children *enrolled* in the KidCare program, it has used various methods including: (i) public service announcements on television and radio (ii) public presentations at fairs and festivals; (iii) public presentations at community meetings; (iv) grants to community groups to assist in promoting KidCare to hard-to-reach groups or

targeted groups such as families in certain ethnic groups, families in rural areas, and families who do not speak English; (v) radio, television, newspaper, and community advocacy directed to African-American families; (vi) radio, television, newspaper, and community advocacy directed to Hispanic and Spanish-speaking families; (vii) sponsorship of events such as the Ringling Brothers Barnum and Bailey Circus; (viii) general advertising radio, newspaper, and bus billboards in the Chicago area; (ix) mass transit advertising in East St. Louis; and (x) distribution of KidCare-branded objects such as bookmarks, tattoos, stickers, coloring books, crayons, balloons, pins, and hand fans at fairs (including the Illinois State Fair).

130. However, in providing information about EPSDT to those already enrolled in Medicaid, IDPA has not used *any* of these methods.

131. The State has not issued guidance or instructions to non-primary care medical providers (such as emergency room doctors, hospitals, and specialists) about informing emergency room, acute care or specialty patients about EPSDT services.

132. The State does not provide financial incentives for successful referrals of children receiving Medicaid to EPSDT providers.

133. Neither IDPA nor IDHS has widely disseminated information regarding the availability of EPSDT and the benefits of preventive health care by outreach activities such as (i) the development of cooperation agreements with local school districts, public health agencies, clinics, hospitals and other health care providers, including developmental disability and mental health providers, or with charities, to notify the constituents of EPSDT, (ii) using the media for public service announcements and advertisements of EPSDT, or (iii) developing posters advertising EPSDT for display in hospital and clinic waiting rooms.

7. ***The State Does Not Provide Necessary Assistance To Help Children Find Providers.***

(a) The State's Physician Referral Service Is Inadequate

134. IDPA provides a general hotline to field all calls from recipients or applicants who may have questions of any kind. The general hotline can provide information about doctors who might be willing to provide EPSDT services. That hotline and the database used by the people who staff it provides inadequate information.

135. The hotline manual used to guide the staff who answer hotline calls is over 1,000 pages and contains information on various aspects of the Medicaid program for adults as well as children. Only one page of this voluminous manual gives any direct guidance to hotline staff on EPSDT services. Moreover, the hotline is often understaffed and as a result has had a call abandonment rate as high as 25%.

136. For Medicaid recipients who request assistance in finding a doctor, the hotline provides names of doctors participating in Medicaid in the caller's zip code. However, IDPA includes in its hotline referral database every doctor who has billed Medicaid for a service even once within the prior 18 months. IDPA does not determine, at the time it gives out the name of a specific doctor, whether that doctor is then taking new Medicaid patients.

137. Annually, approximately 2,000 providers are determined to be non-participating which means that that provider has not billed for a single service in the past 18 months. During the entire preceding 18 months, however, the hotline staff would have considered every one of those 2,000 providers to be an adequate referral.

138. IDPA does not attempt to maintain information regarding the willingness or availability of doctors listed in the hotline database to accept Medicaid patients, although

more than 70% of the doctors in Cook County who had treated children from July 1, 1998 through December 31, 2001 had not provided a single preventive care service to a Medicaid child.

139. IDPA does not attempt to maintain information regarding the number of Medicaid patients a given provider in the hotline database will accept. IDPA does not request information from enrolled providers on their availability to accept Medicaid patients. Physicians will stay on the IDPA hotline referral list as an active provider even if their practice is closed to new Medicaid patients, and even if the practice has turned down Medicaid patients in the past; IDPA does not attempt to keep track of this information.

140. IDPA leaves it to the recipient to call individual physicians from the referral list and determine if that physician is accepting Medicaid patients. IDPA does no follow-up to determine whether a recipient who has been given a physician referral through the hotline was able to see that physician or any physician. In fact, parents of children on Medicaid call many doctors referred by the hotline and are rejected for treatment because the doctor will not accept Medicaid reimbursement.

141. In providing referrals, the hotline staff does not have information about, and does not consider, quality of care issues, such as waiting times for appointments, board certification of physicians, or availability of office hours of physicians.

142. It is difficult for parents of children on Medicaid to locate pediatricians and pediatric specialists to treat their children, and the hotline is, at best, only of marginal value.

(b) Failure Of Local IDHS Offices' Doctor Referral System To Assist Children In Finding Doctors To Provide EPSDT Services

143. IDHS also does not maintain an adequate system for providing physician referrals. IDHS Local Office staff are instructed by IDPA policy that they have responsibility for providing assistance to clients in finding physicians and dentists and in scheduling doctor or dentist appointments for children enrolled in Medicaid. But IDHS Local Offices do not have access to any computer database containing names of available physicians to make referrals to children on Medicaid; and IDHS Local Office staff do not receive training on how to make referrals for children on Medicaid to available physicians. Local Offices initially refer clients to the local clinics, and some of the staff might then look at a written physician list if the person cannot be seen at the clinic. The doctor list has many of the flaws of the hotline, including that it is compiled solely based on the fact that in the past a provider has billed Medicaid for at least one service. Many IDHS caseworkers are unaware that local offices even have referral books with doctor lists and do not know what to do when asked by recipients for help finding a doctor.

144. IDHS Local Office staff do not have any information regarding the availability of doctors enrolled in the Medicaid program to accept a new Medicaid patient. Local IDHS Office staff do not have any information on the specialties nor the board certification status of doctors enrolled in the Medicaid program.

145. IDHS Local Office supervisors do not check to ensure that IDHS local office caseworkers offer assistance in locating providers, and local IDHS Office staff do not keep records of any referrals to physicians that they have made for children on Medicaid.

146. IDHS Local Offices do not provide the KidCare Hotline number to clients seeking information about physicians.

147. IDHS Local Office staff do not have a procedure in place for updating the information on physician referrals contained in the physician binders in the local offices.

148. IDHS Local Office staff do not call or otherwise communicate with physicians prior to making a referral for a recipient and they do not check with a Medicaid recipient after making a referral to a physician to ensure that the client was able to see that doctor.

149. IDHS Local Office staff do not keep records on how many or which clients call back after being referred to a physician for another referral.

150. IDHS Local Office staff also do not have a system for assisting recipients in scheduling appointments with doctors.

8. **Failure Of IDPA And IDHS Follow Up With Children Who Are Not Receiving Any EPSDT Services.**

151. The State could easily identify those children who have not received well-child examinations, appropriate tests, or immunizations (Dr. Darling did so with a few thousand dollars worth of off-the-shelf hardware and software.). Nonetheless, the State neither attempts to identify those Medicaid-enrolled children who have not received mandated EPSDT services, nor follows up with them to ensure that they do.

152. The State also does not attempt to determine if a child needs case management services to gain access to services required to diagnose and/or treat a condition found during a screening service.

153. The State provides case management services to some children through the IDHS Family Case Management program. This case management program has limited

eligibility and limited enrollment (under 30,000 children were enrolled in May 2003). IDHS also administers a nutrition program – the Women, Infant, and Children program -- that encourages immunizations. This program also has very modest enrollment.

154. These limited case management programs have had some success in increasing the number of children receiving some EPSDT services. These successes show that IDPA and IDHS can improve the provision of EPSDT services through outreach and case management activities if they choose.

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

a. The State has not evaluated the level or quality of health education being provided by EPSDT providers, including the need for making EPSDT visits

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

c. The State has not studied or evaluated whether geographical, demographic, or ethnographic factors amongst the Children impact EPSDT usage.

d. The State does not follow up to determine why no EPSDT services have been billed as to certain recipients.

e. The State does not engage in outreach efforts to increase the level of EPSDT services received by the great majority of the Children.

f. The State does not conduct "chart reviews" to assure that all EPSDT services are being provided to the Children.

g. If an invoice from a provider shows that the child did not receive a full EPSDT screen, the State takes no action to determine whether the child is receiving appropriate EPSDT services.

h. The State does not require that providers submit any EPSDT reports or other information on the care provided to children; instead, the State relies solely on the invoices for services.

i. The State does not conduct in-person checks of providers to determine whether they are providing the full complement of EPSDT services, nor does the State determine whether a provider has received appropriate training in providing the full complement of EPSDT services.

j. The State does not evaluate the quality of EPSDT services provided, or whether providers carry out all EPSDT components.

k. The State does not require caseworkers at or after intake to inquire whether families and children have regular doctors and to identify possible doctors for families and children who do not have a doctor.

l. The State does not collect survey or other data that would allow the quality of EPSDT services to be evaluated.

m. The State does not pay incentives for providers whose patients receive the full schedule of EPSDT services.

n. The State does not evaluate whether acute care services received by children receiving Medicaid are related to inadequate receipt of EPSDT services.

o. The State does not evaluate the distribution of information regarding transportation assistance for EPSDT, or its provision of transportation assistance to the Children, and has not evaluated transportation as a factor in whether recipients will or will not receive EPSDT services.

p. The State fails to assist with scheduling appointments and does not keep records of requests for scheduling or transportation assistance for EPSDT services.

9. The State Fails To Provide For Transportation

156. Children in Cook County must receive prior approval from Dyntek (an IDPA transportation subcontractor) before they can receive any transportation assistance. Dyntek staff make all decisions as to what type of transportation assistance will be provided such as whether a child's medical condition precludes medical transportation by bus. Dyntek, however, makes improper assessments for transportation assistance by, for example, erroneously denying taxi assistance for children with asthma or physical disabilities who cannot take public transportation.

157. Dyntek does not sufficiently subcontract with Medicare providers to serve the Children and thus requests for transportation from hospitals are routinely denied, cannot be arranged due to an overloaded hotline system, or are not usable due to tardy or absent Medicare providers.

158. Hospitals such as University of Chicago Hospitals often have to arrange for their own transportation for children who must come to necessary appointments after the children have tried unsuccessfully to arrange transportation through Dyntek.

159. Dyntek has sent transportation providers to hospitals who have unsafe cars without seatbelts and has denied transportation to siblings of children coming in for appointments.

F. Equal Access

1. Reimbursement Rates For Physician Services Are Inadequate

160. IDPA creates a schedule of reimbursement rates for each service that physicians regularly provide to the Children. IDPA creates that schedule without taking into account any of the factors that could result in a willingness by doctors to provide an appropriate level of care to the Children.

161. The Children presented the testimony of Dr. Samuel Flint, who is a consultant in the fields of health policy, health economics, and child health care, and who received his Ph.D. from the University of Chicago. Dr. Flint compared Illinois' Medicaid reimbursement rates for pediatric physician services in Cook County to (i) Medicare rates for the same region; and (ii) private insurance reimbursement rates for the same region. Dr. Flint concluded that Medicaid reimbursement rates are, on average, approximately half of the Medicare reimbursement rates for the same service, delivered in the same location, by the same provider. Importantly, Medicare rates for services, including services provided to children, are compiled by the CMS, in collaboration with the American Medical Association, based on the cost of providing the service. Those base rates are then modified to take into account differences in regional costs. Medicare rates are set to allow a physician to recover his overhead costs and a modest profit. Health care economic analyses and other government agencies such as the Federal General Accounting Office generally use Medicare reimbursement rates as an appropriate comparison to Medicaid reimbursement rates.

162. For example, the most commonly billed service in the Illinois Medicaid program is the "Established Patient Office Visit; Moderate Complexity." The maximum Medicaid reimbursement rate received for this service in 2002 was \$29.85 (this includes an add-on rate which was paid to only 37% of the providers who billed for this service). The Medicare reimbursement rate for this same service was \$54.16. Thus, Medicaid paid, at most, only 55% of the rate that Medicare paid for the same service. The rate Illinois paid to 63% of billing physicians was even lower because those physicians did not receive the "add-on."

163. Todd Menenberg, the State's retained expert witness, as well as IDPA staff, stated that the numerical conclusions, data, and analysis comparing Medicare and Medicaid reimbursement reported by Dr. Samuel Flint was accurate.

164. Medicare rates for children's services are an appropriate comparison to Medicaid rates for the same service, and they show the inadequate level of Medicaid rates in Illinois.

165. Medicaid reimbursement rates are also, on average, significantly lower than private insurance reimbursement rates for the same pediatric service in Cook County. Dr. Flint's analysis demonstrates that IDPA reimburses less than 50% of the amount provided by private health insurance.¹⁴ This testimony is supported by the testimony of providers and an analysis the IDPA performed of private market rates in Springfield.

166. Dr. Flint also analyzed a physician's cost to practice in Cook County and concluded that the Medicaid rates do not even cover a physician's cost of overhead, much less

¹⁴ It is appropriate to use private market reimbursement rate analysis gathered from two Cook County pediatric populations with a combined caseload of 14,000 patients as representative of the prevailing Cook County private insurance market rate if that rate analysis is consistent with all other data sources.

provide any remuneration to the physician. In other words, a physician loses money on every medical patient (s)he sees.

167. Illinois does not pay Medicaid reimbursement rates that are competitive with Medicare or private insurance rates. The only reason that a provider would accept IDPA's rates to provide the full service required is because of the provider's feeling that (s)he must provide care to this population, not because the reimbursement covers the costs of practice.

168. A pediatrician practice relying solely on Medicaid beneficiaries' maximum reimbursements could not survive since Medicaid pays nearly 10% less than the median practice costs.

169. Physician professional societies regularly complain to the IDPA regarding the low Medicaid reimbursement rates and physician participation.

170. The primary issue for the provider constituency of the Illinois Academy of Pediatrics is increasing provider participation in the Medicaid program through increases in pediatric reimbursement rates. A coalition of pediatricians through the Illinois Chapter of the American Academy of Pediatrics is advocating with the state to increase reimbursement rates to pediatricians in order to increase the numbers of physicians participating in the Medicaid program.

171. Pediatric departments at major hospitals in Cook County have large Medicaid patient populations and also are sustaining significant losses each year due to low Medicaid reimbursement rates.

2. *Providers Are Opting Out Of The Medicaid System And Restricting Their Practices.*

172. Dr. Flint also analyzed the effect that low reimbursement rates have on a physician's willingness to provide care to Medicaid patients. He has been actively studying this issue for 25 years, and to prepare his report he canvassed a wealth of literature on this topic.

173. The major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in the decision to participate in the Medicaid program at all, to participate in a limited fashion, or to participate fully. When Medicaid rates are too low, physicians will opt to treat non-Medicaid children first or exclusively. In communities in which there is not a competitive Medicaid reimbursement rate, there is insufficient access for Medicaid recipients to physicians. Pediatricians also limit their Medicaid practices because of an unpredictable Medicaid payment system and Medicaid payment delays.

174. When physicians can treat children covered by insurance plans that pay higher than Medicaid, they generally will do so before treating Medicaid patients. The doctors who testified confirmed that this is happening in Cook County. Pediatric practices throughout Cook County have closed to new Medicaid patients, or entirely, due to economic problems caused by a high Medicaid pediatric patient population and low Medicaid reimbursement rates and slow Medicaid payment systems.

175. Pediatric patients throughout Cook County who are on Medicaid are more likely to be seen at a federally qualified health clinic (FQHC) or a resident clinic rather than a private pediatrician due a limited number of private physicians who accept Medicaid.

(a) The University Of Chicago's 47th St. Clinic Closed Because Of Inadequate Reimbursement Rates

176. The University of Chicago Hospitals pediatric department had a clinic on the south side of Chicago. The clinic's mission, in part, was to provide care to the poor. The clinic made an economic decision to close its practice to Medicaid patients, and to open new practices in areas that do not have large Medicaid patient populations, due to the low reimbursement rates for Medicaid.

(b) Medicaid Recipients Have Very Limited Access To Pediatric Dental Care

177. Dentists limit their practice to Medicaid patients because their practices would fail financially if they accepted all Medicaid patients who presented themselves for treatment due to the low Medicaid reimbursement rates.

178. There are virtually no pediatric dentists in Cook County who accept Medicaid reimbursement; and dentists have difficulty referring children with Medicaid to a pediatric dentist in Chicago because most or all of the pediatric dentists in Cook County do not accept Medicaid patients.

179. Children on Medicaid are less likely to see a pediatric dentist than children with private insurance due to the limited number of pediatric dentists who accept Medicaid reimbursement.

3. Quality Of Care

180. Children who receive primary care in clinical settings ordinarily must wait long periods of time for an appointment and, for a walk-in emergency must wait in line often for hours or return on a different day. The crowded nature of clinics operates as a disincentive to seeking routine and timely well-child care. Children served by private-pay pediatric practices

ordinarily receive much prompter appointments and access to care for emergencies without undue waiting.

181. Virtually all parents of young children have, at some time, a need to speak with their pediatrician at night and on weekends. Twenty-four hour emergency call capabilities are an important component of a pediatrician's service, and it can frequently provide needed information and avoid unnecessary trips to the emergency room. Much of the care that the Children receive is from clinics that do not provide this type of service.

182. Parents of children on Medicaid rarely get vision and hearing screens from the physicians who provide well-child services to their children.

183. Board certification of a physician is considered a marker of quality and training and level of competence. Children who have insurance of any type other than Medicaid generally receive well-child care and medical treatment from physicians who are either board-certified pediatricians or board-certified family practitioners. The Children are more likely to be treated by a doctor who is not a board certified pediatrician or family practitioner due to the limited number of private board certified pediatricians or family practitioners who accept Medicaid.

4. Level Of Provider Participation

(a) There Are Few Doctors Actively Providing Service To Medicaid Recipients

184. Only a few doctors provide the majority of preventive and ongoing health care to kids and most of the doctors who provide sick child visits do not also provide well-child exams. Though many doctors have "enrolled" in the Medicaid program, the majority enroll in

order to seek reimbursement for providing care to an occasional child.¹⁵ 63% of enrolled medical providers in Cook County who billed for treating children between July 1, 1998 and December 31, 2001, did not provide a single well-child examination to any recipient during that same period and approximately another 6% of enrolled medical providers provided only one well-child exam during the same period of time.

(b) A Cross-Section Of Doctors Testified That Medicaid Patients Face Difficulties In Finding Pediatric Providers To Serve Them.

185. Most doctors in Cook County either will not see children on Medicaid or they significantly limit the number of children on Medicaid that they will accept as patients.

186. There are especially few doctors willing to provide well-child services in those geographic areas that are low income and have high percentages of children on Medicaid.

187. Doctors who practice in Cook County have difficulty finding a pediatrician or specialist who will accept referrals of Medicaid patients; many pediatricians and specialists in Cook County limit their practice by not accepting Medicaid patients or accepting only a limited number of Medicaid patients. In contrast, it is much easier to refer patients with other forms of health insurance.

188. A substantial number of children on Medicaid have had adverse health outcomes because they have not been able to see a pediatrician regularly due to their difficulty in finding a pediatrician. In addition, waiting times in specialty treatment clinics for the Children are long and put patients in danger.

¹⁵ A provider must "enroll" in the Medicaid program to receive any reimbursement at all from IDPA. In order to enroll, a provider need not make any commitment to see a certain number of children.

189. A high percentage of patients who are on Medicaid do not have a regular pediatrician. A much lower percentage of patients with other forms of insurance do not have a regular pediatrician.

190. The numbers of pediatric patients on Medicaid coming to emergency rooms to receive treatment for primary care medical issues because they cannot find a primary care physician to treat them has been increasing significantly due to a lack of pediatricians who accept Medicaid.

191. IDPA has chosen not to study these issues. Specifically, IDPA (i) has not studied or collected data on whether or how physicians limit their practice to Medicaid patients; (ii) has not compared the number of doctors willing to provide services to the Children to the number of services that the Children need; (iii) does not know how many providers in Cook County are accepting new Medicaid patients; (iv) does not know how many providers have limited the number of Medicaid patients that they will accept; and (v) does not know how many providers are not accepting any Medicaid patients.

(c) The IDPA's Assertion Regarding The Number Of Doctors "Participating" In Medicaid Is Flawed

192. IDPA has taken the position that in any given year there is a large number of providers that seek payment from IDPA for providing services to the Children, and that this high number demonstrates that there are "enough" doctors. The IDPA's position is flawed on several levels.

a. First, the mere fact that a provider has billed IDPA for one or more services does not supply any reason to believe that the individual provider is willing to provide more services, especially as reimbursement rates continue to

decline. Also, IDPA has not analyzed how many active providers in Cook County are willing to treat children on Medicaid.

b. Second, IDPA has never evaluated whether there is sufficient medical capacity in Cook County to provide all scheduled EPSDT services to all eligible recipients even assuming that all of the enrolled providers were willing. IDPA does not collect data on how many pediatricians in Cook County are enrolled in Medicaid, how many family practitioners in Cook County are enrolled in Medicaid, how many physicians provide services, including how many provide well-child exams, lead blood tests, immunizations, vision or hearing screenings, to children on Medicaid in Cook County. In fact, if all children entitled to EPSDT services came forward to demand them, the Medicaid-funded system in Cook County would be overwhelmed and could not supply the care.

c. Third, IDPA has significantly increased the numbers of children who are on Medicaid in Cook County, yet it cannot show that there is a corresponding increase in the number of providers willing to provide service to them.

193. Furthermore, IDPA has not performed any analysis or study to determine whether doctors who have provided one or more services in the past are willing to provide additional services and, if not, why not. IDPA has not studied the impact of rates or the length of its payment cycle on provider participation in Medicaid.

194. IDPA does not require that participating physicians be board certified in family practice or pediatrics to provide medical services to children. Instead, the physician need only be licensed in Illinois.

195. IDPA reports show approximately 14,000 providers statewide in all areas of children and adult medicine who bill Medicaid more than 100 times per year and this number has remained fairly steady or increased slightly throughout last few years. IDPA does not know how many how many of these providers care for children, how many are located in Cook County, how many are board certified in either pediatrics or family practice or how many are specialists who treat children.

196. IDPA has never studied the individual capacity of board certified pediatricians or family practitioners in Cook County and compared that capacity to the number of children on Medicaid in Cook County who require health care services.

197. IDPA has never studied or obtained research on the level of access to care that children in Cook County have who are insured by private or other public insurance, to determine a benchmark or goal for access to care for Medicaid children. By providing inadequate information, outreach and case management, together with difficulties and delays in obtaining care, the State effectively controls the "demand" side of the health care supply issue and thus artificially justifies the limited supply.

5. ***The Rate At Which Medicaid Recipients Utilize Healthcare Services Is Lower Than The Rate At Which The Generally Insured Population Uses Those Services***

198. The evidence shows that the rate of screenings and immunizations for patients on Medicaid is lower than the rate for the generally insured patient population.

6. ***There Is A Stream Of Reports That Recipients Are Having Difficulty Obtaining Care.***

199. Several Medicaid recipients testified to their individual challenges in obtaining services for their children and finding providers willing to provide those services.

They also testified to their efforts in attempting to obtain care for their children. This testimony supports the conclusion that the Children do not have access to care that is equal to the access of children with other forms of insurance.

200. Medicaid recipients have difficulty in locating quality pediatric primary and specialty care providers and pediatric dentists for children on Medicaid. IDPA, IDHS and IDPA-contracted MCOs do not provide assistance to Medicaid recipients in locating quality pediatric primary and specialty care providers and pediatric dentists, scheduling medical appointments, or in arranging for transportation to health care providers. Medicaid recipients may have to travel great distances to find a dentist or pediatric provider willing to accept Medicaid, if they can find them at all. Children on Medicaid frequently seek care at emergency rooms because they cannot find a pediatrician willing to accept Medicaid. Medicaid recipients often must wait several hours to see a provider at a clinic willing to accept Medicaid.

201. Medicaid recipients must engage in extensive efforts to locate dentists and pediatric primary and specialty care providers willing to accept Medicaid, including seeking referrals from state agencies, local charities, and calling physicians listed in the phone book. Medicaid recipients are often referred by the IDPA's hotline to doctors who are unwilling to accept new Medicaid patients.

7. **Defendants Effectively Have Admitted That Reimbursement Rates Are Inadequate.**

202. IDPA admits (i) that if reimbursement rates were increased, more providers would participate in the Medicaid program and (ii) that IDPA reimbursement rates are low and not very attractive and that they are lower than the usual and customary charges of physicians.

203. IDPA has also admitted that physicians' opinions on whether to accept Medicaid are influenced by whether the reimbursement rates cover their overhead costs and whether the reimbursement rates provide a profit. As Dr. Flint demonstrated, the rates do not.

204. IDPA staff admits that the length of the IDPA payment cycle affects physicians' willingness to participate in the Medicaid program. The IDPA's cycle is much longer than other payers.

205. IDHS admits that pediatric providers choose not to see patients on Medicaid due to the low reimbursement rates because the reimbursement is not paid in a timely manner.

206. IDPA has also admitted that it is possible that the number of doctors participating in the Medicaid program is not sufficient to provide all of the required EPSDT services to Medicaid enrolled children in Cook County.

8. **IDPA Rate Setting**

(a) **IDPA Sets Reimbursement Rates Without Reference To Any Appropriate Factors**

207. Medicaid physician reimbursement rates are chiefly determined by the amount of funds allocated to IDPA by the Illinois Bureau of the Budget (the "available pie") with little or no consideration or study of the affect of rates increases or decreases on provider participation or the comparison of Medicaid rates to Medicare or private insurance rates.

208. For example, IDPA decreased rates by 3% in 2002 solely because of a budget downturn. If IDPA were to be allocated more funds by the Bureau of the Budget, IDPA would increase provider reimbursement rates.

209. Yearly budget-making for Medicaid services is not based on any long-range plan and it is not targeted to any optimal level of funding.

210. IDPA has not conducted any analysis to determine the ideal or target reimbursement rates for pediatric well-child services which would maximize access and reimbursement rates for pediatric well-child services are not designed or targeted to maximize access to care.

211. IDPA's outreach efforts to recruit providers are not aimed at any particular target or optimal number.

212. IDPA has never compared, adjusted or increased reimbursement rates to physicians based on inflation.

213. Since 1998, IDPA has not collected information comparing the reimbursement rates of private insurance companies to the Medicaid reimbursement rates except once comparison in 2000 of Medicaid rates to rates in Springfield, Illinois.

214. In setting reimbursement rates, IDPA does not consider the costs of fee for service physicians. Nonetheless, IDPA recognizes the importance of marketplace rates. For example, IDPA considers marketplace insurance rates in order to attract more nurses into the Medicaid program because, as IDPA admits, nurses need to receive enough reimbursement to entice them to provide services to Medicaid recipients. It is worth noting that Illinois law requires IDPA to consider the cost of a provider's operations, yet IDPA refuses to do so. See 89 Ill. Admin. Code § 140.400(4).

215. The costs of medical practice are generally more expensive in Cook County than in downstate Illinois, yet the Medicaid reimbursement rates in Cook County are the same as the rates elsewhere in the State.

(b) IDPA Has Not Analyzed The Impact Of Rates On Access To Care

216. Despite the mandates of the Medicaid Act, IDPA has never conducted a study to measure access to care or the impact of rates on that access.

217. Reimbursement rates have a direct impact on access. Indeed, when IDPA has increased rates for office-based medical services, there has been a corresponding increase in the number of office-based services billed by providers.

218. IDPA does not analyze Medicaid usage data from previous years when determining reimbursement rates.

219. IDPA has not studied the impact of payment cycle delays on access to pediatric well-child services.

220. IDPA has not analyzed the number of providers necessary to provide the full schedule of recommended pediatric services to all eligible children ("optimal system capacity").

221. IDPA has not conducted comparison studies between children served by Medicaid and children served by private insurance to assess (i) whether children served by Medicaid have equal access to well-child services; (ii) whether children served by Medicaid have access to a choice among providers of well-care services; (iii) whether there are differentials as between children served by Medicaid and children served by private insurance in (a) waiting

times for appointments; (b) quality of care; (c) provider patient loads; (d) access to specialists; or (e) well-child providers' relationships with hospitals.

222. IDPA has not studied and does not know the relative impact of various factors on access to care for children receiving Medicaid, such as (i) reimbursement rates; (ii) outreach efforts; (iii) geographical location of clinic/practice; (iv) case management; (v) parent behavior; and (vi) managed care.

(c) IDPA's Information And Testimony On Rates Is Irrelevant

223. IDPA offered the testimony of Todd Menenberg. Mr. Menenberg has no formal training in healthcare. He is an accountant whose career consists of providing expert testimony. He purports to be an expert in virtually every field of study, including the internet industry, the real estate industry, the communications industry, the investment industry, the information system industry, the aerospace industry, the office and paper products industries, the sewage treatment and waste management industries, the educational services industry, the lawn care industry, the tourism industry, the hotel industry, the golf industry, the financial services industry and the tobacco industry. See Todd Menenberg Expert Report at Attachment 2 and Menenberg Dep., at 19-23, 257-62. Mr. Menenberg compared Illinois Medicaid rates to the Medicaid rates paid by other states and concluded that Illinois' rates are "adequate" because they are not out of line with other states. Mr. Menenberg did not analyze the cost of providing care in those other states, nor did he analyze whether children in those other states had "equal access" as that term is used in the Medicaid Act.

224. Reimbursement rates from states other than Illinois are irrelevant to Illinois because providers in Illinois compare Illinois Medicaid rates to the payments that they will get by providing care to patients in their geographical area with other insurance. Medicare

and private insurance rates are in direct competition with the Illinois Medicaid rates, and those are the rates that the provider will consider. Reimbursement rates from other states have no impact on a physician's willingness to provide care to children in Cook County. Further, an analysis of Medicaid rates from states with the highest Medicaid enrollment (Mr. Menenberg's comparison) is not appropriate because the prevailing Medicare and private insurance market rates vary in each state and region.

225. Mr. Menenberg testified that it is inappropriate to compare Medicaid rates in Illinois to anything other than Medicaid rates in other states because children on Medicaid are inherently different than children on Medicare. He cites no evidence in support of his conclusion that Medicaid and Medicare populations are different or that the resources required to treat these populations may be different. The testimony is to the contrary; the costs to treat a child with a certain condition or to provide a certain screening exam does not vary based on his or her coverage by Medicaid or Medicare (or private insurance).

226. Mr. Menenberg's analysis and conclusions are unpersuasive.

IV. CONCLUSIONS OF LAW

A. The State's Violations Of EPSDT

227. The State has violated and continues to violate the Children's rights under the EPSDT requirements of the Medicaid law and implementing regulations, 42 U.S.C. §§1396a(a)(10) and (43), 1396d(r), and 42 C.F.R. §430 et seq., and the State Medicaid Manual, in the following ways:

a. The State's EPSDT program, taken as a whole, has failed to deliver EPSDT services to all of the Children as demonstrated by the Dr. Darling analysis and the State's own data.

b. The State has failed to effectively inform all of the Children of the EPSDT program by:

i. Failing to use written notices and informational materials that are adequately tailored to families with low literacy or English skills or that are distributed sufficiently frequently;

ii. Failing to use adequate oral methods to supplement the written materials;

iii. Failing to use person-to-person outreach and case management to a sufficient extent to ensure that all Children are aware of the program and receiving services;

iv. Failing to use Medicaid usage data to identify Children who are not using the program according to the periodicity schedule and to target them for more effective informational activities, outreach and/or case management;

v. Failing to use adequate methods to keep track of physicians enrolled in the Medicaid program who also are currently willing to provide EPSDT services to the Children and inform the Children of those physicians;

vi. Failing to use such methods as are sufficient to induce all of the Children to come forward for EPSDT services.

c. The State has failed to deliver immunizations as required by the periodicity schedule.

d. The State has failed to deliver general health, vision, hearing, and blood lead screens of the type and frequency required in the periodicity schedule.

e. The State has failed to deliver adequate treatment for diagnosed medical conditions or injuries.

f. The State has failed to recruit and retain in the program sufficient medical providers to provide EPSDT services to all of the Children according to the periodicity schedule and to treat diagnosed conditions or injuries.

B. The State's Violations Of The Equal Access Provision

228. The State has violated and continues to violate the Children's rights under the equal access provision, 42 U.S.C. §1396a(30)(A) and 42 C.F.R. §447.204, by failing to provide them with access to health care equal to the access to health care enjoyed by children in Cook County insured by private or other public health insurers.

229. Independently of the preceding paragraph, the State has violated and continues to violate the Children's rights under the equal access provision, 42 U.S.C. §1396a(a)(30)(A) and 42 C.F.R. §427.204, by setting Medicaid reimbursement rates for pediatric physician services in Cook County that are arbitrary and capricious, in that the rates are significantly below the cost of providing care and were arrived at without any attempt to ascertain the physicians' cost of providing the services or to anticipate the impact of the rates on access to health care.

Dated: December 19, 2003

MEMISOVSKI, et al.

By _____
One of Plaintiffs' Attorneys

John M. Bouman
National Center on Poverty Law
111 N. Wabash, Suite 500
Chicago, IL 60602
312-263-3830

Stephanie F. Altman
Thomas Yates
Health & Disability Advocates
205 W. Monroe, 3rd Floor
Chicago, IL 60606-5013
312-223-9600

Frederick H. Cohen
David J. Chizewer
Hillary Levitt Dunn
Matthew H. Metcalf
Goldberg, Kohn, Bell, Black,
Rosenbloom & Moritz, Ltd.
55 East Monroe, Suite 3700
Chicago, IL 60603-5802
312-201-4000

APPENDIX

42 U.S.C. § 1396a(a)(43) mandates:

(a) A state plan for medical assistance must-

...

(43) provide for –

- (A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance ... of the availability of [EPSDT] services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,
- (B) providing or arranging for the provision of such screening services in all cases where they are requested,

arranging for (directly or through referral to appropriate agencies, organizations or individuals) corrective treatment the need for which is disclosed by such child health screening services....

Pursuant to 42 U.S.C. § 1396d(r), the term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services--

(A) which are provided--

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include--

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in

section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services--

(A) which are provided--

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services--

(A) which are provided--

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services--

(A) which are provided--

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

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

EPSDT services are further defined at 42 C.F.R. § 441.56 to include:

(a) Informing. The agency must--

(1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.

(2) Using clear and nontechnical language, provide information about the following--

(i) The benefits of preventive health care;

(ii) The services available under the EPSDT program and where and how to obtain those services;

(iii) That the services provided under the EPSDT program are without cost to eligible individuals under 18 years of age, and if the agency chooses, to those 18 or older, up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy recipients; and

(iv) That necessary transportation and scheduling assistance described in § 441.62 of this subpart is available to the EPSDT eligible individual upon request.

(3) Effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language.

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

(b) Screening.

(1) The agency must provide to eligible EPSDT recipients who request it, screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. (See paragraph (c)(3) of this section for requirements relating to provision of immunization at the time of screening.) As a minimum, these screenings must include, but are not limited to:

(i) Comprehensive health and developmental history.

(ii) Comprehensive unclothed physical examination.

(iii) Appropriate vision testing.

(iv) Appropriate hearing testing.

(v) Appropriate laboratory tests.

(vi) Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. An agency may request from CMS an exception from this age requirement (within an outer limit of age 5) for a two year period and may request additional two year exceptions. If an agency requests an exception, it must demonstrate to CMS's satisfaction that there is a shortage of dentists that prevents the agency from meeting the age 3 requirement.

(2) Screening services in paragraph (b)(1) of this section must be provided in accordance with reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations involved in child health care.

(c) Diagnosis and treatment. In addition to any diagnostic and treatment services included in the plan, the agency must provide to eligible EPSDT recipients, the following services, the need for which is indicated by screening, even if the services are not included in the plan--

(1) Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;

(2) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and

Appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.)

Section 5140(A) of the State Medicaid Manual elaborates on the requirement for a state-adopted schedule of periodic medical services:

Distinct periodicity schedules must be established for screening services, vision services, hearing services, and dental services (i.e., each of these services must have its own periodicity schedule).

Screening, vision, and hearing services must be provided at intervals which meet reasonable standards of medical practice. You must consult with recognized medical organizations involved in child health care in developing reasonable standards.

Dental services must be provided at intervals you determine meet reasonable standards of dental practice. You must consult with recognized dental organizations involved in child health care to establish those intervals. A direct dental referral is required for every child in accordance with your periodicity schedule and at other intervals as medically necessary. Prior to enactment of OBRA 1989, HCFA, in consultation with the American Dental Association, the American Academy of Pediatrics, and the American Academy of Family Practice (as well as other organizations), required direct referral to a dentist beginning at age 3 or an earlier age if determined medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial, direct referral to a dentist) conform to your periodicity schedule, which must be established after consultation with recognized dental organizations involved in child health care. The periodicity schedule for other EPSDT services may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.