UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

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

Plaintiffs,

v. Case No.:

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

Defendant.
_____/

MOTION FOR CLASS CERTIFICATION

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

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

MEMORANDUM OF LAW

I. INTRODUCTION

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

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

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

II. LEGAL BACKGROUND

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

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

III. FACTUAL BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. The Facts of the Named Plaintiffs.

1. W.B.

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

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

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

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

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

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

2. A.W.

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

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

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

IV. ARGUMENT

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

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

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

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

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

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

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

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

a. Numerosity

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

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

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

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

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

b. Commonality

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

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

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

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

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

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

c. Typicality

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

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

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

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

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

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

d. Adequacy of representation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. CONCLUSION

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

Plaintiffs by their Attorneys,

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CERTIFICATE OF SERVICE

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

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