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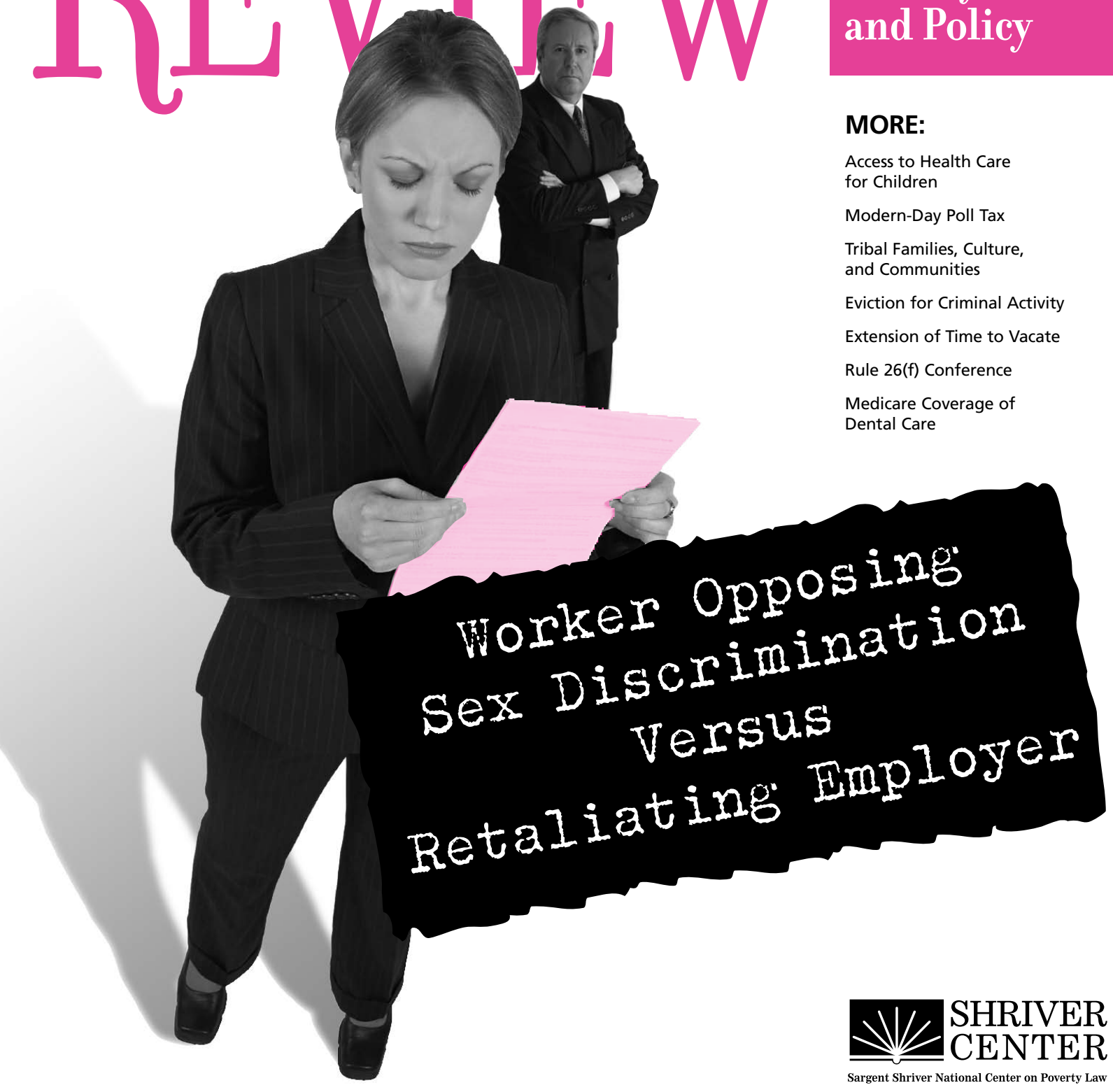

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Litigation to Improve Access to Health Care for Children: Lessons from *Memisovski v. Maram*

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Illinois recently adopted a new delivery system for its Medicaid and related programs to link all insured children to regular sources of medical care so that they receive all the recommended well-child services and screens as well as timely treatment of diagnosed conditions and injuries.[1] These developments are the result of health policy choices that the administration of Gov. Rod Blagojevich made. In part, however, these developments are also the result of changes that the outcome of the Medicaid lawsuit *Memisovski v. Maram* prompted.[2] We brought the case on behalf of all children covered by Medicaid in Cook County, Illinois (some 600,000 overwhelmingly minority children at any given time), under federal Medicaid provisions that require the states to furnish prescribed levels of service to covered children (the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Program provisions) and ensure access—equal to the access enjoyed by children with other types of health insurance (the "equal-access" provision)—to doctors and other medical providers.[3]

In this article we discuss the ideas that went into building the record, the decision, and the settlement in the *Memisovski* case, and some of the lessons learned. We consider, among other factors, the use of retained experts; the best use of the state's own database of paid Medicaid claims; testimony from the leading doctors in the community who served as both fact witnesses and nonretained experts, and how to handle discovery disclosures for such witnesses; and testimony from class members. We also discuss the reasoning behind the decision to settle the case and particular aspects of the settlement.

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[1]This new system of "primary care case management" is known as Illinois Health Connect; it has a disease management component known as "Your Healthcare Plus." See www.illinoishealthconnect.com. Illinois Health Connect requires beneficiaries to select (or they will be assigned to) a primary care provider who functions as a "medical home" and provides or coordinates all care. Illinois remains overwhelmingly a "fee for service" system, and Illinois Health Connect is not a move to capitated managed care in the style of health maintenance organizations. The primary care coordinator receives a monthly fee for that service and may bill separately for any care for the beneficiary. People who have chronic illnesses may enroll in Your Healthcare Plus to get enhanced "disease management" services that help them keep appointments, comply with medication regimes, and avoid duplicative services or medicines. Effective in 2006, Illinois adopted the All Kids program of health coverage for every Illinois child regardless of income or status or family circumstances. See www.allkids.com.

[2]*Memisovski v. Maram*, No. 92 C 1982, 2004 WL 18783312 (N.D. Ill. Aug. 23, 2004) (Clearinghouse No. 53,827) [hereinafter Opinion]. The Opinion, other decisions by the court, and many case materials are available free of charge in the Sargent Shriver National Center on Poverty Law's website; see www.povertylaw.org/poverty-law-library/case/53800/53827. Page citations here are to the slip opinion found at the website.

[3]*Id.* at 1. The provisions on Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services are located in several different portions of the Medicaid Act: 42 U.S.C. §§ 1396a(a)(10) & (43), 1396d(a)(xiii)(4)(B) & (r) (2007). A state Medicaid plan must make available medical assistance that includes EPSDT services for eligible individuals under 21. The equal-access provision, at 42 U.S.C. § 1396a(a)(30)(A), requires a state plan to enlist a sufficient number of providers so that care and services are available at least to the extent that they are available to the general population in the geographic area.

We filed the *Memisovski* case in 1992 on behalf of a class of children who complained that despite being enrolled beneficiaries of the Medicaid program they were unable to find doctors who would provide them health care. After class certification and initial rounds of discovery and motion practice, the parties agreed to stay the case for several years while Illinois sought permission from the federal government for a major Medicaid managed care restructuring (which ultimately never saw implementation).[4] The stay permitted informal discovery. With the stay lifted in 1999, the case entered its active phase of preparing for trial. A hotly contested formal discovery took place over several years; an eleven-day trial followed in May 2004.

I. The Decision

After a bench trial that lasted eleven days, U.S. District Judge Joan Humphrey Lefkow issued a comprehensive decision on the merits on August 23, 2004. She declared the Illinois Medicaid program to be out of compliance with both the equal-access and EPSDT provisions of the Medicaid Act.[5]

A. Plaintiffs' Enforceable Rights

The decision begins with an exhaustive analysis that concludes that the plaintiffs have enforceable rights under the equal-access and EPSDT provisions. In both pretrial and posttrial briefing, the defendants moved for judgment on the pleadings on this issue. Although defendants had lost two motions to dismiss—both were based on the same "enforceable rights" theory—in their motion for judgment on the pleadings they alleged that the legal landscape had changed when the U.S. Supreme Court decided *Gonzaga University v. Doe*.[6]

Before *Gonzaga,* the Supreme Court had set forth a three-part enforceable-rights analysis in *Blessing v. Freestone*.[7] In *Blessing*'s analysis, a plaintiff must show that (1) Congress intended the statutory provision in question to benefit the plaintiff; (2) the asserted statutory right is not so "vague and amorphous" that its enforcement would strain judicial competence; and (3) the statute unambiguously imposes a binding obligation on the states in mandatory rather than precatory terms.[8] In 2001, holding that plaintiffs met the *Blessing* test and could pursue their equal-access and EPSDT claims, Judge Lefkow denied the defendants' second motion to dismiss.[9]

When the defendants raised the issue again in their posttrial motion for judgment on the pleadings, Judge Lefkow held that *Gonzaga* did not change anything about the *Blessing* three-part enforceable-rights analysis other than to clarify that the first factor requires "rights-creating" language. Therefore, invoking law-of-the-case principles, Judge Lefkow limited her ruling to the first *Blessing* factor; *Gonzaga* requires that the statute afford plaintiffs "rights," not just that plaintiffs be in the "zone of interests" where a statute confers benefits. Both the equal-access and the EPSDT provisions meet this test, Judge Lefkow held. The details of this ruling are beyond the scope of this article, but the well-reasoned decision is worth the attention of advocates contemplating this kind of

[4]The class was defined as "[a]ll 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." A separate class of women in Cook County who receive Medicaid benefits and "have been, are, or will be pregnant" was also certified. However, the claims on behalf of this class were voluntarily dismissed on May 29, 2003. Opinion at 1.

[5]*Id*. at 101.

[6]*Gonzaga University v. Doe*, 536 U.S. 273 (2002) (Clearinghouse No. 54,643).

[7]*Blessing v. Freestone*, 520 U.S. 329, 340 (1997) (Clearinghouse No. 50,109).

[8]*Id*. at 340–41.

[9]*Memisovski v. Maram*, No. 92 C 1982, 2001 U.S. Dist. LEXIS 16963 at *21 (N.D. Ill. Oct. 17, 2001). In 1992 the court in an oral ruling had denied a similar motion to dismiss. *Memisovski v. Wright*, No. 92 C 1982 (N.D. Ill. Sept. 11, 1992) (Clearinghouse No. 53,827) (transcript available in the Poverty Law Library, www.povertylaw.org/poverty-law-library/case/53800/53827).

case, where the issue will certainly arise at least once.[10]

B. Findings of Fact and Conclusions of Law

After dispensing again with defendants' recurring claim that plaintiffs had no enforceable rights, Judge Lefkow made 174 findings of fact derived from the diverse types of evidence that plaintiffs presented at trial. The evidence included reports from retained experts; testimony from local doctors who served as nonretained hybrid fact-expert witnesses, from parents and guardians of class member children, and from officials who administered the program; and documents. We describe the evidence in more depth in the following sections of this article. The findings of fact based on this deep record supplied a solid foundation for the court's sweeping conclusions of law.

1. Plaintiffs' Equal-Access Claim

The court's conclusions of law start by establishing the proper framework for the equal-access claim. The benchmark for measuring whether children who receive Medicaid benefits have appropriate access to care is the access to care that children who are in the same community and have private or other public insurance experience. The comparison group thus excludes uninsured children.[11]

The court fully credited plaintiffs' retained expert and the hybrid witness pediatricians in holding that what influences doctors to serve Medicaid patients is primarily reimbursement rates, followed by payment delays and other "hassles." Average Medicaid rates for well-child services in Cook County were about half of Medicare rates for the same services, and Medicare rates in turn were lower than private market rates. Pediatric practices in Cook County could not even recover their overhead serving Medicaid children, making it impossible to earn a living. Hospital staff doctors could not find primary care physicians to whom to refer Medicaid patients upon discharge, although they had no problem referring children with other forms of insurance. Parents found it very hard to obtain care for Medicaid-insured children. Parents of both Medicaid and privately insured children easily found care for their privately insured children but struggled to find care for their Medicaid children, even from the same doctors. The pediatrician witnesses gave their expert opinions on the ultimate issue: that the plaintiff children did not have equal access to health care. These facts dictated the court's conclusion that defendants violated the equal-access provision.[12]

2. Plaintiffs' EPSDT Claims

Judge Lefkow found two separate violations of the EPSDT provisions. States must "effectively inform" Medicaid families of the availability of the screening, diagnostic, prevention, and treatment services of the EPSDT program. Defendants were not giving adequate written information or adequate reinforcement of that information and did not achieve the results that would flow from adequate information. The court credited plaintiffs' retained expert's opinion that the written information that class members did receive was too complex to inform the target population effectively and that health information of this nature is too complex to convey without one-on-one reinforcement of written materials. The court concluded that defendants violated the requirement that they effectively inform plaintiffs of the EPSDT services.[13]

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[10]The court first analyzes the *Gonzaga* ruling in detail to frame the discussion and goes on to hold that the equal-access provision creates enforceable rights based on the provision itself, the additional section of the Medicaid Act (42 U.S.C. §1320a-2) that affirms the enforceability of "state plan" provisions, and the weight of authority in the circuits and the U.S. Supreme Court. The court holds that the EPSDT provisions create enforceable rights by their terms and that the weight of authority affirms this interpretation. Opinion, at 4–19.

[11]*Id.* at 75–76.

[12]*Id.* at 77–82, 85.

[13]*Id.* at 85–90.

The court also decided that the defendants did not deliver the level of services that the EPSDT provisions of the Medicaid Act require. The Act requires states to establish for the timing and amount of services a standard that comports with established medical and dental practice. Illinois adopted the American Academy of Pediatrics' standard. The court framed the issue thus: "Significantly, plaintiffs do not suggest that the inquiry is whether or not some children receive EPSDT services. Certainly some do, and it would be unrealistic to hold the [defendant] liable for not providing EPSDT services to every single child. Instead, plaintiffs' theory is that the [defendant] has not established a Medicaid program designed to provide all EPSDT services to all Medicaid-enrolled children on a timely basis."[14]

The court fully credited plaintiffs' expert's report drawn from the Medicaid paid-claims database. The report showed that huge percentages of children covered by Medicaid in Cook County were not getting the well-child care required by EPSDT rules. For example, almost half the infants did not receive any well-child services at all, and two-thirds of infants received zero or one doctor visit rather than the recommended six. Plaintiffs' expert also demonstrated the flaws in the state's official reports to the federal agency on EPSDT compliance.[15] Even with their flaws, however, the reports showed large-scale noncompliance by the state. The court held that the state was violating the EPSDT provisions of the Medicaid Act by failing to establish a system designed to deliver the full amount of recommended health care to all covered children.[16]

The court ordered the parties to attempt to negotiate a judgment order specifying appropriate relief. Instead the parties negotiated a comprehensive settlement.

II. Medicaid Paid-Claims Data and Expert Report

Under Medicaid, states pay health care providers for each service rendered to a beneficiary. The computerized record of payment of these claims—the state's paid-claims data—is thus an excellent source of information about exactly how much and what kind of health care beneficiaries receive from which providers, and about how the system performs in delivering required EPSDT services. These data show how many doctors participate in the program and the extent to which each of them serves the Medicaid population—an important factor in the equal-access analysis. Prior to *Memisovski*, however, the Medicaid paid-claims database was little used in litigation on these issues primarily because states themselves did not tap the database for program analysis or evaluation. Thus regular analyses were not available through discovery, and states could resist discovery by asserting the cost of the programming necessary to extract information from the database. One of our main concerns in *Memisovski* was to obtain the paid-claims database and tap into its information.

When we filed the case in 1992, several academic studies had measured the lack of access to care on the part of children and pregnant women receiving Medicaid benefits. Researchers at the American Academy of Pediatrics and the University of Illinois at Chicago primarily led studies of access problems that Medicaid-insured Chicago children faced. We contacted the authors of these studies to discuss the types of data and evidence we might need to prove access problems on a larger scale. Over the course of the litigation we worked with Dr. James Fossett, Dr. Thomas A. Darling, and Dr. Blair Gifford to create a data set that would yield primary evidence of the access problems of individual children on Medicaid in Cook County.

Until the late 1990s, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS)) required the states to report annually regarding whether children on Medicaid had access to care equal to that

[14] *Id.* at 91.

[15] The reports are U.S. Centers for Medicare and Medicaid Services' Form 416.

[16] Opinion at 91–101.

of children who lived in the same state and had other forms of insurance. Regulations allowed states to prove compliance in one of three ways: by showing that (1) over 90 percent of the state's physicians were enrolled in the Medicaid program; (2) Medicaid reimbursement rates were at least 90 percent of private insurance reimbursement rates; or (3) at least half of Medicaid-enrolled physicians were full Medicaid providers. There was an extensive national debate among states about the exact meaning of those requirements, especially the definition of "full Medicaid provider" and about the Health Care Financing Administration's difficulty enforcing the equal-access provision because of a lack of accurate data from the states. As a result, Congress removed the state-reporting requirement from the equal-access section of the Medicaid Act, and the Health Care Financing Administration stopped requiring states to complete these reports of compliance with the equal-access provision. Eliminating the reporting requirement, however, did *not* absolve states of the legal obligation to comply with the Medicaid Act's equal-access provision.

As the case progressed, we discussed and rejected multiple types of evidence that could prove the lack of equal access, including, most notably, a simple comparison of the number of physicians accepting Medicaid to the number of physicians accepting private insurance. The problem with this method was primarily the difficulty in assessing each physician's level of effort or percentage of time devoted to Medicaid. An accurate analysis would require looking more deeply into whether physicians who participated in Medicaid were accepting all Medicaid patients who sought treatment or whether the physicians limited the number of Medicaid patients whom they would see.

To overcome these limitations, we requested paid-claims data reports on the number, frequency, and types of medical services that children on Medicaid received, and from which providers. After we created and served a set of informal interrogatories and requests to produce documents containing the type of data sets we sought, the state responded that its computer systems were not equipped to produce such reports and that the cost and the effort required would be prohibitive. (The court had stayed formal discovery indefinitely as the parties attempted to reach a settlement over the implementation of a mandatory managed care program.) At a 1995 pretrial conference on the production of data evidence, the court, while not yet lifting the stay of discovery, ordered the state to comply with the informal discovery requests, including production of the data reports requested.

We retained as an expert Dr. Darling, assistant professor of government and public administration in the University of Baltimore's School of Public Affairs and director of government and technology in the university's Schaefer Center for Public Policy. With Dr. Darling's help, we developed a data request that centered on a child-by-child analysis of the medical services provided to children enrolled in Medicaid in Illinois.

The request asked the state to produce, for every child on Medicaid during the preceding six years, the child's birth date and a record of every service that was delivered to the child and for which Medicaid was billed, including the date of the service and the doctor who provided it. The state objected to giving information in this form and claimed that generating these reports would be too expensive. However, we were able to obtain data tapes from the state with the raw data; the state produced the tapes with coded identifiers so that the children's identity was protected but the relevant information was preserved.

Using over-the-counter software, Dr. Darling cleaned and organized the data and produced reports that compared individual records with the schedule of well-child care, or "periodicity schedule," recommended by the American Academy of Pediatrics and adopted by Illinois for its EPSDT program, to determine which children timely received the required periodic screenings and immunizations. For example, the periodicity schedule calls for children in the first year of life to receive six well-child ex-

aminations after leaving the birth hospital. Dr. Darling's report showed all children who were age 0 to 12 months during the data period, and the numbers who received zero, one, two, three, four, five, and six well-child examinations while in that age bracket. Our primary goal in analyzing these data was to determine the percentage of children who were on Medicaid and not receiving timely EPSDT services. Dr. Darling's reports proved that over a third of the class aged 0 to 12 months did not receive *any* EPSDT services during that period and nearly all of them received far fewer services than the EPSDT periodicity schedule required.[17] We were also able to show that very few of the doctors who participated in Medicaid billed the program for a significant number of services. In fact, just a few hundred of the thousands of doctors enrolled in Medicaid were carrying the weight of the program.[18]

The defendants attempted to explain the data away by claiming that the data did not reflect services rendered to children but never billed to the state's Medicaid program due to the state's low reimbursement rates to physicians and the complexity of billing Medicaid. Many physicians, the defendants contended, provided free care to Medicaid patients instead of bothering to bill the state. We conceded that physicians might not have sought reimbursement for some services (and, indeed, the state was admitting that physicians were poorly reimbursed). However, we quantified for the court the amount of free services that would have been required to reach the service level necessary for EPSDT compliance: hundreds of thousands of separate services. The court agreed and pointed out in its decision that for the state to claim that physicians whom it could not even name, locate, or quantify provided some vast "black hole" of services was "sheer fantasy."[19]

Notwithstanding Dr. Darling's analysis, the state argued that it was compliant, or nearly so, as reflected in annual state reports to the federal CMS. Federal law requires the Illinois Department of Public Aid to use a form known as CMS-416 to report the level of care that children on Medicaid receive, breaking down the information by age group and other criteria.[20] However, these forms, even when completed properly, skew the reported data to make a state's performance appear better than it actually is. Illinois skewed the figures even more.

Under the CMS-416 methodology, the department calculates a "screening ratio" for several age groups: birth to age 1; ages 1–2; ages 3–5; ages 6–10; ages 11–14; ages 15–18; and ages 19–20. To calculate the "screening ratio" the department divides the number of well-child screens of Medicaid children in a certain age category by the "expected" number, that is, the number of screens that children in the category would have had if their screens followed the periodicity schedule. While this methodology has superficial logic, the results are misleading because a state may count more screens for each child than the periodicity schedule recommends, so long as the number of screens a child receives is less than the number required for the period in which the child is counted. For example, a child who is 5 years old is counted in the age 3–5 category and the department counts up to three well-child examinations *per year* per child because the Illinois periodicity schedule recommends three well-child

[17]*Id.* at 40–54 (Findings of Fact 74–108).

[18]*Id.* at 30 (Finding of Fact 46) (63 percent of the doctors who billed at least one Medicaid service during a three-and-a-half-year period did not bill a single well-child service). See also *id.* at 83–84.

[19]*Id.* at 99. In Illinois most Medicaid services are delivered in "fee for service" arrangements. However, about 15 percent of the children who receive Medicaid are served in optional capitated managed care (health maintenance organizations (HMOs)), and the paid-claims database does not track each of these services. The state claimed that plaintiffs could not prove any shortfall in the care provided in those settings. However, the defendants' contracts with the HMOs required those organizations to report on the level and frequency of care. Defendants had never enforced that contract provision and so were unable to show the level of care provided or EPSDT compliance. Thus the court was not persuaded that HMOs provided enough unbilled and unrecorded services to make up for the overall lack in the program.

[20]42 U.S.C. § 1396d(r) (2007).

examinations during the *three-year* period during which the child is from 3 to 5 years old.

At trial, we had the official who prepared these forms walk through several examples to show how the results would be skewed. For example, she conceded that if two children in the ages 3–5 group were continuously eligible for Medicaid throughout a reporting year, and one child received two examinations and the other child received no examination during that time, the methodology would show a screening ratio of 100 percent—a result at least 50 percent too high.

The department also skewed the results by using a child's age on September 30, the last day of the federal fiscal year, for each annual report. The results necessarily overstate the state's EPSDT performance by understating the number of well-child examinations that a child should receive. For example, a child born on August 1 would be 2 months old through 14 months old during the fiscal year October 1 through September 30. The department's methodology would assign this child the age of 1 year for reporting purposes; under the periodicity schedule a 1-year-old should receive two well-child screens during a year. Thus, if this child received two well-child examinations between the ages of 2 and 14 months, the methodology would show that the child had received 100 percent of the expected screens. However, that child should have received five well-child examinations (at 2 months, 4 months, 6 months, 9 months, and 12 months).

The state also skewed the results with respect to children who were eligible for Medicaid for less than a full year. During her first year a child should receive six well-child examinations in addition to a well-child screen at birth. The Illinois Department of Public Aid's witness conceded that in the case of a child who is born on January 1 and eligible for Medicaid for eight months the department expects only four examinations—two-thirds of the six examinations the child should receive in a year—because the child is eligible for only two-thirds of a year. However, in such a scenario, the child should receive screens at two weeks, one month, two months, four months, and six months, for a total of five. Here the state would record four well-child screens as 100 percent compliance for this child, even though he did not receive the number set forth on the periodicity schedule.

The state also exaggerated the number of screening examinations for Medicaid-eligible children by counting many types of doctor visits— including prenatal visits and brief visits with a nurse lasting only a few minutes—that do not comply with the EPSDT well-child screening criteria.

Although we were able to show that the state failed on several EPSDT measures even under the CMS-416 methodology, we had to deconstruct that methodology to prove that the court could not rely on the CMS-416 numbers at all to determine whether the state was actually providing the required level of care to children. In short, an advocate attempting to undermine the CMS-416 results must drill down as deeply as possible into the state's methodology to uncover all the ways in which the state skews the results.[21]

III. Expert Report on Reimbursement Rates and Physician Practice Decisions

The equal-access claim required proof that the Medicaid system was not designed to produce access to care equal to that available to children with other kinds of insurance, and that the system's rates of pay for health care services were one reason for the disparity. We retained Dr. Sam Flint, an expert in health policy, health economics, and child health care, to prepare three analyses. From our investigation we concluded that many pediatricians were unwilling to serve Medicaid patients because the reimbursement rates were very low and the Medicaid system included very many other administrative challenges (so-called Medicaid hassle). To support our conclusions, we asked Dr. Flint to (1) compare Medicaid reimbursement rates to various bench-

[21]See Opinion, at 95–96.

mark reimbursement rates to show that the Medicaid rates were much lower than any comparable benchmark; (2) analyze the adequacy of Medicaid reimbursement rates when compared to a physician's overhead costs, such as rent and nonphysician personnel, to show the effect on a pediatrician of serving a significant number of Medicaid patients; and (3) review the research on why pediatricians choose to participate or not to participate in a Medicaid program.

A. Rate Comparison

To prove that the Illinois Medicaid system had inadequate reimbursement rates, Dr. Flint identified the twenty-two most frequently billed service codes for children's services and compared the Medicaid rate to three different benchmarks. He prepared separate charts showing the Medicaid rates with and without various state "add-ons" to make sure that we considered both average Medicaid reimbursement rates and the maximum rates that a pediatrician could obtain.[22]

In doing so, Dr. Flint's main challenge was to compile sufficient and persuasive evidence of comparable rates. He looked to three sources: rates from a national survey, Chicago Medicare rates, and rates reported by two geographically separated Cook County practices that serve approximately 14,500 children.

The national survey consisted of "all payer" rates, which are an average of payments to providers from commercial insurers, patients who pay from their own pockets, Medicaid, State Children's Health Insurance Programs (SCHIP), and any other sources. These are well below the commercial insurer market level since they include public payers that historically have paid less than the commercial market. "All payer" rates were nonetheless a valuable comparison because they were calculated from a national stratified survey.

Dr. Flint compared Medicaid rates to Medicare rates because the latter are the result of an involved private-public process that incorporates a wealth of data on various billing codes (representing various types of health care services). While relatively few children receive Medicare benefits, the process that creates the Medicare rates is well documented. Accepted comparisons between Medicare rates and private insurance rates also were a valuable tool in analogizing to Medicaid rates. Because of their predictability and universality, Medicare rates are frequently used in research studies, constituting an additional basis for comparison.

Dr. Flint surveyed certain commercial insurance rates in Cook County. While this was the most direct evidence of the prevailing market, Dr. Flint faced a variety of challenges in obtaining these rates. Commercial insurers, seeking to maintain their payment rates as trade secrets, generally bind contracting physicians to an agreement not to disclose their practice's payments, and Dr. Flint was unable to identify any public-use data sets with private rate information. Also, antitrust concerns are sometimes cited as reasons that physician organizations do not collect current payment rate information. Dr. Flint concluded that these data, though unscientific by accepted rigorous research standards, were the best proxy obtainable to show private rates.[23]

Dr. Flint's conclusions were stark. For example, the Illinois Medicaid program paid roughly half of the Medicare rate for the same service delivered in the same location by the same provider. The Illinois Medicaid program paid less than half of private insurance rates.

B. Production Cost Analysis

We were convinced that the court would find persuasive an analysis comparing a pediatrician's cost of providing services with the Medicaid reimbursement rates. Dr. Flint identified a variety of practice cost estimates, including estimates from the medical Group Management Association, the industry journal *Medical*

[22]Illinois's Medicaid program provides a reimbursement add-on for pediatricians who agree to certain conditions. See Opinion at 23 (Finding of Fact 17).

[23]Opinion at 23, n.11.

Economics, the National Association of Healthcare Consultants, and the Society of Medical-Dental Management Consultants. Based on this information, Dr. Flint concluded that a pediatric practice generally spends more than half its revenue on overhead expenses. Accordingly, given that Illinois's Medicaid program paid *less* than half of private insurance rates, Dr. Flint concluded that a pediatrician practice relying solely on Medicaid beneficiaries' (maximum) reimbursements could not survive since Medicaid paid nearly 10 percent less than median practice costs. Even a physician willing to work for free could not keep a practice open. Dr. Flint also noted that while a practice might make money on a marginal basis by seeing a few Medicaid patients, low reimbursements could cause Medicaid children to be a second-class patient population due to their insurance status. He concluded that

> [t]he inability of Medicaid reimbursement to pay for median practice costs also has other more subtle consequences affecting Medicaid beneficiary access. Physicians choose practice locations, particularly in urban areas, based in part on the payer mix in the community. At the margin, the choice to open an office closer or further from a bus line that serves a poorer area or establish a satellite office where a large Medicaid-eligible population resides, would likely be impacted negatively by the inadequacy of Illinois Medicaid reimbursement levels.[24]

C. Literature Review

Dr. Flint reviewed the existing academic literature and research on the factors that cause physicians to accept Medicaid patients. The literature demonstrates that the level of reimbursement rates is the most important factor that physicians consider. We pointed out another significant factor, "Medicaid hassle," which refers to burdensome paperwork, slow payment cycles, complex provider manuals, retroactive claims denials, and other bureaucratic difficulties.

IV. Expert Literacy and Readability Report and Testimony

Our theory of the EPSDT law is that a strong and independent statutory framework requires states to give to children and families effective notice of available services and to design programs to deliver the services to every child. While the service-delivery claim, if successful, offered the possibility of more far-reaching relief, legal and evidentiary challenges and risks accompanied it. The effective-notice claim was an important added angle, with clear law and less demanding evidentiary challenges. And, if successful, it could produce a remedial order that extended into service-delivery issues on the grounds that performance on service delivery was the only way to determine if the notice was "effective." The effective-notice claim, while important in its own right, also was a fallback on the issue of liability in the event of difficulties with the more ambitious service-delivery claim. In the end, as noted above, we won both.

We retained Dr. Timothy Shanahan, a professor of urban education at the University of Illinois at Chicago and director of the UIC Center for Literacy. Dr. Shanahan is a national expert on literacy and readability, particularly with respect to health-related information and low-income and minority target audiences in Cook County.[25] He analyzed the basic notices and informational materials that the defendants used in the EPSDT program. He concluded that they were written at a reading level too high to be effective with a large number of the plaintiff class. Significantly he also concluded that the EPSDT program information, while it could be conveyed at a lower reading level than the state's materials, was too complex to be reduced to a level low enough to communicate effectively to many low-income people. Improved

[24]Expert report of Dr. Sam Flint (on file with John Bouman).

[25]Among his many other duties, Dr. Timothy Shanahan handles the notice and information for human subjects associated with health-related research for the University of Illinois Hospitals.

written materials had to be combined with oral explanations and reinforcement. Dr. Shanahan's opinions, along with the discovery information that revealed a near-complete lack of personal contact between the defendants and the target audiences with respect to EPSDT program information, proved to be decisive on the effective-notice issue.

V. The Doctors—Hybrid Fact-Expert Witnesses

One important group of plaintiffs' witnesses consisted of doctors who had served a high number of children receiving Medicaid. These doctors—many of Chicago's preeminent experts in providing health care to children—included the chairman of the Department of Pediatrics at the University of Chicago Pritzker School of Medicine, the physician-in-chief of the University of Chicago Children's Hospital, the president and immediate past president of the Illinois Chapter of the American Academy of Pediatrics, the physician-in-chief at Children's Memorial Hospital, and the chairman of the Pediatrics Department at Northwestern University Medical School. We also presented testimony of the city's top pediatric dentist and a leading children's surgeon.

We categorized these witnesses as "hybrids" because they offered a mix of fact and expert testimony. Their fact testimony was based on their direct experiences providing care to class members, both personally and through the entities or departments they managed. For example, they testified about how the medical issues that the children faced were consistent with a lack of access to preventive care, about the difficulty the doctors faced in referring class members to primary care doctors who could provide a medical home for the children, and about how the low Medicaid reimbursement levels put their departments and practices in financial distress. They also gave expert testimony on, for example, the children's access to care, the economic effects of low Medicaid rates, and the medical necessity of EPSDT services. Because the witnesses testified about their direct experience, they were unlike a typical expert who comes to a case with no independent knowledge of the unique facts and instead simply applies scientific expertise to an "assumed" set of facts.

The use of these "hybrid" witnesses posed four primary strategic challenges: how to prepare the witnesses to testify in depositions and at trial; how to disclose them to the defendants; what, if any, expert report to prepare; and what evidentiary standard would govern the admissibility of the witnesses' testimony.

Addressing the first challenge dictated to a large extent the resolution of the remainder. For institutional and political reasons, the doctors preferred not to be retained as experts and were not interested in being paid for their time. Instead we obtained their testimony pursuant to subpoena, although we were able to schedule several meetings with them in advance of their testimony in order to learn what they could offer. The use of subpoena power, albeit cooperatively, gave their testimony a degree of independence that is not ordinarily available from a retained and compensated expert. It did, however, limit the amount of time we were able to spend with the doctors, compared to the time normally available from a retained expert who is paid by the hour.

Our decision to use subpoena power and not to retain the doctors dictated the manner in which we disclosed these doctors to our adversary. The Federal Rules of Civil Procedure require each party to disclose to other parties the identity of witnesses whom the party may call to present evidence; if a witness is "retained or specially employed to provide expert testimony," a written report that meets certain criteria must accompany the disclosure.[26] Our "experts" were neither "retained" nor "specially employed," and so simple disclosure of their identities and the general substance of their testimony met the rule's requirements. We informed the defendants that

[26]Fed. R. Civ. P. 26(a)(2).

> [p]laintiffs will present expert testimony to assist the Court in understanding how the State of Illinois' rate and funding decision impact this wide variety of medical service providers. Plaintiffs will also present expert testimony on subjects such as the medical necessity of the services at issue here to the Plaintiff cases (e.g., EPSDT), and also on the general standards of medical (pediatric and obstetric) care provided to members of the Plaintiff classes and to the general public. These witnesses will be presented as experts under Rule 702 to provide specialized medical and statistical knowledge relating to Defendants' administration of the Illinois Medicaid system. However, many of these anticipated witnesses will not be "retained or specifically employed to provide expert testimony" to Plaintiffs, and will not be compensated for their time. As such, these expert witnesses will not be subject to the expert report requirements of Rule 26(a)(2).

In this disclosure we conceded that the admissibility of at least certain aspects of the doctors' testimony would be governed by Federal Rule of Evidence 702, which states that if specialized knowledge will help the court "understand the evidence or … determine a fact in issue," an expert witness may offer testimony that is "based upon sufficient facts or data, … the product of reliable principles and methods, and the witness has applied the principles and methods reliably to the facts of the case."

A witness' experience can satisfy the standard for expert testimony under Rule 702, courts have found.[27] Thus the doctors' extensive experience in treating children who receive Medicaid, as well as in dealing with the business side of their practices, formed the evidentiary foundation for the specialized testimony. The testimony of a "treating physician" in a personal injury case offers a useful analogy in thinking about the admissibility of the testimony by these witnesses.

By anticipating all of these issues in the discovery phase of the case, planning the strategy in advance, and making detailed disclosures, we created a solid foundation for the admission of the testimony at trial. We forced the defendants to confront the issues during discovery, and, at the time, the defendants did not object.[28] As a result, when the defendants attempted to bar testimony from these witnesses in a motion *in limine* filed weeks before trial, their objections were overruled.[29]

VI. Parents and Guardians

Plaintiffs' counsel first became aware of the problems that led to the filing of this case when they received calls from individual clients who were attempting to gather medical evidence to support their children's applications for Supplemental Security Income benefits. Many of these children had no pediatrician or family doctor and thus no adequate medical records. Instead the parents' practice was to bring the child to the nearest hospital emergency room if the child was sick with a sore throat or fever. The parents rarely were able to find a doctor to provide primary preventive care such as well-child checkups and immunizations. Many parents tried to obtain care for the

[27] *United States v. Brumley*, 217 F.3d 905, 910-11 (citing *Daubert v. Merrill Dow Pharmaceuticals Inc.*, 509 U.S. 509 (1993), and *Kumho Tire Company v. Carmichael*, 526 U.S. 137 (1999)) (affirming admission of Drug Enforcement Administration agent's opinion, based only on his own personal experience, that a specified amount of methamphetamine was a "distribution" amount as opposed to an amount for personal consumption); *Nutrasweet Company v. X-L Engineering Company*, 227 F.3d 776, 789 (7th Cir. 2000) (affirming admission of expert's interpretation of aerial photos based on witness' twenty years of experience in the field).

[28] One shrewd discovery tactic with the hybrid witnesses was to help them acquire their own counsel (private attorneys acting pro bono) to assist in answering documentary requests and to defend their depositions. This reinforced their independence from plaintiffs and their counsel. While seemingly obvious in hindsight, the first impulse of the public interest attorneys on plaintiffs' litigation team was themselves to represent the hybrid witnesses through discovery.

[29] The court's memorandum opinions and orders with respect to all the motions *in limine* are available at the Shriver Center website. See *supra* note 2.

children from neighborhood doctors, only to find that many of those doctors were not qualified pediatricians or family physicians and that their offices often were not clean and had no necessary equipment. Furthermore, many of these neighborhood physicians, even if they would treat medical conditions, did not offer complete well-child examinations or immunizations; instead they sent the parents to city clinics to receive immunizations for school admission years after the children should have received them.

We obtained similar information from people who were in the waiting rooms of area emergency departments and had told hospital-based physicians that they had no access to primary care. Despite the major problems highlighted in Dr. Darling's reports, we found it difficult to identify specific families. Many low-income parents did not expect to have access to qualified medical care and tended not to recognize lack of access as a legal problem that a lawyer might help remedy. Ultimately, however, the case was filed with several named plaintiffs.

Over the many years of litigation, some of the original named plaintiffs reached adulthood or moved out of Cook County; approximately two years before trial, only two had not yet moved or aged out of the class. In 2002 we moved to substitute representative class members; the motion was granted after discovery and oral argument.

The testimony of individual class members about their failed attempts to get necessary health care for their children was an important part of the evidence at trial. Six parents offered very powerful evidence of the lengths to which they had gone to find qualified doctors and dentists to treat their children. Some testified that they had called over twenty or thirty physicians from referral hotlines, phone books, and state lists, and none of the physicians would accept Medicaid patients. Several of the plaintiffs' parents testified that they could easily find doctors for their biological children with private insurance but that the same doctors refused their foster children on Medicaid as patients. This kind of testimony was the starkest example of the importance of the equal-access provision and how its violation harms real children.

VII. Documentary Evidence

We presented as documentary evidence primarily the typical government program documents, including rules, notices, reports, and charts. We found it useful to think about the evidentiary themes, such as program notices and information relevant to the EPSDT effective-notice claim, the CMS-416 forms and related worksheets, and analyses of rates and other factors and their relationship to access to care. We had to probe beneath the official documents. For example, we obtained the state's CMS-416 worksheets done with solely Cook County data. CMS requires only statewide information, but Illinois had completed a Cook County version for its own purposes. These were key data for the lawsuit since the plaintiff class consisted only of Cook County children.

We had to know the number of participants in the medical-social programs that the defendants operated (e.g., targeted case management; the Women, Infants, and Children food program; immunization programs; early intervention programs) so that the defendants could not merely claim that, in the aggregate, the programs amounted to compliance with the effective-notice or even the service-delivery requirements for EPSDT (their attempted factual basis for the "black hole" defense).

An important theme of both the documentary and oral discovery was to identify everything that the defendants had *not* done in administering the Medicaid program. Every answer along the lines of "I don't know" or "no such document" or "we never did anything like that" was relevant: for example, the defendants had never studied the relationship between reimbursement rates and access to care, or assessed access to care on the basis of geography or population, or experimented with various ways to promote well-child care either orally or in writing, or

compared Medicaid and other forms of insurance.[30]

VIII. Deposition Evidence and Defense Witnesses

We decided to reduce the number of witnesses at trial by seeking admission into evidence of designated portions of deposition testimony. Ruling on a motion *in limine* before trial, the court agreed that deposition testimony of employees of the defendants constituted admissions that could be entered into evidence in the plaintiffs' case in chief. This deposition testimony, among others, was evidence that defendants were not administering Medicaid to achieve equal access to care. For example, the deposition testimony established that equal access was never a goal in setting Medicaid reimbursement rates. Instead the rates were based on a division of each year's Medicaid appropriation, an amount driven not by access considerations but by politics, and divided among provider groups based on politics. The deposition testimony helped prevent any attempts by the defendants to introduce surprise evidence or new interpretations of these issues at trial.

IX. Relief and Settlement

After Judge Lefkow issued her opinion that the state was violating the Medicaid Act, she ordered the parties to attempt to negotiate a remedial final judgment order. Winning a case, counsel knew from experience, is sometimes just the beginning of much longer and more difficult implementation and enforcement. A willing administration that owns reforms and is proud of them is almost always preferable to a recalcitrant administration that, after losing in court, balks at every step, hides information, and regularly approaches contempt of court.

Therefore we had a settlement offer on the table from 1999, when the case was entering its active phase after the long stay of proceedings. In January 2003 Illinois swore in Gov. Rod Blagojevich, the first Democrat to hold that office in twenty-five years. In his campaign Blagojevich had promised that improved access to health care, especially for children, would be a top priority. Although he faced unprecedented budget shortfalls, he pressed for increased health care allocations in his first budgets, which were otherwise fairly austere.[31]

New to the office, the governor did not focus on *Memisovski* until trial preparations were well under way. We renewed settlement overtures, pressing the point that the reforms sought in the case were fully consistent with the governor's own health care policy theme of children and prevention. Discussions held in late 2003 were not fruitful but were left open-ended. The pressures of the ensuing winter-spring legislative session distracted the administration, however, and our focus shifted to trial preparations and the trial itself in May 2004. Even before the judge released her opinion in August 2004, however, we sought to start the conversation. Thereafter, with the opinion in hand, and favoring the plaintiffs, discussion finally became serious.

For the defendants, a settlement might mitigate and phase in a huge expense that could substantially disrupt the administration's plans for coping with the ongoing fiscal crisis, and it would avoid embarrassment and political fallout from public perception that the governor opposed better health care for children. For the plaintiffs, a settlement would avoid an appeal, with the risk of an unfavorable outcome and, even if successful, substantial delay in the implementation of reform, and it would avoid the potential for battles of attrition with a recalcitrant state agency over implementation of the court's order.

After a long negotiation, in June 2005 the parties reached an agreement. After notice to the class and a fairness hearing,

[30] See Opinion at 72–74 (Finding of Fact 172(a)–(q)), a long litany of tasks that Illinois never did in implementing the Medicaid program and its equal-access and EPDST provisions.

[31] See John Bouman, *The Path to Universal Health Coverage for Children in Illinois*, 39 Clearinghouse Review 676 (March–April 2006); *id.*, *The Power of Working with Community Organizations: The FamilyCare Campaign—Effective Results Through Collaboration*, 38 Clearinghouse Review 583 (Jan.–Feb. 2005).

the agreement became final in November 2005.[32] The state had begun to move from an adversarial mind-set to embrace the concept of investing in health care for children and understand the political benefits of leading that effort. The governor, in fact, was fixing a problem that he had inherited. The defendants' main concessions were to forgo an appeal and to agree to a declaratory judgment and a corresponding injunction requiring compliance with the equal access and EPSDT provisions of the statute. With those concessions in place, plaintiffs reciprocated with concessions on the pace and size of the investments to be made in the program in the early years.

We agreed to relief in phases. Immediate rate increases took effect in January 2006 for the common well-child doctor and dentist codes. Set below but close to Medicare rates, the new rates at least doubled most of the previous payment levels, and the payment cycle for these billing codes was reduced to thirty days. The agreement also provided for bonuses to doctors, effective in 2007, for each child age 0–5 who received all recommended well-child screens and services in a year. Access to specialty care was to be studied and then negotiated, with no immediate change in rates specifically mandated for that care. The consent decree also required the state to issue new informational materials, to hire a contractor to recruit doctors and match families with doctors who would see them, and to implement several other program changes.[33]

The decree provides the infrastructure for a "constant improvement" implementation plan. Using Dr. Darling's reports as a model, the state will produce quarterly reports that identify the number of children who are in each periodicity schedule age group and receive the recommended number of well-child visits and services in the preceding (rolling) twelve months. The reports will inform us of trends and help us decide when further negotiation or a motion for compliance may be necessary with respect to well-child care. If the relief does not produce the desired results, we may fall back on the declaratory judgment and the general injunction to support a motion for further relief, even if the defendants comply in good faith with the specific directives of the decree. In other words, an order for further relief need not be based on an allegation and proof of or bad faith or noncompliance with the specific requirements of the consent decree.

X. Conclusion

Memisovski offers several lessons for advocates who are contemplating filing such a case. Among the lessons:

- *Enforceable rights*—government defendants are likely to raise the claim that plaintiffs who are beneficiaries of public programs have no right to enforce the terms of the program. This is a developing area of the law that should be assessed carefully when a case is considered.
- *Building a record*—gaining access to the paid-claims database, planning the use of paid experts, and setting up the use of hybrid fact-expert witnesses were all central to a successful outcome. The costs of developing a deep and diverse record can be significant, however; be sure to assess costs realistically.[34]
- *Finding and keeping plaintiffs*—in litigation that goes on for years, finding named plaintiffs and trial witnesses is a constant challenge that may give rise to legal questions regarding standing

[32]The Consent Decree is available at the Shriver Center website, *supra* note 2, by clicking on "Joint Motion for Preliminary Approval of Consent Decree, Class Notice, and to Set a Date for Fairness Hearing" (the decree is an exhibit to that motion).

[33]This relief has been swallowed whole by the state's new Illinois Health Connect program (see *supra* note 1), which seeks to implement the "medical home" concept and emphasize primary and preventive care for the entire Medicaid caseload, not just children.

[34]In *Memisovski* all of the partners representing the plaintiffs contributed to the costs of litigation. The Impact Fund and the Nathan Cummings Foundation contributed financial help with expert fees and other litigation costs. We also relied on the general fund-raising efforts of the nonprofit organizations representing the plaintiffs. As part of its pro bono commitment, Goldberg Kohn advanced a substantial amount of the litigation costs.

and mootness. Even after class certification, counsel may have to address the propriety of proceeding with a "headless" class. But, at trial, stories that personalize the reality of the problem can be moving. Strong ongoing relationships with ground-level service providers and other community resources should be cultivated to maintain access to "real people" who can tell these stories. Families in which some children have private insurance and other children have Medicaid can offer especially compelling testimony.

- *Keeping an eye on the political landscape*—the road to the *Memisovski* settlement forced the defendants to consider the costs and benefits of preventive health care, including the value of a "medical home," or regular source of care, not just for children but for all Medicaid beneficiaries. In late September 2005, even before the decree was final, the governor announced his new All Kids program of health coverage regardless of income for every child in Illinois. In a companion measure, he announced the creation of a new Medicaid delivery model based on "primary care case management." This program requires most Medicaid recipients to select a primary care doctor who becomes the regular source of their primary care and coordinator of their other care.[35] This is a far-reaching policy turnabout for Illinois. Such a litigation outcome is admittedly rare, but the lesson is to keep an eye on the larger political landscape even while in the heat of litigation.
- *Composing the litigation team*—before undertaking such a case, think about the composition of the litigation team. The *Memisovski* team—we the authors of this article—includes an experienced public interest litigator; a team of top-notch Medicaid and health care experts; and an excellent litigation group from a private firm, working pro bono. The members of the team have smarts about state politics, seasoned capacity in the legislative arena, and access to media strategists and relationships in the legal community. We built a highly collegial relationship, with each team member deferring to others' areas of expertise at appropriate times while still participating vigorously in conversations to move the case forward.

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[35]This is not "capitated" or HMO-style managed care. The doctors in the Illinois system will receive a modest case-coordination fee but also will bill separately for all the services they provide.

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