IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, FLORIDA

GABRIELLE GOODWIN by her Agent Under Durable Power of Attorney, **DONNA ANSLEY** 7069 Carmel Drive Tallahassee, FL 32309 *individually and on behalf of a class of persons similarly situated* Plaintiff v. **FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION** 2727 Mahan Drive Tallahassee, FL 32308 **ELIZABTH DUDEK, SECRETARY FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION** 2727 Mahan Drive Tallahassee, FL 32308 **FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES** 1317 Winewood Blvd. Building 1, Room 202 Tallahassee, Florida 32399-0700 and **DAVID WILKINS, SECRETARY FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES** 1317 Winewood Blvd. Building 1, Room 202 Tallahassee, Florida 32399-0700, Defendants.	Civil Action No. _____ CLASS REPRESENTATION

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CLASS ACTION COMPLAINT

Plaintiff, by and through her attorneys, brings this Class Action Complaint, on behalf of herself and all other persons similarly situated, to obtain declaratory and injunctive relief, damages, costs of suit, and attorneys' fees from Defendants, the Florida Agency for Health Care Administration ("AHCA"), its Secretary, Elizabeth Dudek, the Florida Department of Children and Families ("DCF") and its Secretary, David Wilkins (collectively, "Defendants").

NATURE OF ACTION

1. For years, the State of Florida has violated federal and state law and shortchanged its most vulnerable citizens – the elderly poor who reside in nursing homes – by failing to give them the full Medicaid long-term care benefits to which they are entitled. This class action, on behalf of elderly and poor Medicaid recipients who are now receiving, or in the future will receive, long-term nursing home care, seeks to remedy that persistent and unlawful conduct and vindicate federal and state law.

2. Defendants' unlawful reduction of Medicaid benefits occurs in the calculation of Medicaid recipients' monthly "patient responsibility amount," the portion of recipients' income that federal and state law requires be contributed to the cost of their long-term nursing care. The patient responsibility amount is similar to a copayment, and is equal to a recipient's monthly income, less deductions which protect a portion of recipient income so that recipients can pay certain, enumerated expenses (*e.g.*, health insurance premiums). The remaining, non-protected income is the patient responsibility amount which recipients pay to nursing homes toward the cost of their long-term care, with the Medicaid program making up the difference.

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3. Among the expenses the federal Medicaid statute requires be deducted from a Medicaid recipient's total income in determining patient responsibility amount are all unpaid medical expenses incurred prior to Medicaid eligibility. When properly applied, the required deduction for pre-eligibility medical expenses (or "PEME") reduces a recipient's patient responsibility amount, increases the State's Medicaid benefit for that recipient, and thereby enables the recipient to use protected, post-eligibility income to pay the nursing home for unpaid pre-eligibility medical expenses.

4. Defendants have refused fully to honor and implement the federal requirement for the PEME deduction. Indeed, their ACCESS Florida Program Policy Manual, which DCF case workers are instructed to use in determining Medicaid recipients' monthly patient responsibility amounts, states that "[a] medical expense deduction is not [deducted from income] when . . . the medical expense is for nursing facility services." Policy Manual § 2640.0125.01. Instead, Defendants unlawfully restrict the PEME deduction to non-nursing home medical expenses.

5. Defendants' conduct in violation of federal and state law has forced Medicaid recipients to pay excessive patient responsibility amounts, with the results that (a) the State of Florida has underpaid Medicaid benefits; (b) Medicaid recipients have been unable to use post-eligibility income to pay for pre-eligibility long-term care; and (c) Florida nursing homes have provided uncompensated long-term care to residents who later become Medicaid-eligible.

6. This class action seeks to remedy Defendants' violation of federal and state law by (a) declaring the rights of class members who have been, or will be, recipients of Medicaid long-term care benefits to the PEME deduction; (b) enjoining Defendants to re-

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calculate the patient responsibility amounts of all class members who have been recipients of Medicaid long-term care benefits at any time during the applicable class period; and (c) enjoining Defendants to comply with federal and state law by granting a full and unlimited PEME deduction to all class members who will be recipients of Medicaid long-term care benefits in the future.

7. In addition, Defendants' refusal fully to honor and implement the PEME deduction constitutes a breach of AHCA's uniform contract with Florida nursing homes that provide Medicaid long-term care benefits, contracts to which class members are intended beneficiaries. Pursuant to these AHCA-nursing home contracts, nursing homes may not "bill or collect from the recipient or the recipient's responsible party any additional amount except, and only to the extent AHCA permits or requires, co-payments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided." Defendants' refusal to allow a full and unlimited PEME deduction as required by federal and state law constitutes a breach of AHCA's contractual obligation to calculate Medicaid recipients' co-payments accurately by granting the PEME deduction, thereby causing nursing homes to (a) receive less in Medicaid reimbursement than they are entitled to receive from the State; and (b) make up that difference by billing recipients erroneous patient responsibility amounts. This class action seeks to remedy that persistent breach of contract.

JURISDICTION

8. This Court has jurisdiction over this class action pursuant to FLA. STAT. § 26.012 (original jurisdiction of all actions at law and to issue injunctions); and FLA. STAT. § 86.011 (declaratory judgment).

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PARTIES

9. Plaintiff Gabrielle Goodwin, 61, is a resident of Leon County. Ms. Goodwin is disabled and wheelchair-bound as a result of cervical spine decompression and complications from spinal surgery. She suffers from a variety of physical ailments, including involuntary movements (extrapyramidal symptoms), incontinence, and hypothyroidism; and mental impairments, including depression, bi-polar disorder, and paranoia. Since November 2010, Ms. Goodwin has resided at Heritage HealthCare, a skilled nursing facility at 3101 Ginger Drive, Tallahassee, FL 32308. She is a recipient of Medicaid long-term care benefits. She brings this action by her agent under a Durable Power of Attorney, Donna Ansley, who was appointed by Ms. Goodwin on November 15, 2011.

10. Defendant AHCA is an agency of the Florida state government that oversees operations of the entire health and human services system in Florida. Pursuant to 42 U.S.C. § 1396a(a)(5) and 42 C.F.R. § 431.10, a state participating in the Medicaid program is required to designate a "single state agency" to administer its Medicaid program; and pursuant to FLA. STAT. § 409.902, AHCA has been so designated by the State of Florida.

11. Defendant Elizabeth Dudek ("Dudek") is the Secretary of AHCA and charged under FLA. STAT. § 20.42 with the responsibility for administering the Medicaid program. She is sued in her official capacity.

12. Defendant DCF is the state agency responsible under FLA. STAT. § 409.902 for Medicaid eligibility determinations, including but not limited to, determination of patient responsibility amounts.

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13. Defendant David Wilkins ("Wilkins") is the Secretary of DCF. Pursuant to FLA. STAT. § 20.19(2)(d), he has the authority and responsibility to ensure that the mission of the department is fulfilled in accordance with state and federal laws, rules, and regulations. He is sued in his official capacity.

14. Together, Defendants AHCA, Dudek, DCF, and Wilkins are responsible for implementation of the Medicaid program in the State of Florida.

VENUE

15. Venue is proper in Leon County pursuant to FLA. STAT. § 47.011.

STATEMENT OF FACTS

A. The Medicaid Program

16. The federal Medicaid program is authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq*. ("the Medicaid Act"). Under this program, the federal government provides financial support (half or more) of the costs a participating state incurs for providing medical care to the poor. Pursuant to § 1902 of the Act, 42 U.S.C. § 1396a, states participating in the Medicaid program must comply with Title XIX and its implementing federal regulations (codified at 42 C.F.R. §§ 435 *et seq*.), including post-eligibility determinations of patient responsibility amounts.

17. The Medicaid Act grants the Secretary of Health and Human Services the power to promulgate rules and regulations for efficient administration of the Medicaid program. The Secretary of Health and Human Services has delegated that authority to the Centers for Medicare and Medicaid Services ("CMS"). *See* Statement of Organization, Functions, and Delegations of Authority for the Dep't of Health and Human Services, Pt. F, 46 Fed. Reg. 13262-13263 (1981).

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18. Pursuant to FLA. STAT. § 409.902, Florida has chosen to participate in the Medicaid program through a program of medical assistance designated as the "Medicaid program." Defendant AHCA is the single state agency designated by the State of Florida to administer the Medicaid program, and Defendant DCF is the state agency charged with responsibility for making eligibility determinations for the Medicaid program, including, but not limited to, determination of patient responsibility amounts.

19. By participating in Medicaid, Florida has agreed to comply with the program requirements contained in the Medicaid Act and its implementing federal regulations. Defendants are therefore responsible for the Florida Medicaid program's compliance with federal law; the proper promulgation of rules and regulations in the Florida Administrative Code; and administration of the State's Medicaid program by giving information and directions to DCF case workers and staff on how to determine Medicaid eligibility, including determination of each individual beneficiary's patient responsibility amount.

20. In addition, Defendants are also required by State law, including FLA. STAT. § 409.902, to implement the State's Medicaid program in conformity with federal law, including the Medicaid Act and its implementing federal regulations.

21. As a State that participates in the Medicaid program, Florida is also required to develop and submit for federal approval a "State Plan" that complies with the federal Medicaid statute and regulations. The State Plan is the operating manual for each state Medicaid program and, pursuant to 42 C.F.R. § 430.10, describes "the nature and scope of its Medicaid program and giv[es] assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department [of Health and Human Services]."

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22. The State Plan contains the information necessary for CMS to determine whether Florida's Medicaid program complies with all federal requirements and thus entitles Florida to federal funding under the Medicaid program.

B. Medicaid Coverage for Long-Term Care

23. Medicaid pays for long term care for individuals who meet certain financial and non-financial requirements, including (a) the individual's income is insufficient to pay for the cost of that care; (b) the individual has no more than $2,000.00 in non-exempt assets; (c) the individual's monthly countable income is not greater than $2,094.00; and (d) the individual requires a nursing home level of care.

24. Florida residents apply for Medicaid long-term care benefits with DCF, whose staff apply the rules set out in the FLA. ADMIN. CODE §§ 65A-1.712, *et seq.*, using the guidance provided in the ACCESS Program Policy Manual (the "Policy Manual"). The Policy Manual is a document issued by DCF and revised from time to time that contains the agency's policies and procedures for implementing Florida's Medicaid program.

25. For individuals such as Plaintiff who are institutionalized in nursing homes, applying for Medicaid benefits involves a two-step process: (1) determining eligibility; and (2) determining the individual's co-payment, or patient responsibility amount, for his or her medical care (the "post-eligibility process"). This case concerns the second step, *i.e.*, the "post-eligibility" calculation of recipients' patient responsibility amounts.

C. Determining the Contribution of Beneficiaries (the "Post-Eligibility Process")

26. DCF must determine how much a nursing home resident pays for his or her cost of care, known as the "patient responsibility amount" under the Florida Medicaid program, pursuant to Federal standards. This requirement derives from the authority of

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the Secretary of Health and Human Services to promulgate standards for determining "the extent of medical assistance under the plan," *i.e.*, how much will be paid by the individual and how much by Medicaid, as well as explicit authority to set rules for taking into account costs incurred for medical care. 42 USC § 1396a(a)(17); 42 C.F.R. § 435.832. A Medicaid beneficiary in a nursing home is required to pay the nursing facility for a portion of the cost of care, with the State's Medicaid program making up the difference between that contribution and the price the nursing home has agreed with the State to accept for providing services to Medicaid beneficiaries.

27. Once the recipient's contribution to care is determined, the nursing home collects that amount from the resident and bills the Medicaid program for the difference between that amount and the amount the nursing home agreed to accept under its contract with the Medicaid program. Pursuant to FLA. ADMIN. CODE § 65A-1.7141, the amount of a Florida Medicaid beneficiary's contribution is known as the patient responsibility amount.

28. The calculation of a recipient's patient responsibility amount involves reducing a beneficiary's total available income by certain deductions as required by federal law (*e.g.*, health insurance premiums and a monthly personal needs allowance). The remaining amount is the amount the beneficiary must contribute to his or her cost of care. Thus, the greater the deductions, the smaller the beneficiary's patient responsibility amount and, accordingly, the greater the amount of the Medicaid benefit.

D. The PEME Deduction

29. One of the deductions required by federal law is a deduction for unpaid medical expenses incurred prior to eligibility, or pre-eligibility medical expenses ("PEME").

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The requirement for the PEME deduction is set forth at § 1902(r)(1)(A) of the Social Security Act, 42 U.S.C. § 1396a(r)(1)(A), which states:

> [W]ith respect to the post-eligibility treatment of income of [institutionalized] individuals. . . , there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—
>
> > (I) medicare and other health insurance premiums, deductibles, or coinsurance, and
> >
> > (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

42 U.S.C. § 1396a(r)(1)(A).

30. This statutory requirement for the deduction of incurred, pre-eligibility medical expenses is implemented by federal regulations at 42 C.F.R. § 435.725, which state:

> **§ 435.725 Post-eligibility treatment of income of institutionalized individuals . . . : Application of patient income to the cost of care.**
>
> (a) **Basic rules**.
>
> > (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,
> >
> > * * *
>
> (c) **Required deductions**. In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. . .
>
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> (4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—
>
> > (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
> >
> > (ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

This same deduction for incurred, pre-eligibility medical expenses is required for Medicaid recipients who are receiving home and community-based services furnished under a waiver, pursuant to 42 C.F.R. § 435.726.

31. CMS has long interpreted the Medicaid Act and its regulations to mean that medical expenses "not covered" under a state's Medicaid Plan includes all incurred expenses, regardless of whether or not they are of a type which the state's Medicaid plan would cover.

32. CMS's construction of its own regulation means that unless a state establishes "reasonable limits" to the contrary, as allowed by § 1396a(r)(1)(A)(ii) of the Act, a state is required to deduct all pre-eligibility medical expenses in determining a beneficiary's contribution to the cost of his or her nursing home care. *See* Exh. A (copy of *Maryland Dep't of Health and Mental Hygiene v. CMS*, 542 F.3d 424 (4th Cir. 2008)) (at p. 430: "By longstanding policy predating the enactment of that statute, CMS had mandated consistent deduction of incurred medical expenses in both the spenddown and posteligibility processes"); Exh. B (letter dated March 19, 2004 from CMS to Louisiana Bureau of Health Services Financing) ("a state [may not] exclude from post-eligibility protection an incurred

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medical expense that could be deducted from a person's income under the medically needy spenddown process"); Exh. C (letter dated September 13, 2004 from CMS, Disabled and Elderly Health Programs Group to Ron M. Landsman, Esq.) ("amounts for incurred expenses for medical or remedial care . . . must be deducted from patient income in the post-eligibility process").

33. Indeed, when CMS sought to revise its regulations in 1988 to remove the post-eligibility deduction for PEME, Congress enacted 42 U.S.C. § 1396a(r)(1)(A) as part of the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, to restore the PEME deduction. Exh. A at p. 431 ("Congress' reaction was swift and negative. In July 1988, it enacted 42 U.S.C. § 1396a(r)(1) (A), which incorporated in whole CMS's prior regulatory language regarding the posteligibility treatment of incurred medical expenses. Congress also made § 1396a(r)(1)(A) retroactive to April 8, 1988."). As the conference committee report on that legislation (Exh. D) explained:

> The conferees note that, until recently, [CMS] regulations required that Medicaid-eligible nursing home residents be allowed to deduct uncovered medical costs from their income before contributing toward the cost of nursing home care. However, a recent [CMS] regulation . . . altered this rule to allow States to limit this deduction substantially, or to eliminate it altogether. The conference agreement is intended to reinstate the previous rule, retroactive to the effective date of the recent change (April 8, 1988). [H.R. CONF. REP. 100-661 at 266 (1988)]

34. Thus, federal law as implemented by CMS requires states (subject to any reasonable limits which they may establish) to deduct all pre-eligibility medical expenses from a Medicaid long-term care recipient's available income when calculating the recipient's contribution to his or her long-term care. This deduction protects Medicaid

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recipients' post-eligibility income so that it can be used to pay for unpaid pre-eligibility medical expenses.

35. As set forth in 42 U.S.C. § 1396a(r)(1)(A) and its implementing regulations, federal law permits States to impose "reasonable limits" on the PEME deduction, so long as those reasonable limits are approved by CMS and set forth in a State Plan. CMS has approved an amendment to Florida's State Plan addressing post-eligibility treatment of institutionalized individuals' income, and a copy of that State Plan amendment is attached hereto as Exh. E.

E. DCF's Policies and Procedures for Determining a Recipient's Patient Responsibility Amount

36. DCF purports to follow federal law with regard to the deductions from available income in determining recipients' patient responsibility amounts. For example, FLA. ADMIN. CODE § 65A-1.7141 ("Medicaid Post-Eligibility Treatment of income") states that "the department allows a deduction for the actual amount of . . . medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized the Medicaid State Plan and in accordance with" federal regulations.

37. FLA. ADMIN. CODE § 65A-1.7141 goes on to list the criteria for deducting an incurred medical expense in determining a recipient's patient responsibility amount:

1. The medical/remedial care service or item must meet all the following criteria:
    a. Be recognized under state law;
    b. Be medically necessary;
    c. Not be a Medicaid compensable expense; and

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d. Not be covered by the facility or provider per diem.

. . .

3. Expenses for services or items received prior to the first month of Medicaid eligibility can only be used in the initial projection of medical expenses if the service or item was provided during the three month period prior to the month of application and it is anticipated that the expense for the service or item will recur in the initial projection period.

38. Notwithstanding that these Florida regulations require a PEME deduction for unpaid nursing home services incurred prior to the date of application for Medicaid benefits, the Policy Manual upon which DCF caseworkers are instructed to rely in actually determining recipients' patient responsibility amounts specifically excludes the PEME deduction. The Policy Manual provides, in pertinent part:

> When an individual incurs medical expenses that are not Medicaid compensable and not subject to payment by a third party, the cost of these uncovered medical expenses must be deducted from the individual's income when determining his patient responsibility. To be deducted, the medical expense only needs to be incurred, not necessarily paid.
>
> . . .
>
> The following types and amounts of medical expenses may be deducted from an individual's income available for patient responsibility:
>
> . . .
>
> 2. The actual amount (if reasonable) incurred for medical services or items that are recognized under state law and medically necessary.
>
> ***A medical expense deduction is not budgeted when*:**
>
> **. . .**
>
> **3. *The medical expense is for nursing facility services,*** including those incurred during a penalty period.

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Policy Manual § 2640.0125.01 (emphasis added). By the term "budget," the Manual means "allow as a deduction."

39. By expressly disallowing a deduction where the "medical expense is for nursing facility services," DCF does not allow a deduction for nursing home expenses incurred prior to a Medicaid recipient's eligibility for Medicaid long-term benefits.

40. Even if Defendants were actually providing the PEME deduction for nursing home services, FLA. ADMIN. CODE § 65A-1.7141 and the Policy Manual contain three additional restrictions on this deduction that have never been approved by CMS and are not included in the State Plan, and thus would be unlawful "reasonable limitations" on the PEME deduction. These additional limitations are that the expense must (i) be incurred within three months prior to eligibility, FLA. ADMIN. CODE § 65A-1.7141(3); (ii) not be incurred during a penalty period, Policy Manual § 2640.0125.01(3); and (iii) be anticipated to recur, FLA. ADMIN. CODE § 65A-1.7141(3). Indeed, CMS has specifically directed that states wishing to exclude expenses incurred during a penalty period may only do so through an amendment to the State Plan, which Florida has not done. Exh. F (Apr. 18, 2006 CMS directive). Moreover, none of these limitations on the PEME deduction have been adopted by AHCA or DCF in accordance with Florida law.

41. Thus, Defendants, through AHCA regulations and its Policy Manual for DCF caseworkers, impose at least four limitations on the deduction for PEME that have not been submitted to CMS, have not been included in the State Plan, and have not been approved by CMS and are therefore unlawful, to wit, the exclusion of:

a. all nursing facility expenses;

b. expenses incurred prior to the retroactive period;

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c. non-recurring expenses ; and

d. expenses incurred during a penalty period.

Each of these limitations on the PEME deduction imposed by Defendants is prohibited by 42 U.S.C. § 1396a(r)(1)(A) and 42 C.F.R. § 435.725.

42. Moreover, upon information and belief, Defendants also impose these same unlawful limitations on the PEME deduction for Medicaid recipients who are receiving home and community-based services furnished under a waiver, as required by 42 U.S.C. § 1396a(r)(1)(A) and 42 C.F.R. § 425.726.

43. By not allowing the PEME deduction for nursing home expenses incurred prior to a Medicaid recipient's eligibility for Medicaid long-term benefits as aforesaid, AHCA and DCF have engaged in a pattern and practice of violating (a) the Medicaid Act and implementing CMS regulations which require a deduction for all pre-eligibility medical expenses including nursing home expenses, subject to any reasonable limits which Florida may have established; and (b) state law which requires AHCA and DCF to implement the Medicaid program in accordance with, and conforming to, federal law.

44. Federal Medicaid regulations, including 42 C.F.R. § 431.246, require Defendants to "promptly make corrective payments retroactive to the date an incorrect action was taken" in the determination of Medicaid benefits. Similarly, FLA. ADMIN. CODE § 65-2.066(6) requires Defendants to take "corrective action retroactively to the date the incorrect action was taken." Thus, because Defendants have violated, and are continuing to violate federal and state law which require that PEME be deducted in the calculation of Medicaid recipients' patient responsibility amounts, Defendants are required to recalculate patient responsibility amounts for Named Plaintiff and members of the class and to make

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corrective payments of Medicaid benefits for the benefit of Named Plaintiff and members of the class, retroactive to the date the error was made, *i.e.*, the date of recipients' Medicaid eligibility.

F. AHCA's Contracts With Florida Nursing Homes

45. Upon information and belief, AHCA has used, and continues to use, a standard contract with Florida nursing homes entitled the "Institutional Medicaid Provider Agreement" regarding the provision of Medicaid long-term care benefits to Medicaid recipients (the "Provider Agreement"). A copy of the Provider Agreement between AHCA and Heritage, the facility providing nursing services to Plaintiff, is attached hereto as Exh. G.

46. The Provider Agreement states that the provider shall:

> Accept Medicaid payment as payment in full, and not bill or collect from the recipient or the recipient's responsible party any additional amount except, *and only to the extent AHCA permits or requires, co-payments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided*.

Exh. G ¶ 5(h) (emphasis added).

47. FLA. STAT. § 409.902 requires AHCA "to make payments for medical assistance and related services under Title XIX of the Social Security Act . . . to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law." AHCA's statutory obligation to comply with federal and state law in making Medicaid payments to Florida nursing homes is thus incorporated in every Provider Agreement as a required contractual obligation by AHCA.

48. By obligating the provider to bill or collect from Medicaid recipients only those patient responsibility amounts which AHCA permits or requires, AHCA has agreed and

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contracted to calculate such patient responsibility amounts accurately and lawfully in accordance with applicable federal and state law.

49. Named Plaintiff and members of the class are intended third-party beneficiaries of Provider Agreements because AHCA's obligation to calculate accurately and lawfully recipients' patient responsibility amounts in order to make full and lawful Medicaid reimbursement payments to nursing homes is solely intended to protect Medicaid recipients who must make up the difference resulting from any erroneous application of law in that calculation.

50. Named Plaintiff and members of the class relied upon the AHCA's obligation to calculate patient responsibility amounts in accordance with applicable federal and state law.

51. As a direct and proximate result of AHCA's breach of its implied promise to calculate patient responsibility amounts in accordance with applicable federal and state law, Named Plaintiff and members of the class have paid, and are continuing to pay, patient responsibility amounts to their nursing homes in excess of what federal and state law require.

G. Named Plaintiff

52. Before November 2010, Plaintiff Gabriele Goodwin lived in her home at 3711 Shamrock Street West, Apt. N265, Tallahassee Florida, and was a 14-year employee of Publix Super Markets. She underwent cervical spinal surgery in October 2010 to relieve spinal cord decompression and related spinal problems but complications from that surgery have left her disabled and unable to care for herself. She was admitted to Heritage HealthCare in Tallahassee ("Heritage") on November 23, 2010.

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53. Ms. Goodwin, through Heritage, first applied to DCF for Medicaid long-term care benefits under Florida's Institutional Care Program ("ICP") in March 2011, but these requests were denied for various reasons unrelated to this lawsuit. On January 19, 2012, an application for ICP benefits was again made to DCF on Ms. Goodwin's behalf, seeking retroactive coverage effective December 2011. Her application indicated that there were pre-eligibility medical expenses, including amounts owed to Heritage for nursing home care during her period of pre-eligibility (*i.e.*, before December 1, 2011) of $70,607.58. Exh. H (Heritage Statement of Account).

54. DCF approved Ms. Goodwin's applications on March 16, 2012, with benefits effective retroactive to December 1, 2011. Exh. I (Notice of Application Disposition).

55. DCF also determined that Ms. Goodwin's monthly patient responsibility amount was $1,032.41, calculated as follows:

Income:

Social Security	$1,314.00
Long-term disability	$ 100.00
Total income	$1,414.00

Deductions:

Personal needs allowance	$ 35.00
Health insurance premium	$ 346.59
Total deductions	$ 381.59

Patient Responsibility Amount:

Total income	$1,414.00
Total deductions	$ 381.59
Balance / Patient Responsibility Amount	$1,032.41

Exh. J (Notice of Case Action) and Exh. K (supporting documentation).

56. In determining Ms. Goodwin's patient responsibility amount, DCF failed to deduct from her total available income the $70,607.58 in unpaid nursing home expenses.

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If DCF had properly applied this deduction, Ms. Goodwin's patient responsibility amount would have been $0.00 for 68.4 months (nearly six years), *i.e.*, the time it would have taken Ms. Goodwin to use her $1,032.41 in available monthly income to pay the $70,607.58 in unpaid nursing home expenses.

57. On March 20, 2012, Ms. Goodwin's representative contacted DCF to request again that her unpaid, pre-eligibility nursing home bills be deducted from her available income to reduce her patient responsibility amount, but DCF refused in an email response of that same date, stating "[a]s you are aware we are not able to do this – our policy on this has not changed." Exh. L.

58. On April 12, 2012, Ms. Goodwin, through her representatives, appealed the DCF refusal to deduct her unpaid, pre-eligibility nursing home bill in the calculation of her patient responsibility amount to DCF's Office of Appeal. Exh. M (notice of appeal). A hearing was held on July 24, 2012 and a Final Order was issued on August 16, 2012 (Exh. N). In the Final Order, the DCF hearing office denied Ms. Goodwin's appeal.

59. Subsequent to the filing of this Class Action Complaint, Named Plaintiff intends to file, as a protective measure, a notice of appeal in the Florida First District Court of Appeal from that Final Order denying her the PEME deduction in the calculation of her patient responsibility amount (the "DCA Matter"). Ms. Goodwin will ask that court to stay the DCA Matter unless proceeding with that appeal is found to be required in order to proceed with this Class Action. Rather, Ms. Goodwin intends to prosecute this Class action to judgment and by doing so, to (a) develop fully all facts relevant to a determination whether the State of Florida is currently complying with federal and state Medicaid law; and (b) ask this Court to determine the applicable law regarding that issue.

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CLASS REPRESENTATION ALLEGATIONS

60. Named Plaintiff brings this action on behalf of herself and all other similarly situated individuals comprising a class pursuant to FLA. R. CIV. P. 1.220 (the "Class") consisting of all persons in the State of Florida who (1) have been recipients of Medicaid long-term care benefits at any time during the period commencing four years prior to the filing of this action to the present, or (2) will receive such Medicaid benefits in the future, where such persons at the time of eligibility had or will have outstanding incurred medical benefits, including nursing home charges, during a time when they were not eligible for such benefits.

61. The Class is identifiable, and Named Plaintiff is a member of the Class.

62. Pursuant to FLA. STAT. § 95.11(3)(f), the Class period is the period commencing four years prior to the filing of this action to the present.

63. This action satisfies the requirements of FLA. R. CIV. P. 1.220(a) because, on information and belief, (1) the Class is so numerous that joinder of all members is impracticable, (2) there are questions of law and fact common to the Class, (3) Named Plaintiff's claims are typical of the claims of the Class, and (4) Named Plaintiff can and will fairly and adequately protect the interests of the Class.

64. The approximate number of class members cannot be estimated but, upon information and belief, numbers in the tens of thousands of people.

65. This class action is maintainable under FLA. R. CIV. P. 1.220(b)(1) because the prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications that would establish incompatible standards of conduct for Defendants.

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66. This class action is also maintainable under FLA. R. CIV. P. 1.220(b)(2) because Defendants acted on grounds generally applicable to the class, thereby making both preliminary and final injunctive and declaratory relief appropriate with respect to Plaintiff and to the class as a whole.

67. This class action is also maintainable under FLA. R. CIV. P. 1.220(b)(3) because the common questions of law and fact enumerated above predominate over questions affecting only individual members of the Class, and a class action is the superior method for fair and efficient adjudication of the controversy. The likelihood that individual members of the Class will prosecute separate actions is remote due to the time and expense necessary to conduct such litigation. To the best of Named Plaintiff's knowledge, no litigation against Defendants concerning the PEME deduction is pending or has been brought by other members of the Class.

68. The questions of law or fact common to the claims of Named Plaintiff and members of the Class within the meaning of FLA. R. CIV. P. 1.220(a)(2) and which predominate over any questions affecting only individual Class members include, but are not limited to:

a. Whether federal law requires Defendants to provide the PEME deduction to members of the Class when determining their patient responsibility amount;
b. Whether Florida law requires Defendants to provide the PEME deduction to members of the Class when determining their patient responsibility amount;
c. Whether, and to what extent, Defendants refused to provide members of the Class with the PEME deduction when determining their patient responsibility amount;

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d. Whether Defendants lawfully established any reasonable limits on the PEME deduction;

e. Whether 42 U.S.C. § 1983 provides a remedy for Defendants' denial of the PEME deduction to members of the Class;

f. Whether Florida law provides a remedy for Defendants' denial of the PEME deduction to members of the Class;

g. Whether federal law, including CMS regulations, requires the recalculation of Medicaid benefits retroactive to the date an error was made in determining Medicaid recipients' patient responsibility amounts;

h. Whether state law requires the recalculation of Medicaid benefits retroactive to the date of eligibility to include a deduction for PEME in the determination of Medicaid recipients' patient responsibility amounts;

i. Whether Defendants utilized a standard Provider Agreement to enter into contracts with Florida nursing homes regarding the provision of Medicaid long-term care benefits to Medicaid recipients;

j. Whether the standard Provider Agreement obligates Defendants to make all payments to nursing homes in accordance with federal law, including federal law requiring the PEME deduction when determining recipients' patient responsibility amount; and

k. Whether members of the Class were intended third-party beneficiaries of the standard Provider Agreement.

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69. The claims of Named Plaintiff are typical of the claims of each member of the Class within the meaning of FLA. R. CIV. P. 1.220(a)(3) and are based on and arise out of identical facts constituting the unlawful policies and procedures of Defendants.

70. Named Plaintiff can and will fairly and adequately protect the interests of the Class, because she has retained experienced counsel to represent the Class; she has no conflict of interest with the Class; and she brings this action specifically for the protection of other members of the Class who have been and will be injured by Defendants unlawful policies and procedures.

~~70.~~71. All conditions precedent to this action have been performed or have occurred, including specifically but without limitation such service as is required by FLA. STAT. §§ 284.30 and 48.121.

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FIRST CAUSE OF ACTION
Violation of Medicaid Act – 42 U.S.C. § 1983

~~71.~~72. Named Plaintiff repeats the allegations in paragraphs 1 to 7~~1~~0 as if fully set forth herein.

~~72.~~73. By virtue of the foregoing, Defendants have violated and are continuing to violate 42 U.S.C. § 1396a(r)(l)(A)(ii) with respect to determination of Class members' patient responsibility amounts, by failing to deduct from Class members' income amounts for incurred and necessary medical care recognized under Florida law, not subject to payment by a third party, but not covered by the Florida State Plan because the expenses were incurred prior to Medicaid eligibility, and for which relief is available under 42 U.S.C. § 1983 and the Supremacy Clause of the U. S. CONST., art. VI, cl. 2.

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SECOND CAUSE OF ACTION
Violation of Medicaid Act and State Law

~~73.~~74. Named Plaintiff repeats the allegations in paragraphs 1 to 7~~0~~ as if fully set forth herein.

~~74.~~75. By virtue of the foregoing, Defendants have violated and are continuing to violate 42 U.S.C. § 1396a(r)(l)(A)(ii), FLA. STAT. §§ 409.902, *et seq.*, and FLA. ADMIN. CODE § 65A-1.7141 with respect to determination of Class members' patient responsibility amounts, by failing to deduct from Class members' income amounts for incurred and necessary medical care recognized under Florida law, not subject to payment by a third party, but not covered by the Florida State Plan because the expenses were incurred prior to Medicaid eligibility, for which relief is available under state law.

THIRD CAUSE OF ACTION
Declaratory Judgment and Supplemental Relief

~~75.~~76. Named Plaintiff repeats the allegations in paragraphs 1 to 7~~0~~ as if fully set forth herein.

~~76.~~77. By virtue of the foregoing, Defendants have violated and are continuing to violate 42 U.S.C. § 1396a(r)(l)(A)(ii), FLA. STAT. §§ 409.902, *et seq.*, and FLA. ADMIN. CODE § 65A-1.7141 with respect to determination of Class members' patient responsibility amounts by failing to comply with 42 U.S.C. § 1396a(r)(l)(A)(ii) by not deducting from Class members' income amounts for incurred and necessary medical care recognized under Florida law, not subject to payment by a third party, but not covered by the Florida State Plan because the expenses were incurred prior to Medicaid eligibility, and for which declaratory and supplemental relief are available pursuant to FLA. STAT. §§ 86.021 and 86.061.

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FOURTH CAUSE OF ACTION
Breach of Contract – Third Party Beneficiary

~~77.~~78. Named Plaintiff repeats the allegations in paragraphs 1 to 7~~10~~ as if fully set forth herein.

~~78.~~79. Named Plaintiff and other Class members are intended beneficiaries of the Provider Agreement, pursuant to which Defendants have a duty to calculate a recipient's patient responsibility amount in accordance with state and federal law.

~~79.~~80. By virtue of the Defendants' actions as aforesaid, Defendants have breached the Provider Agreement, *inter alia*, by failing to deduct pre-eligibility nursing home expenses from recipients' available income in determining recipients' patient responsibility amounts, in violation of applicable state and federal law. As a direct and proximate result of this breach, Named Plaintiff and other Class members have paid, and are paying, more for post-eligibility long-term care than federal and state law directs.

WHEREFORE, Plaintiff prays for judgment:

A. Declaring that Defendants' policy of denying deductions for unpaid pre-eligibility medical expenses in the form of unpaid nursing home expenses recognized under Florida law, not subject to payment by a third party, but not covered by the Florida State Plan because the expenses were incurred prior to Medicaid eligibility, is illegal, null and void;

B. Declaring that any determinations by Defendants that Named Plaintiff or any Class member are liable for current patient responsibility amounts without deductions for unpaid pre-eligibility medical expenses in the form of unpaid nursing home expenses are illegal, null and void;

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C. Supplemental and further declaratory relief ordering Defendants to rescind all determinations of recipient patient responsibility amounts that failed to deduct unpaid pre-eligibility medical expenses in the form of unpaid nursing home expenses for Named Plaintiff and Class members and ordering Defendants to issue revised determinations of recipient patient responsibility amounts reflecting such deductions, where such deductions are (i) retroactive to the dates the erroneous and unlawful patient responsibility amount calculations were made, and (ii) not subject to any limitations not approved by CMS and set forth in the State Plan;

D. Preliminary and final injunctive relief ordering Defendants to rescind all determinations of recipient patient responsibility amounts that failed to deduct unpaid pre-eligibility medical expenses in the form of unpaid nursing home expenses for Named Plaintiff and Class members, and ordering Defendants to issue revised determinations of recipient patient responsibility amounts reflecting such deductions, where such deductions are (i) retroactive to the dates the erroneous and unlawful patient responsibility amount calculations were made, and (ii) not subject to any limitations not approved by CMS and set forth in the State Plan;

E. An award of damages pursuant to the Fourth Cause of Action; and

F. Awarding Plaintiff such other and further relief as seems proper and just, including costs and reasonable attorney's fees pursuant to 42 U.S.C. § 1988.

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Dated: September 12, 2012

Respectfully submitted,

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