UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 05-23037-CIV-JORDAN/MCALILEY

FLORIDA PEDIATRIC SOCIETY/ THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, et al.

Plaintiffs,

vs.

ELIZABETH DUDEK, in her official capacity as the Secretary of the Agency for Health Care Administration, et al.,

Defendants.
_____/

SECRETARY DUDEK AND SURGEON GENERAL ARMSTRONG'S MOTION TO REOPEN RECORD FOR TRIAL ON LIABILITY

Defendants, the Secretary of the Agency for Health Care Administration (AHCA) and the Surgeon General of the Department of Health (DOH), both sued in their official capacities, in the interests of justice move this Court to reopen the factual record in this case to allow new evidence to be presented regarding the substantial changes that have been made to the Florida Medicaid Program which should result in a finding of no liability on all of Plaintiffs' claims. Separately, the interim Secretary of the Department of Children and Family Services (DCF) has filed on this date a Suggestion of Mootness, or in the Alternative, Motion to Reopen Record on Liability, arguing that changes in the Medicaid application and eligibility determination process render claims against DCF moot. Defendants further state:

Introduction

In the more than two and a half years since the factual record in this case closed (on February 2, 2012), there have been many significant changes in how the Florida Medicaid Program is operated, particularly as it relates to children. Defendants have previously brought to the attention of the Court changes in the Medicaid service delivery system (now the overwhelming majority of Florida Medicaid children and **ALL** of the Plaintiff children are served in Managed Care, in the Managed Medical Assistance Program, or MMA Program), which the Court has already acknowledged "is potentially a big game changer." Tr. 7/8/2014, p. 79.[1] However, at the time that Defendants presented information about those changes, MMA had not been fully implemented; now it has. There was limited evidence about how MMA was working. Now, AHCA has the benefit of complaint and grievance reporting available to show how well the MMA Program is working.

The named Plaintiffs are exemplars of how MMA is working. The two named Plaintiffs who are enrolled in the Department of Health's Children's Medical Services (state CMS) also show how state CMS is helping to provide needed care for Medicaid enrolled children.

Effective August 1, 2014, state CMS became an MMA plan. Like other MMA plans, state CMS has a contract with AHCA which obligates it to meet all of the detailed provider network requirements imposed on other MMA plans. It is complying with its provider network requirements in a completely different manner than it did previously. State CMS has contracted with two well established Integrated Care Systems to provide its provider network. The Pediatric Care System (Ped-I-Care) is a program operating under the auspices of the University of Florida, College of Medicine's Department of Pediatrics. It operates in 51 counties in Central

[1] /References to Transcripts shall be made by use of the abbreviation "Tr." followed by the date, page number(s) and where applicable line numbers.

and North Florida. The South Florida Community Care Network (SFCCN) is a partnership of large health systems in South Florida, and operates in 16 counties, including the populous South Florida counties of Miami-Dade, and Broward counties.

As a MMA MCP, state CMS is required to and does have a number of resources which will help it to ensure that services are appropriately utilized (including the ability to conduct utilization analyses - looking at both over utilization and under utilization of services). It has the capability to receive and report on complaints about access to care on a centralized level, and, therefore, is capable of providing statistically valid and accurate date and information regarding the adequacy of patient access to care - rather than having to rely on the unsubstantiated anecdotes, and potentially biased and unsupported opinions of a relatively small number of providers about care.[2]

As is described in further detail below, the methods of service delivery have changed to such a degree that the evidence adduced at trial is so stale as to not support a finding of liability. Defendants have filed declarations and exhibits to provide the evidentiary basis for the statements made herein.

I. AHCA's implementation of Managed Medical Assistance (MMA) constitutes a substantial and significant change such that the factual record should be reopened.

A. The MMA Program - current status and monitoring initiatives

With a change in state law and approval by federal CMS, AHCA has implemented Managed Medical Assistance (MMA) statewide in Florida.[3] Supp. Dec. of Abby Riddle, dated 10/20/2014.[4] MMA is one of the two components of Florida Medicaid's new delivery system,

[2] / The potential for bias by physician and dental providers who have offered anecdotes cannot be denied, given that the remedy Plaintiffs seek (to deal with the alleged network inadequacies) is to increase their Medicaid reimbursement rates. D.E. 1172, pp. 46 & 217.
[3] / For prior filings describing MMA, *see* D.E. 1265 & 1267-1268.
[4] / To the extent that declarations referenced herein have not previously been filed, they are being filed contemporaneously with the filing of this motion.

known as Statewide Medicaid Managed Care, which Medicaid Director Justin Senior has described as a dramatic transformation of Medicaid in Florida. Dec. of Justin Senior, Medicaid Director, D.E. 1268-1, p. 2. The MMA Program covers the vast majority of children enrolled in the Medicaid program, and **all** of the individual named Plaintiffs, and provides Medicaid through MCPs. *See, e.g.*, D.E. 1267-3 & 1268-1, p. 1-2; Dec. of D. Rich dated 10/17/2014.

On July 31, 2014, federal CMS granted an extension of the MMA Waiver so that it will remain in effect until June 30, 2017. Dec. of L. Macdonald, Exh. A. The MMA program is both described in Florida Statutes (see §§ 409.961-409.977 (2014); 2014 Fla. Sess. Law Serv. Ch. 2014-57, §4) and in the CMS approved section 1115 Research and Demonstration Waiver, Number 11-W-00206/4, entitled Managed Medicaid Assistance Program Waiver (MMA Waiver).[5] D.E. 1265-1-1265-6.

As has previously been briefed, the contracts for the MMA MCPs have been extensively changed from pre-MMA managed care contracts to: (1) ensure that MMA MCPs constantly maintain provider networks that are adequate to fully meet the needs of recipients enrolled in each plan; (2) provide ongoing and verified monitoring of network adequacy; (3) provide strict enforcement mechanisms should an MCP fall short of network adequacy requirements; (4) include additional consumer protections to ensure access to needed services; and (5) minimize perceived administrative barriers for providers. D.E. 1267, p. 22.

The new MMA MCP contract terms for provider network requirements are more stringent and were developed after meetings with Miami Children's Hospital, All Children's Hospital and Nemours in November 2011, and with the Medicare-Medicaid Coordination Office to discuss their recommendations regarding provider networks. D.E. 1267-2, pp. 2-3, The network requirements include specific specialty to patient ratios (previously the only ratios were

[5] / Section 1115 refers to a section of the Social Security Act. See 42 U.S.C. §1315.

for primary care providers) that must be met, as well as maximum time and distance travel standards (previously the contracts provided only average time travel standards). D.E. 1267-2, pp. 3-4; 1265-17, pp. 76-78. Each plan must report its network on a weekly basis, and that weekly report is used to evaluate network adequacy. D.E. 1265-8, pp. 39-40.

The ability to utilize liquidated damages to enforce the requirements of the contract has greatly increased with the MMA MCP contracts, and AHCA has not hesitated to use that and its sanction authority where appropriate against MMA plans. Additionally, AHCA has used corrective action plans where appropriate to ensure compliance with the terms of the MMA MCP contracts. Supp. Dec. of A. Riddle, p. 3.

Now, six months into implementation of the MMA Program, AHCA has several important sources of information about how well the MMA MCPs are performing. Two sources of information are addressed here. First, in 2013, AHCA implemented its Statewide Medicaid Managed Care Complaint/Issues Resolution Center, also referred to as the "Complaint Hub."[6] The Complaint Hub was an initiative associated with the implementation of the Statewide Medicaid Managed Care (SMMC) Program, to allow recipients, providers, or other state agencies to pose questions, present issues, or submit complaints.[7] These queries may be submitted to AHCA through an on-line complaint form accessible through AHCA's website, or by telephone (using several available toll free numbers). Dec. of D. Rogers, p. 1-2; Dec. of E. Kidder, p. 2.

[6] / The nickname "Complaint Hub" is a misnomer, because not all queries received are actual complaints. Rather, the queries include questions, requests for information or clarification on policy, requests for training, etc. They have included such broad topics as exemption requests, provider contracting/credentialing, inquiries about whether providers are in network, concerns regarding transportation, durable medical equipment, therapy, assistive care, and billing matters. Dec. of A. Riddle, p. 3; Dec. of D. Rogers, p. 2-3; Dec. of E. Kidder, p. 2.

[7] / The SMMC Program has two components, the Long Term Care Program, not at issue here, and the MMA Waiver. §§ 409.961-409.985, Fla. Stat. (2014).

AHCA wanted to encourage affected individuals to ask questions, submit complaints or raise issues about the implementation of SMMC. It provided extensive multi-media outreach about the Complaint Hub for this very reason. In addition to providing ready access to the on-line complaint/issue form on all of the SMMC web pages, AHCA posted information on its website about how to make complaints or raise issues using toll free phone numbers. It issued nine press releases that encouraged the use of the online complaint/issue form. It also posted information on its slideshare.net website, and its YouTube page.

Additionally, AHCA conducted 84 MMA-related webinars, which all included information about how to submit a claim or issue online or by calling the local Medicaid office. There were also an additional 106 presentations or meetings related to SMMC, and for all presentations starting in August 2013, attendees and participants were encouraged to submit any complaints or issues and advised how to do so. AHCA also directly emailed information about the MMA Program on three occasions to more than 34 stakeholders including advocacy organizations and other state agencies that serve Medicaid recipients and provider organizations. Those emails contained information about how to report issues and complaints to AHCA. A theme throughout AHCA's extensive outreach to providers and to persons who deal with recipients has been the ability to file a complaint or bring an issue to AHCA's attention using either the Complaint Hub or one of the toll free numbers available for this purpose. Dec. of E. Kidder.

Once issues are brought to AHCA's attention either through the website or by telephone, they are entered into AHCA's Complaint/Issue Reporting & Tracking System (CIRTS), and then assigned to the appropriate AHCA units for researching and resolution. Generally, the issues must be triaged and entered within 24 hours of receipt, and management reports are produced

regarding these issues on a daily basis. On a weekly basis there is a reporting of issues, including any outstanding issues, with the MMA MCPs. Dec. of D. Rogers, p. 2.

Between July 2013 and September 2014, AHCA recorded only 4,303 issues involving not only the MMA Program, but also the other component of SMMC - the Long Term Care Program. However, the 4,303 issues is from all of the different sources noted above, including providers, as well as the 2.8 million recipients affected by the roll out. **Importantly, none of the issues reported was reported by or on behalf of the individual named Plaintiffs**. Dec. of D. Rogers, pp. 2-3. With the advent of the Complaint Hub (and the publicity surrounding it), AHCA has a rich data source to evaluate how MMA and the Long Term Care Program are doing.

The second source of data is the required monthly "Enrollee Complaints, Grievance and Appeals Report," which must be submitted by each MMA MCP. This report includes, among other things, the county where the grievance or complaint arose, identification of the relevant recipient, the date and type of the grievance or complaint, the date and type of appeal, the total numbers of days the grievance or appeal is open, whether it is resolved (disposed of), and how.[8, 9] These reports are reviewed by AHCA to determine whether they reflect trends or potential issues that need to be resolved. AHCA also looks at whether the reports reflect unresolved issues, and if so, the period of time the issues are unresolved. **None of the monthly reports relates to any of the individual named plaintiffs**. Review of these monthly reports is

[8] /The complaint or grievance types or categories include quality of care, access to care, emergency services, medically necessary, excluded benefit, billing/claim dispute, enrollment/disenrollment, out of plan services authorization, in plan services authorization, experimental/investigation, and pharmacy benefits. Exhibit A to Supp. Dec. of A. Riddle.

[9] /The types of dispositions or resolutions include referral made to specialist, PCP appointment made, claim paid, procedure scheduled, reassigned PCP, reassigned center, referred to Area Office for non-plan benefit, unable to contact member, member withdrew grievance/appeal, confirmed original decision, benefit/pharmacy approved, LTC Program issue. Exhibit A to Supp. Dec. of A. Riddle.

just one way that AHCA is presently monitoring plan performance. Supp. Dec. of A. Riddle, pp. 2-3.

As addressed previously, the legislatively established policy about MMA plan assignments is different than the plan assignment policy that existed prior to MMA. Now, if a recipient must be automatically enrolled (because they have not chosen an MMA plan despite the repeated plan assignment correspondence sent to their last known address), there are certain mandatory criteria which must be considered, including:

1. Whether the plan has sufficient network capacity to meet the recipient's needs;

2. Whether the recipient has previously received services from one of the plan's primary care providers; and

3. Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

§ 409.977(2), Fla. Stat. (2014). Also, newborns are deemed enrolled in the MMA MCP of the mother, if she is enrolled in a plan at the time of the birth. The MMA MCP is responsible for providing Medicaid services to the newborn, unless and until the mother chooses a different plan for the baby. § 409.977(3), Fla. Stat. (2014).

Certain programs about which Plaintiffs presented evidence at trial no longer exist, such as the following programs: the Florida MediPass Program, Prepaid Mental Health Program, and Prepaid Dental Health Plans. § 409.912(4) & (41), Fla. Stat. (2014); § 409.9122, Fla. Stat. (2014). Since MediPass no longer exists, the phenomenon of switching from MediPass to an MMA MCP is no longer possible. There is no evidence in the record about any of the MMA plans, in terms of access to or quality of care provided to Florida Medicaid children.

B. Named Plaintiffs

A. Plan Selection/Assignment

All but two of the individual named Plaintiffs' parents specifically selected a MMA MCP for their child as part of the plan selection process. K.K.'s mother, A.D., expressly selected Staywell as her plan of choice using the enrollment broker, despite the fact that, at trial, A.D. claimed she had been coerced by a Staywell representative to select Staywell previously and even though there were four MMA plans in her Region that were open to all Medicaid recipients. K.K.'s enrollment in Staywell took effect on June 1, 2014. Dec. of D. Rich, p. 3.

In April 2014, N.V.'s mother, K.V., initially chose United as N.V.'s MMA MCP through the online portal, but decided to change plans in July 2014. She then sought to change his plan to the state CMS MMA MCP, but N.V. had not been determined eligible for state CMS (without that determination, he could not be enrolled in the state CMS MMA MCP). K.V. applied to have N.V.'s state CMS eligibility determined (this is discussed further below in the section relating to DOH), but he has not been determined to be eligible for CMS. His mother chose the Sunshine MMA MCP as her second option for N.V. Effective September 2014, N.V. was enrolled in Sunshine. Dec. of D. Rich, p. 4-5.

J.W. was enrolled in the Integral MMA MCP, effective July 1, 2014, based on his guardian's choice made through AHCA's enrollment broker. L.C. was enrolled in Amerigroup MMA MCP, based on his mother's selection of the plan on May 19, 2014. J.S. was enrolled in the Molina MMA MCP based on her mother's selection of the plan through the online enrollment portal. Dec. of D. Rich, p. 3.

N.G. is the only individually named Plaintiff who is not a mandatory enrollee in MMA, because he resides in a developmental disabilities group home. However, his mother opted to enroll him in the state CMS MMA MCP, effective August 1, 2014. N.R. was transitioned to the

state CMS MMA MCP, also effective August 1, 2014, because he was previously enrolled in state CMS. Dec. of D. Rich, p. 3.

Only S.M. was automatically assigned to a MMA MCP, Staywell. Before his actual enrollment date (May 1, 2014), three letters were sent to S.M.'s parent about the MMA MCP options available to him, and explaining how to choose a plan. Nonetheless his parent did not choose a plan, and he is now in the Staywell plan. Dec. of D. Rich, p. 4.

B. Services Provided to Plaintiffs

By way of an update regarding the individual Plaintiffs, since the trial ended, each child has had at least two primary care (PCP) visits, and half of the plaintiffs had 17 or more separate office visits. Dec. of K. Chang, pp. 3-4 & Exhibit A. According to claims analysis, half of the individual plaintiffs had qualifying EPSDT screens. Dec. of K. Chang, p. 4 & Exhibit C.

Regarding specialty care, claims data shows that J.S. has seen an allergist twice and an orthopedic surgeon once. Dec. of K. Chang, pp. 4-5. J.W. continues to receive necessary radiology care. K.K. has received specialty pediatric treatment. N.R. has seen an ophthalmologist six times since February 2012. N.G. has been seen by an ophthalmologist once and an orthopedic surgeon twice. N.V. has been seen by a pediatric oncologist twice, a gastroenterologist twice, an otolaryngologist twice, and a pulmonary disease specialist three times. Dec. of K. Chang, p. 5.

All of the individual plaintiffs were eligible to receive their dental services through the prepaid dental plan, before being enrolled in an MMA MCP. Claims data shows that both N.V. and N.G. received specialty dental services, however. N.G. was treated by a pedodontist on three separate dates and N.V. was seen by a pedodontist twice. Dec. of K. Chang, p. 3 & Exh. B.

Further, while the encounter data is not complete, the available data shows that named Plaintiffs are receiving services through their MMA MCPs. For example, L.C. has filled prescriptions since enrolling in Amerigroup, effective July 1, 2014. K.K. has visited a pediatrician and had a medication filled. N.V. has received hospital outpatient services, prescription medications, PCP visits, and specialty care visits with a pulmonary disease specialist. J.S. has had prescriptions filled. Dec. of K. Chang, pp. 5-6 & Exh. J-M.

Since the trial there have been a multitude of significant changes to the Florida Medicaid service delivery system that affect the issues in this case, and that render the existing record on liability stale. The named Plaintiffs are excellent exemplars of those changes. For all of these reasons, the record on liability should be reopened to allow presentation of current evidence as to the claims against AHCA to incorporate the changes in the MMA program.

II. DOH's implementation of Managed Medical Assistance (MMA) constitutes a substantial and significant change such that the factual record should be reopened.

A. There have been substantial changes in the way that state CMS provides services to Medicaid eligible children.

At the time of trial, state CMS was responsible for providing services to Medicaid enrolled children with special healthcare needs, through a provider network which it established and coordinated. Services were provided through a combination of CMS specialty care clinics and private office visits. Now that state CMS is a MMA MCP, it has become an insurer and no longer is in the business of providing specialty and dental care services. It is now principally a payer *vis a vis* doctors and dentists. While it still provides care coordination, the responsibility for maintaining an adequate provider network is now the responsibility of one of two Integrated Care Systems ("ICS"), Pediatric Integrated Care System (Ped-I-Care), which operates in 51

counties for state CMS, and South Florida Community Care Network (SFCCN), which operates in 16 counties. Dec. of M. Vergeson, p. 2.

Both Ped-I-Care and SFCCN now have the responsibility for many functions, some of which state CMS provided in 2010-2012, such as: provider relations, recruitment and retention; member services; service authorization; utilization management; and, the receipt and resolution of complaints. *Id;* and Exh. A & B to Dec. of M. Vergeson. Regarding provider network, each ICS is required to have a dedicated toll free number so that they may reach a representative to learn how to become a provider, obtain technical assistance, and obtain answers to questions about covered services, authorization requirements and health plan services. *Id.*, pp. 2-3.

Regarding provider recruitment and retention, the ICSs are responsible to provide a network which meets contractual standards - including specialty physician and dentist specific patient to provider ratios, and time and distance travel standards set for urban and rural counties. The ICSs are required to produce weekly reports on new and terminated providers, which will permit CMS to monitor changes in the provider networks. *Id.*, p. 3.

Members of the state CMS MMA MCP receive a standard packet of materials on enrollment, including a member handbook and a provider directory for their region. The member handbook describes covered services, and provides, among other things, contact information for care coordinators. The same information is also available on-line and is updated on a weekly basis. Additionally, there is a nurse hotline available 24 hours a day, 7 days a week. *Id.*, p. 3.

As a courtesy to state CMS clients, they have extended the period applicable to the contractual continuity of care provisions for another 60 days, or until November 30, 2014. This means that the state CMS MMA MCP will continue to honor any service authorizations

previously received or any ongoing treatment plans through November 30, 2014. Additionally, state CMS has eliminated the referral requirement to access specialty care. *Id.*, pp. 3-4.

Although during the trial, state CMS did not have any centralized, standard system for the payment of claims, it has now retained MED 3000 as a third party administrator ("TPA") to pay claims. *Id.*, at pp. 5-7. Important to providers, the TPA will handle claims resolution and technical assistance to providers. There are also stringent provisions in the state CMS MMA contract for claims processing, with which the TPA must comply. *Id.*, pp. 6-7. The TPA will also provide for electronic health records for state CMS children, allowing care coordinators and physician and dental providers to quickly access information needed to ensure that the children's needs are met. *Id.*, p. 6.

The TPA will facilitate reporting on performance measures, using nationally developed HEDIS measures. The TPA data will also facilitate a level of monitoring and oversight that state CMS has never had before. *Id.*, p. 6.

With MMA, the role of the state CMS central office in Tallahassee has changed. *Id.* at 7. It is able to focus on monitoring activities, such as provider network compliance, as well as quality management. It has the capability to better manage utilization and coordination of all services. In the past, state CMS was responsible for one aspect of the healthcare of Medicaid eligible children with special healthcare needs. Now, it is a one-stop shop, and it provides a fully integrated and comprehensive system of care, including not just medical care, but also behavioral, dental, and pharmaceutical services. *Id.*, p. 7.

State CMS now has a statewide, comprehensive quality improvement system that includes the vendor partners and, ultimately, the primary and specialty providers. This should yield better outcomes for children. *Id.*, at 7. State CMS also performs regular statewide

satisfaction surveys of members and providers using national standards. The survey results should allow CMS to have a more comprehensive picture of its healthcare delivery system, enabling it to adjust or change aspects as needed. *Id.*, at 8.

B. The named Plaintiffs

Two individual plaintiffs, Nathaniel Gorenflo and N.R., are enrolled in the state CMS MMA MCP. Effective August 1, 2014, Nathaniel and N.R. have both successfully transitioned from the old state CMS program to the state CMS Managed Medical Assistance plan. (Dec. of J. Hollis and P. Dorhout). Based on an examination of medical records and documented interactions, the recent transition to the state CMS MMA plan has resulted in no issues in accessing medical care for both individual plaintiffs. Dec. of J. Hollis at p. 2; Dec. of P. Dorhout at p. 2-3.

Further, since February 2012, Mr. Gorenflo and N.R. have had many documented interactions with their care providers and state CMS nurse care coordinators. *Id.* Mr. Gorenflo has a dentist and is regularly receiving dental checkups. P. Dorhout at p. 2. State CMS also provides for his behavioral/mental health treatment. *Id.* There have been no complaints from Mr. Gorenflo or his mother regarding his ability to access medical care, whether from specialty or primary care providers. *Id.*

N.R. received a well-child checkup or EPSDT screen in November 2013 and regularly visits the ophthalmologist. J. Hollis at p 2. At N.R.'s annual assessment, it was also reported that his primary care physician is adequately managing his medical needs. *Id.* State CMS coordinates the delivery of speech therapy services to N.R. through his school district. *Id.* Finally, there have been no complaints regarding N.R.'s ability to access medical care from N.R. or his guardian. *Id.*

Another named Plaintiff, N.V., applied to become a state CMS client during the transition to the state CMS MMA MCP. However, when state CMS attempted to determine clinical eligibility, the telephone contact provided for N.V.'s mother was no longer in operation. As a result, state CMS was not able to complete the eligibility determination. Dec. of J. Ryan.

In sum, there have been a variety of significant and substantial changes relating to the administration of state CMS, such that the existing record is stale and will not support a present finding of liability.

Memorandum of Law

A. The facts and circumstances of this case justify reopening the record.

This Court has the authority to reopen the record after the parties have rested, when new evidence exists, even in the absence of a rule expressly authorizing this. *See, e.g., Caracci v. Brother International Sewing Machine Corp. of La.*, 222 F. Supp. 769 (E.D. La. 1963), *aff'd by* 341 F.2d 377 (5th Cir. 1965).[10] In *Caracci*, after the close of the trial but before a decision was rendered, defendant argued that there was no evidence to support compensatory damages. The plaintiff moved to reopen the case, and the court agreed to allow submission of the missing evidence. The court noted that a motion to reopen the record made before any indication of the court's decision would be considered more favorably than would be the case if a decision has been rendered (even if findings of fact and conclusions of law had not been formally entered). Regarding the lack of any rule authority, the court stated:

> Even though there is no express statutory provision of substantive law specifically allowing the reopening of a trial, the court finds that such has become a rule of law supplied by jurisprudence. It appears to be a cannibalization of those qualities found in Rules 59 and 60, Federal Rules of Civil Procedure . . . .

[10] / In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981), the Eleventh Circuit adopted as binding precedent all decisions handed down by the former Fifth Circuit before October 1, 1981.

222 F. Supp. at 771. The Court further noted that "the purpose of [a motion to reopen the record] is to seek the right to offer additional evidence before the Court has reached a final decision thereon, so that the Court may have all of the facts upon which it can render full justice on the merits of the plaintiff's cause of action." 222 F. Supp. at 771.

In *In re United Refuse L.L.C.*, No. 04-11503-RGM, 2007 WL 1695332 (E.D. Va. Bankruptcy Jun., 7, 2007), the court applied similar standards to a motion to reopen record as would govern a motion brought under Rule 59, Fed. R. Civ. P., stating:

> A motion to reopen a case to present additional evidence considers similar factors. A court should consider the diligence of the movant. The proffered evidence should not be cumulative. It should affect the outcome of the case by, for example, offering a new theory of liability or present a significant alteration of the evidence presented at trial. The prejudice to the opposite party resulting from the delay in discovering the proffered evidence should be considered. The court should consider whether the decision has been announced.

2007 WL 1695332 *3.

Yet another authority concludes that the standards applicable to Rule 59 or Rule 60(b) motions do not fully apply to a motion to reopen the factual record made on other grounds. "Although similar to a Rule 59 or Rule 60(b) motion based on newly discovered evidence, a motion to reopen does not require that the evidence be newly discovered or that it could not have been discovered during the pendency of the trial by a party acting with due diligence." 12 JAMES WM. MOORE ET AL., MOORE'S FEDERAL PRACTICE, § 59.13(3)(c) (3d Ed. 2013). "Further, the Court must decide the motion in the interests of fairness and justice." *Id*.

This Court should exercise its discretion to reopen the record to allow submission of the substantial and significant new evidence described herein (and further detailed in the previously filed Supplement to Suggestion of Mootness, D.E. 1267). Here, the evidence at issue is such that it could not have been presented prior to the close of trial, because the evidence is about events

that have occurred since trial. Also, many of the events were the result of changes in federal law (the ACA), changes in state law, and the need for federal approval before implementing a section 1115 Waiver (as amended).[11] While Plaintiffs may be expected to argue that the delay in presentation of this evidence prejudices them (because they continue to wait for increased reimbursement rates), there is no evidence of a delay on the part of Defendants in discovering the proffered evidence. Rather, this is a circumstance where evidence has only become available through the changes in law and action by federal CMS. Therefore, this factor should not weigh against reopening the record. Finally, the Court has not announced a decision. The evidence presented clearly may change the Court's mind on liability. For all of these reasons, the Court should exercise its discretion to reopen the record on liability.

WHEREFORE Defendants move this Court to reopen the record in this case to allow Defendants, after appropriate discovery, to present evidence of the substantial changes in the operation of the Florida Medicaid program as they affect children, including the changes in the way that services are provided to children who are Medicaid recipients and enrolled in the CMS MMA MCP.

CERTIFICATE OF CONFERRING WITH OPPOSING COUNSEL

On October 22, 2014, the undersigned emailed Stuart Singer and Carl Goldfarb, counsel for Plaintiffs, seeking their position on this motion. The same day, Mr. Singer emailed the undersigned stating: "Please send us the motion if you would like us to take a position as we have no idea based on your email as to the alleged grounds." The undersigned emailed Mr. Singer in return, providing a brief summary of the grounds for this motion and the accompanying motion that was filed by the official capacity agency head of DCF, as follows:

[11] / The reference to the section 1115 Waiver is to a provision of the Social Security Act codified at 42 U.S.C. § 1315.

> The basis for the motion is the substantial and significant changes across all three state agencies in the way Medicaid services are delivered and eligibility is determined, due to implementation of the 1115 waiver and the ACA (as it relates to Medicaid eligibility).

On October 23, 2014, Mr. Singer responded, advising that Plaintiffs could not consent to this motion for two reasons. Mr. Singer contended that Defendants had not provided any meaningful information regarding the substantive basis for the request (which Defendants dispute), and Mr. Singer objected to the timing of the motion, one week before the Court indicated it would issue findings. As to Mr. Singer's latter objection, Defendants have been working diligently to compile all of the affidavits and evidence which is filed with this motion, and believe that this record will support Defendants' diligence.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been served by Notice of Electronic Filing on Stuart H. Singer, Esq., Carl E. Goldfarb, Esq., Damien J. Marshall, Esq., and Sashi Bach Boruchow, Esq., Boies, Schiller & Flexner LLP, 401 East Las Olas Blvd., Suite 1200, Fort Lauderdale, FL 33301, and Robert D.W. Landon, III, Esquire, Kenny Nachwalter, P.A., 201 South Biscayne Boulevard, 1100 Miami Center, Miami, Florida 33131-4327; and by United States Mail on Benjamin D. Geffin, Esq., Public Interest Law Center of Philadelphia, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103; and Louis W. Bullock, Esq., Bullock, Bullock, & Blakemore, 110 W. 7th Street, Tulsa, Oklahoma 74112, on October 23, 2014.

/s/ Stephanie A. Daniel
Stephanie A. Daniel