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.
_____/

DEFENDANTS' MOTION TO AMEND OR ALTER FINDINGS OF FACT CONTAINED IN THE COURT'S DECEMBER 30, 2014TH FINDINGS OF FACT AND CONCLUSIONS OF LAW

Defendants, all sued in their official capacities as the heads of the AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA), DEPARTMENT OF HEALTH (DOH), and DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCF), pursuant to Rule 52(b), Fed. R. Civ. P., move this Court to amend or alter its findings of fact contained in the Findings of Fact and Conclusions of Law issued on December 30, 2014 (hereafter "Findings"). Defendants further state as follows:

Pursuant to Rule 52(b), Fed. R. Civ. P., on a timely motion, the Court may alter or amend its findings of fact. In the instances cited below, the Court's findings have no factual support in the record, and, therefore, must be altered or amended. Moreover, these findings reflect a more fundamental misunderstanding of the evidentiary record and the respective responsibilities of the

named Defendants. The errors cited below call into question the reliability of the findings as a whole.

The result of the requested alterations and amendments below is that no named Plaintiff has proven standing to bring the claims asserted in Count II against AHCA or DOH. Further, Plaintiffs failed to prove their standing to bring the claims asserted in Count I to the extent that any delay in obtaining care is alleged to be due to inadequate reimbursement rates. Finally, no named Plaintiff has proven standing to sue DCF for the claims asserted in Count IV. The following describes the findings that must be altered or amended because they lack any evidentiary support:

a. The Court erroneously found that Plaintiffs proved the standing of S.M. to sue DCF under Count IV (the outreach claim). Findings, pp. 13 and 18. While the Court concluded that "S.M.'s mother was never informed that she was entitled to dental services," and that she "was unaware that she was entitled to free transportation services through Medicaid," (Findings, pp. 13 and 18), there was no evidence presented to establish that DCF was in any way responsible for informing S.M. about the availability of dental or transportation services covered through Medicaid. The only evidence the Court had relating to outreach, in terms of who had responsibility for it, was a Legislative Budget Request submitted by AHCA, not DCF, which sought funding and implementing language to authorize AHCA (not DCF) to conduct KidCare outreach. PX 100. Having said this, AHCA does not concede that the trial record established inadequate outreach to S.M. or K.K., or, more importantly, that there will be ongoing violations of federal law with respect to outreach relating to Child Health Check Up services. (AHCA continues to maintain its argument that 42 U.S.C. § 1396a(a)(43) does not create an enforceable right to outreach.)

Pursuant to federal law, it is the single Medicaid state agency (AHCA) that has the responsibility for outreach (assuming for argument purposes that there is an enforceable right to outreach, which Defendants have previously contested). 42 C.F.R. § 441.56(a). By state law, DCF is only responsible for Medicaid eligibility determinations, including, but not limited to, policy and rules. § 409.902(1), Fla. Stat.; s*ee also* §§ 409.961, 409.963, Fla. Stat. (describing DCF's limited responsibilities under MMA). While under the old Medicaid Managed Care, DCF statutorily had a shared responsibility to provide certain specified information about managed care plans to Medicaid enrollees , it no longer has this responsibility. Section 409.9122(2)(c), Florida Statutes (Mandatory Medicaid managed care enrollment; programs and procedures), which contained this requirement, expired on October 1, 2014. § 409.9122(2)(c), Fla. Stat. (2014); Ch. 2014-19, § 209 at 442, Laws of Fla. (2014). No provision of the MMA statutes in any way authorizes, let alone requires, DCF to provide outreach to anyone regarding Medicaid. *See* §§ 409.961-409.977, Fla. Stat.

Given the lack of evidence that DCF has responsibility for outreach about dental or transportation services (or Medicaid coverage), the Court should amend or alter its findings to conclude that DCF has no responsibility to provide outreach about dental or transportation services to Medicaid enrollees. Further, the Court should find that Plaintiffs lack standing to sue DCF under Count IV.

b. The Court erroneously found that L.C. has standing to assert a claim for inadequate access to care against DOH. Findings, pp. 13 and 18. The Court's finding regarding standing was based on the following factual findings:

> DOH failed to satisfy its duty to ensure that a sufficient amount of psychologists that accepted Medicaid was available in L.C.'s area. As a result, DOH is responsible for L.C.'s lack of access to medical care. There is a realistic danger that L.C. will not have equal access to psychiatric services in the future as

> compared to those that are privately insured because DOH has a policy of setting inadequate reimbursement rates.

Findings, p. 13. There is no evidence in the record that DOH had any responsibility to ensure that L.C. had access to care by psychologists or psychiatrists. The record is devoid of any evidence that DOH had any responsibility for providing any services to L.C. or for ensuring that L.C. had access to any services. It is unclear why the Court concluded that L.C. had been harmed in any way by DOH. There simply is no evidence to support such a conclusion. S.C.'s testimony (S.C. is L.C.'s mother) is devoid of any reference to DOH, any DOH employee, or any DOH programs. Testimony of S.C., 1/11/2010, 1309:1-1386:3. No evidence was presented that L.C. was a client of DOH's Children's Medical Services Program (CMS), and he was not.

Unlike regular Medicaid eligibility, to be a CMS client also requires a determination of medical or clinical eligibility that must be made by DOH (at the request of the parent or guardian). § 391.026(3), Fla. Stat. (2013). Also, eligible individuals seek services from the program. *Id.* CMS is not responsible for providing care to every Medicaid eligible child who might have a special health care need - unless they seek care from CMS. In the "application" section of DOH's CMS rules, the methods of determining eligibility are described - but the eligibility determination process begins with an application made to CMS. Chap. 64C-2, Fla. Admin. Code. There is no record evidence that L.C.'s mother ever asked DOH to provide services for L.C., or applied to CMS for an eligibility determination (or whether he would meet the CMS eligibility requirements). Therefore, the Findings should be amended to state that L.C. is not a CMS client and that there is no record evidence that L.C. ever sought to become a CMS client. The Findings also should be amended to reflect that there is no evidence that DOH was responsible for ensuring that L.C. had access to any psychologists or psychiatrists. The Court should further conclude that there is no evidence in the record below to establish that L.C. was

ever injured by any act or omission of the DOH. Finally, the Court's findings should be corrected to state that L.C. does not have standing to assert Count II against DOH. See Findings, pp. 13 and 18.[1]

c. The Court erroneously found that K.K. had standing to sue DOH for inadequate access to care. Findings, pp. 14 and 18. The Court stated, in part:

> . . . Staywell did not have a sufficient amount of ENT specialists on its panel in the metropolitan area of Fort Myers. This is a result of DOH 's failure to set sufficient reimbursement rates as required by 42 U.S.C. § 1396a(a)(30)(A).

Findings, p. 14. There is no evidence in the record that DOH has anything to do with reimbursement rates paid to or by Staywell. In fact, the testimony about rates paid to managed care entities like Staywell reveals that it is AHCA, and not DOH, that is responsible for setting capitation rates paid to HMOs. 10/12/2011 Testimony of P. Williams, 8597:24-8604:2. However, there is no evidence in the record that Staywell paid its providers at the Medicaid Fee for Service rate schedule (or was required to do so). There is also no evidence in the record that the capitation amount paid by AHCA to Staywell was inadequate to ensure network adequacy (or to ensure an adequate number of ENT providers). There is no evidence in the record of what Staywell paid its ENT providers in Fort Myers.

The record is devoid of any evidence that DOH had any responsibility for providing services to K.K. or for ensuring that K.K. was provided any services. It is unclear why the Court concluded that K.K. had been in any way harmed by DOH. There is simply no evidence to support such a conclusion. A.D.'s testimony (A.D. is K.K.'s mother) is devoid of any reference to DOH, any DOH employee, or any DOH program. No evidence was even presented that K.K. was a CMS client. There is no record evidence that K.K.'s mother ever sought services for K.K.

[1] / Interestingly, the Court's more detailed findings regarding L.C. contain no reference to DOH. Findings, pp. 40-43.

from CMS or requested a CMS eligibility determination. Also, there is absolutely no record evidence that a request was made for a determination that K.K. is a child with special health care needs, which is a requirement for CMS program eligibility. § 391.029(2)(b), Fla. Stat. (2013).[2] See 8/12/2010 testimony of A.D., 4040:18-4108:25; 1/25/2012 Rough Trial Transcript of A.D. 54:11-76:1. Further, K.K. failed to establish standing to sue AHCA for the reasons set forth in paragraph g below.

The Court should alter or amend its findings of fact relating to K.K. to find that K.K. was not a client of CMS, and, that there is no record evidence that he ever applied to become a client of CMS. The Court should further alter or amend its findings of fact relating to K.K. to reflect that DOH had no responsibility to ensure adequate numbers of ENT specialists in the Medicaid HMO, Staywell. The Court should further find that the record shows no injury sustained by K.K. as a result of any act or omission of DOH. Finally, the Court should revise its determination that K.K. has standing to sue DOH.

d. The Court erroneously found that K.K. had standing to sue DCF under Counts 1 and IV. Findings, pp. 14 and 18. After finding that A.D. voluntarily switched K.K. to Staywell, Findings p. 44 ¶ 28, the Court found that, in 2011, after a valid break in K.K.'s regular Medicaid (because his mother's income exceeded eligibility requirements), his mother lost her job again, and K.K. once again became enrolled in Medicaid. Findings, p. 46, ¶ 32. The Court found that K.K.s mother selected Medipass, but that "Medicaid" assigned Staywell as K.K.'s provider. Findings, pp. 14 and 46 ¶ 32. However, there is no evidence that DCF has any authority to

[2] / As was the case with L.C., the Court's more detailed findings regarding K.K. make absolutely no reference to DOH.

make plan assignments. That is AHCA's responsibility.[3] §409.9122(2)(a), Fla. Stat. (2013) ("the agency shall enroll in a managed care plan or MediPass all Medicaid recipients . . .").

There is no evidence in the record to show that K.K.'s assignment to Staywell in 2011 (when the Court found that K.K. was assigned without his mother's knowledge or consent, Findings, pg. 14), was caused by any act or omission of DCF. Specifically, there is no record that DCF made an error in changing K.K. from medically needy Medicaid in which he was enrolled to regular Medicaid. A.D.'s testimony, Rough Trial Transcript, 1/25/2012, 69:25-70:15, 70:23-71:1. Rather, K.K.'s new enrollment in regular Medicaid (after a break in regular eligibility because of his mother's income) triggered a plan assignment process.

The Court also should alter or amend its findings regarding K.K. to address the fact that DCF had no responsibility for K.K.'s assignment to Staywell, and that it is AHCA, not DCF, that was responsible for assigning K.K. to Staywell. Further, nothing in the foregoing is meant to suggest that Defendants agree that Plaintiffs have demonstrated standing to sue AHCA over K.K.'s assignment to Staywell in 2011, or that Plaintiffs will be able to prove an ongoing violation of federal law with respect to their claims of "switching."

Likewise, there was no evidence presented that DCF would be responsible for ensuring that A.D. was aware of the fact that K.K. was entitled to dental coverage through Medicaid, for the reasons described above in part a, with respect to S.M. Therefore, the Court should amend or alter its findings to determine that DCF was not responsible for providing outreach to K.K. regarding coverage for any Medicaid Child Health Check Up Services (including dental

[3] / DCF's sole responsibility relating to managed care was previously to provide "clear and easily understandable information about managed care plans." § 409.9122(2)(c), Fla. Stat. (2014) (as noted herein, this subsection has been repealed). A.D. did not testify that any information provided to her about managed care plans was not easy to understand. Rather, it appears that her son's assignment to Staywell in 2011 was the result of an unexplained error. She testified that she requested MediPass, as the Court found. Findings, p. 46 ¶ 32. Instead, she was apparently assigned to Staywell, and there is no evidence that this assignment to Staywell was due to any act or omission of DCF.

services). The Court should further find that the record shows no injury sustained by K.K. as a result of any act or omission of DCF. Finally, the Court should find that K.K. lacks standing to sue DCF.

e. The Court erroneously found that J.S. had standing to sue DOH (Findings, pp. 15 and 8) in the absence of any record evidence that J.S. had ever become a client of DOH or CMS, and in the absence of any evidence that J.S. ever sought services from CMS or DOH. As was the case with L.C. and K.K., J.S.'s mother never mentioned DOH or CMS in her testimony. 5/17/2010 Testimony of K.S., 1953:18-2024:3. There is no evidence in the record that J.S. ever sought services from CMS or sought a determination that she was eligible for services through CMS.[4]

Defendants request that the Court alter or amend its findings to state that J.S. is not a CMS client, and that there is no record evidence that J.S. ever sought to become a CMS client. The Findings should be amended to reflect that there is no evidence that DOH was responsible for ensuring that J.S. had access to any medical or dental care. The Court should further conclude that there is no evidence in the record below to establish that J.S. was ever injured by any act or omission of the DOH. Finally, the Court's findings should be corrected to state that J.S. does not have standing to assert Count II against DOH. See Findings, pp. 15, 18.

f. The Court erroneously found that J.W. had standing to assert Count I against DCF. Findings, pp. 17-18. The Court drew this conclusion based on its determination that "ACHA and DCF switched J.W.'s primary care physician," and that, as a result, "ACHA and DCF are responsible for improper switching." Findings, p. 17. However, the evidence about DCF's responsibility for switching dealt with (1) switching from MediPass to a managed care

[4] / As was the case with L.C. and K.K., the more detailed findings of the Court make no reference to DOH or CMS. Findings, pp. 50-52.

provider (or from a managed care provider to MediPass); but only (2) in the context of certain specified activities during the Medicaid eligibility process that were generally identified as potential causes of such switching. Neither agency was identified as the cause of J.W. being switched. The general activities that could lead to switching included: an incorrect termination of a child's eligibility followed by reinstatement (which causes AHCA's FMMIS to treat the child as if it is a new enrollee); when the parents make a change, such as applying for food stamps or cash assistance, that may cause switching (because reportedly while the child does not lose eligibility in DCF's system, it may lose eligibility in AHCA's FMMIS system); and when DCF deletes a coverage category for a child and places the child in a new eligibility coverage category, AHCA sometimes interprets that change as a termination of eligibility (a situation that DCF has remedied by instructing workers not to close the old coverage category without also opening the new coverage category at the same time). Findings, pp. 69-71, ¶¶ 115, 118-120.

However, there is no record evidence that any of these things that **might** cause switching, actually occurred to J.W. Specifically, there was no evidence presented that, prior to the change in the assignment of his primary care physician, J.W. had his Medicaid eligibility terminated or interrupted. There is no evidence that he had any changes in coverage categories during that time period (in fact, months earlier he was only newly eligible to Medicaid). DX 5, p. 14.[5] There is no evidence that there were any food stamp or other financial assistance actions that would affect his eligibility in FMMIS. There was no evidence in FMMIS' records that anything occurred which would cause any change in J.W.'s plan assignment. *Id.*

[5] /DX is a screen shot from the Florida Medicaid Management Information System (FMMIS) which shows that, as of 12/7/2007, J.W. had been in the same Medicaid eligibility category (MMC) since February 1, 2005. The screenshot shows no interruptions or changes in the eligibility span, in contrast to what appears in S.M.'s FMMIS screen shots. Compare, DX 73.

The Court seems to have assumed, without record evidence, that if switching occurs, DCF must always be responsible. This assumption is not possible to reach in J.W's case. The change in J.W.'s primary care providers was made by his chosen managed care plan, Healthease. E.W. testified that she chose Healthease for her son. He was not "switched" to Healthease. Deposition of E.W., 97:8-12.

Likewise, there is no record evidence to establish AHCA's responsibility (by policy or otherwise) for J.W.'s assignment to a different primary care physician, and, therefore, there is no evidence proving that J.W. had standing to sue AHCA under Count I. Plaintiffs presented no evidence that would establish causation for AHCA related to J.W.'s assignment to the new primary care physician. There is no evidence of any act or omission by AHCA related to J.W.'s assignment to a new primary care physician in 2005. *See Record*. There also is no factual basis for an inference that AHCA is somehow responsible. The record only shows that after E.W. selected Healthease as J.W.'s managed care plan, Healthease, and not AHCA, assigned J.W. to a different managed care provider. See Deposition testimony of E.W., 18:21-22; DX 8. At a minimum, there must be evidence that AHCA did or did not do something which caused Healthease, J.W.'s selected plan, to assign him to a new primary care physician.

For these reasons, the Court should amend its findings to find that no evidence was presented to establish that DCF took any action with respect to J.W.'s Medicaid eligibility which caused any change in his primary care physician in 2005. Further, the Court should amend its finding to state that no evidence was presented that ACHA caused Healthease to change J.W.'s primary care physician. That being the case, the findings also should be revised to show that J.W. lacks standing to sue DCF or AHCA relating to any change in his primary care physician made by Healthease in 2005.

g. While the Court concluded that L.C., K.K., J.S., and N.V. had standing to sue AHCA and DOH in Count II (Findings, pp. 13-18) for inadequate access to care under 42 U.S.C. §1396a(a)(30)(A), it did so in the absence of any evidence from any provider for any of these individuals that the reason that there were difficulties in obtaining care was because Medicaid reimbursement rates were too low. The same is true with respect to Plaintiffs' claims that they were unable to obtain care with reasonable promptness due to inadequate reimbursement rates to providers (Count I). The Court concluded that "while reimbursement rates are not the only factor determining whether providers participate in Medicaid, they are by far the most important factor." Findings, p.149; *see also* Findings, p. 129 ¶ 300 (making a similar finding with respect to dentist rates). However, that conclusion and Finding of Fact 300 are not supported by evidence regarding what actually motivated the providers who interacted with L.C., K.K., J.S., or N.V.[6] Plaintiffs presented evidence about what generally causes providers not to accept Medicaid; but they presented no evidence from any of the providers with whom Plaintiffs interacted to prove that any of them were motivated by low reimbursements to decline to accept Medicaid or to make Medicaid enrolled children wait for services. Plaintiffs had the burden of presenting evidence at trial that the policies they challenged (physician reimbursement rates set in a budget neutral manner that were below Medicare rates, and dental reimbursement rates which were below the 50th percentile of usual and customary charges) actually "caused" a deprivation to the named Plaintiffs. *See, e.g.*, *Fullman v. Graddick*, 739 F.2d 553, 563 (11th Cir. 1984) (affirming dismissal at the pleading stage because Plaintiff failed to plead that a policy *caused* the deprivation of plaintiff's civil rights). Stated otherwise, it was the named Plaintiffs' burden to prove that their injury (inadequate access) was fairly traceable to the inadequate

[6] / Two providers who interacted with K.K. and N.V. respectively testified by deposition, Dr. John D. Donaldson and Dr. Howard Schneider. Neither testified that his treatment decisions regarding either child were caused by low reimbursement rates.

reimbursement rates. *Accord, Elend v. Basham*, 471 F.3d 1199 (11th Cir. 2006) (finding that the causation requirement was satisfied because Plaintiffs' alleged First Amendment injury was fairly traceable to the purported Secret Service practice or policy). Plaintiffs failed to present any such evidence to the Court. The Court can only speculate that the reason why specific providers would not care for these named Plaintiffs at all or in a timely fashion was reimbursement rates. There is no evidence in the record that this was the actual cause of any access issues found by the Court.

While in the abstract, both Drs. Flint and Crall testified to factors which influenced physician and dentist provider decisions to participate in Medicaid, and the Court found that, based on their testimony, reimbursement rates were the most important factors - their testimony fails to prove that reimbursement rates were the factor which influenced participation decisions made by the providers who interacted with L.C., K.K., J.S., N.V., and their parents. That required testimony by their providers (expert testimony about what generally caused providers to decline to accept Medicaid would not be admissible). While general causation testimony might be useful for the Court to understand what might affect other providers in their decisions to treat Medicaid patients, specific causation testimony should have been presented from the actual providers for Plaintiffs; yet it was not. This is a critical defect in Plaintiffs' proof, because the lack of causation also means that these named Plaintiffs failed to demonstrate standing. Part of Plaintiffs' burden of proof was to show that the injuries to the named Plaintiffs (whether delays in or denials in access to care) were fairly traceable to the policies of AHCA or DOH. They failed to sustain their burden.

There are certain types of testimony which are not appropriate subject matter for expert testimony. What motivates a particular person or entity is generally not an appropriate subject

matter for expert testimony. *RFMAS, Inc. v. So*, 748 F.Supp.2d 244 (S.D. N.Y. 2010) (finding that testimony about why Nieman Marcus reduced its purchases of plaintiffs' jewelry was not appropriate for expert testimony); *Linde v. Arab Bank, PLC*, 920 F. Supp. 2d 282, 285 (E.D.N.Y. 2011) ("Insofar as many of the expert reports submitted by the defendant express opinions as to the state of mind, intent, or motive of a government, a charitable entity, or a person, they do not contain relevant expert evidence. 'Inferences about the intent or motive of parties or others lie outside the bounds of expert testimony.'"); *Baker v. Buffenbarger*, No. 03-C-5443, 69 Fed. R. Evid. Serv. 319, 2006 WL 15048 (N.D. Ill. Jan. 13, 2006) (concluding that expert could not testify on whether decision to file charges was motivated by exercise of free speech, where he did not participate in the proceedings against plaintiffs and had no special insight on the topic). However, in patent cases, the courts have found expert testimony to be helpful in limited circumstances (whether a person of ordinary skill would be motivated to combine the prior art). *See, e.g., Supermarket Energy Technologies, LLC v. Supermarket Energy Solutions, Inc.*, CV-10-2288-PHX-SMM, 2014 WL 1202945, at *10 (D. Ariz. 2014) ("Whether a solution was obvious—i.e., whether a person of ordinary skill in the art would be motivated to combine the prior art—is a question of fact which requires expert testimony.").

Therefore, testimony about what motivated the named Plaintiffs' providers in their treatment decisions would not be an appropriate subject for expert testimony. However, a review of the expert reports and the testimony of Plaintiffs' experts, Drs. Crall and Flint, revealed that they never opined on the specifics of motivation for the particular providers who dealt with the named Plaintiffs. Rather, they opined on what motivated providers generally. Further, they would not have been permitted to opine on what motivated these specific providers both because this would be an improper subject for expert testimony and there is no evidence that they spoke

to any of those providers. Therefore, there is no causation proof for the named Plaintiffs for whom the Court found standing under Count II. Likewise, there is no causation proof for the named Plaintiffs to the extent that the Court found that the reason for any untimely care was inadequate rates, under Count II.

Accordingly, the Court should alter or amend its findings relating to L.C., K.K., J.S., and N.V. to state that Plaintiffs presented no evidence from any of these children's providers (or the providers from whom they sought care) to prove that their treatment decisions for these patients (or any delays in accessing care) were caused by low reimbursement rates in whole or in part. Further, the Court should alter its standing determination to find that no Plaintiff proved standing to sue under Count II of the Complaint against AHCA or DOH. Furthermore, the Court should find that K.K. and N.V. lack standing to sue AHCA under Count I, to the extent that Plaintiffs claimed that low provider reimbursement rates caused a delay in care to K.K. (because there was not an adequate provider network) or to N.V. (because he could not find dental care, and had difficulty getting in to see a neuropsychologist).

Rule 52(b), Fed. R. Civ. P., provides that, on a party's motion filed no later than 28 days after the entry of judgment, the court may amend its findings -- or make additional findings -- and may amend the judgment accordingly. The motion may be filed prior to entry of the judgment. *Greenwood v. Greenwood*, 234 F.2d 276, 278 (3d Cir. 1956); 9 Moore's Federal Practice 3d Ed. § 52.61[2] (2011) ("Because the rule requires that the motion be filed 'no later than' 28 days after judgment rather than 'within' 28 days, it is obvious that motions may also be made before the actual entry of judgment.")

The purpose of a motion for amendment of findings is to give the Court an opportunity to correct manifest errors of law or fact at trial. *Nat'l Metal Finishing Co., Inc. v.*

BarclaysAmerican/Commercial, Inc., 899 F.2d 119, 123 (1st Cir. 1990). "Except for motions to amend based on newly discovered evidence, the trial court is only required to amend its findings of fact based on evidence contained in the record." *Fontenot v. Mesa Petroleum Co.*, 791 F.2d 1207, 1219 (5th Cir. 1986).

The foregoing errors meet the standard for "manifest error" of fact or law, particularly when there is no evidence in the trial record to support them. Therefore, the Court should exercise its discretion to correct the findings of fact and law noted above.

WHEREFOR, Defendants move this Court to alter or amend its findings as discussed above.

CERTIFICATE OF CONFERRING WITH COUNSEL

On January 27, 2015, the undersigned sent an email to Plaintiffs' counsel with a copy of this motion, seeking Plaintiffs' position on the motion. As of the time of filing the motion, the undersigned had not heard from Plaintiffs about their position. The undersigned will notify the Court of Plaintiffs' position on the motion as soon as this is received.

Respectfully submitted,

PAMELA BONDI
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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 January 27, 2015.

/s/ Stephanie A. Daniel
Stephanie A. Daniel