ORAL ARGUMENT NOT YET SCHEDULED

Nos. 16-7065, 16-7085 & 16-7100

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

OSCAR SALAZAR, *et al*.
Plaintiffs-Appellees,

v.

DISTRICT OF COLUMBIA, *et al*.
Defendants-Appellants.

On Appeal from Orders of the United States District Court
for the District of Columbia

FINAL BRIEF FOR APPELLEES

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May 15, 2017

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CERTIFICATE AS TO PARTIES, RULINGS UNDER REVIEW, AND RELATED CASES

1. PARTIES AND AMICI

The following persons were named plaintiffs representing the plaintiff class in the district court. Those individuals designated in boldface type remained named plaintiffs throughout the proceedings in the district court. By the Court's Order of March 24, 1995 (ECF 151), granting plaintiffs leave to file a Second Amended Complaint, the individuals not designated in boldface type were dropped as named plaintiffs and Katy Lisette Alvarez was added as a named plaintiff. Plaintiffs filed their Second Amended Complaint on April 17, 1995. ECF 166.

Natalia Wellington, Belinette Thompson, Maria De Fatima Da Silva Lopez, Christopher Alexander Lopez, **Oscar Salazar, Jr., Oscar Salazar**, Adela Salazar, **Pausi Argueta, Jose Argueta, Teresa Argueta, Mirna Paz Argueta**, Jose Orfolio Argueta, Cristian Javier Baez, Lucila Quinto, **Irma Isabel Flores, Yanet Abigail Flores**, **Luis Alfredo Flores, Carlina Flores, Juan Antonio Flores Perez, Ana Iris Flores**, Justiniano Cruz, **Abigail Flores, Nelson Alvarez, Jessica Cruz, Katy Lisette Alvarez, Sylvia Cruz-Diaz Alvarez**, Janira Sosa, Idalia Sosa, Diana Sosa, Israel Sosa, Maria Flores, Zenet Takele, Meseret Assefa, Samuel Assefa, Hirut Takele, Laurie Barrera, Maria Hernandez, Banderly Reina, Carlos Reina, Alexander Reina, Carlos Reina, and Nila Salazar.

In 1994, the Court certified the plaintiff class to consist of five subclasses (ECF 100, pp. 1-2):

> All persons who have applied, have attempted to apply, or will apply in the future during the pendency of this litigation, for medical assistance pursuant to Title 19 of the Social Security Act ("Medicaid"), and all persons who have received, are receiving, or will receive in the future during the pendency of this litigation, Medicaid in the District of Columbia with respect to the following claims:
>
> Any claims for declaratory, injunctive, or other relief premised on the alleged lack of immediate Medicaid coverage for newborns using the Medicaid number of their mothers, who are eligible for Medicaid at the time of the babies' birth [Sub-class I]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged inability to apply for Medicaid at disproportionate share hospitals and federally-qualified health centers [Sub-class II]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged delay in excess of 45 days in the processing of Medicaid applications [Sub-class III]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged lack of advance notice of the discontinuance, suspension or obligation to recertify Medicaid benefits, after being found eligible [Sub-class IV]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged lack of effective notice of the availability of early and periodic screening, diagnostic and treatment ("EPSDT") services for children under 21 years of age, and/or an alleged lack of EPSDT services for eligible children under 21 years of age [Sub-class V]….

The following are the defendants in the district court: the District of Columbia; Sharon Pratt Kelly, then Marion Barry, then Anthony Williams, then Adrian Fenty, then Vincent C. Gray, then Muriel Bowser, each in his or her official capacity as the

Mayor of the District of Columbia; and Vincent C. Gray, then Vernon Hawkins, then Wayne Casey, then Yvonne D. Gilchrist, then Kate Jesberg, then Brian Wilborn, then Clarence H. Carter, then David A. Berns, then Laura Zellinger, each in his or her official capacity as Director of the Department of Human Services.

The following organizations filed a Brief for Amici Curiae on April 3, 2017, with regard to this appeal (Doc. No. 1669221): The Legal Aid Society of the District of Columbia, Children's Law Center, Bread for the City, and Whitman-Walker Clinic, Inc.

2. RULINGS UNDER REVIEW

This is a case challenging the District of Columbia's operation of its Medicaid program as violative of the Constitution, the Medicaid Act, 42 U.S.C. 1396, and local law (D.C. Code §4-205.26 & 4-205.55(a)). On March 31, 1994, the district court issued an order granting in part and denying in part defendants' motion to dismiss the complaint. *Wellington v. District of Columbia*, 851 F. Supp. 1 (D.D.C. 1994). On October 16, 1996, the district court issued findings of fact and conclusions of law, finding that defendants administered its Medicaid program in a manner that violated the Constitution, the Medicaid Act, and local law. *Salazar v. District of Columbia*, 954 F. Supp. 278 (D.D.C. 1996). On January 21, 1997, the district court issued a remedial order, which was amended on May 6, 1997. There is no official citation to the remedial order or to the amended remedial order.

While an appeal on the merits was pending with this Court, the parties reached a settlement agreement. On January 25, 1999, the district court approved and entered an Order Modifying the Amended Remedial Order of May 6, 1997 and Vacating the Order of March 27, 1997, ECF 663 ("Settlement Order"). The appendix has not yet been prepared and there is no official citation to the Settlement Order of January 25, 1999.

The district court has issued numerous orders since the entry of the Settlement Order of January 25, 1999.

Defendants state in their certificate accompanying their opening brief that they are appealing the following orders, which were issued by United States District Judge Gladys Kessler:

- The district court's Order, entered on April 4, 2016, granting plaintiffs' Motion for Modification of the Settlement Order (ECF 2109), with modifications to the relief requested. Defendants appealed this Order on May 4, 2016.

- The district court's Order, entered on June 2, 2016 (ECF 2141), denying the District of Columbia's Motion to Alter or Amend the April 4, 2016 Order. Defendants appealed this Order on June 23, 2016.

- The district court's Order, entered on July 12, 2016 (ECF 2150), granting in part and denying in part, Plaintiffs' Motion to Modify the Stay Entered on May 7, 2016. Defendants appealed this Order on August 11, 2016.

This Court consolidated all three appeals on August 23, 2016 (Nos. 16-7065, 16-7085, 16-7100).

2. RELATED CASES

The three consolidated cases in this appeal, Case Nos. 16-7065, 16-7085, and 16-7100, are the twelfth time this case has been before this Court.

Consolidated cases, Case Nos. 14-7035 and 14-7050, were before this Court on defendants' appeal of the district court's orders issued on February 18, 2014, and April 7, 2014, requiring defendants to pay attorneys' fees and expenses to plaintiffs' counsel in accordance with its Amended Memorandum Opinion of January 30, 2014 and its Amended Memorandum Opinion of March 21, 2014, granting in part and denying in part, plaintiffs' motions for attorneys' fees and expenses concerning applications from 2011 and 2012. This Court issued an opinion on December 18, 2015, affirming the district court's orders, which is reported at 809 F.3d 58 (D.C. Cir. 2015).

Case No. 10-7166 was before this Court on defendants' appeal of the district court's November 12, 2010, Memorandum Opinion and Order, granting in part and denying in part the motions of Non-Parties Health Services for Children with Special Needs and McKesson Health Solutions for Reconsideration and for a Protective Order. Upon appellants' withdrawal of the appeal, this Court dismissed the case on October 14, 2011.

Case No. 10-7106 was before this Court on defendants' appeal of the district court's August 5, 2010, Memorandum Opinion denying Defendants' Motion to

Terminate the Consent Decree and Subsequent Remedial Orders and to Dismiss the Case. The Court issued an opinion on March 13, 2012, which is reported at 671 F.3d 1258 (D.C. Cir. 2012).

Case No. 10-7031 was before this Court on defendants' appeal of the district court's February 18, 2010, Memorandum and Order denying the District of Columbia's Motion to Vacate the Court's Order Granting Injunctive Relief Dated October 18, 2004. The Court issued an opinion on February 8, 2011, which is reported at 633 F.3d 1110 (D.C. Cir. 2011).

Case No. 09-7154 was before this Court on defendants' appeal of the district court's October 28, 2009, Order awarding plaintiffs attorneys' fees and expenses. Upon defendant-appellants' motion for voluntary dismissal, this Court dismissed the case on February 3, 2010.

Case No. 09-5432 was before this Court on defendants' petition for a writ of mandamus requesting this Court to direct the district court to rule on defendants' Motion to Vacate the Court's Order Granting Injunctive Relief Dated October 18, 2004. On February 18, 2010, the district court denied defendants' motion. Following defendants' suggestion of mootness on February 19, 2010, this Court dismissed defendants' petition for a writ of mandamus on March 18, 2010, on the grounds that the issue had become moot.

Case No. 08-7100 was before this Court on defendants' appeal of the district court's August 13, 2008, Memorandum Opinion and Order assessing civil contempt penalties of $931,050 on defendants for failure to comply with the Settlement Order, subsequent orders of the Court, and applicable Federal Rules of Civil Procedure. On April 9, 2010, this Court affirmed in part and reversed in part. *Salazar v. District of Columbia*, 602 F.3d 431 (D.C. Cir. 2010). The case was remanded to the district court for further proceedings consistent with this Court's opinion.

In Case No. 04-7200, this case was before this Court on defendants' appeal of the district court's October 18, 2004, Order granting in part plaintiffs' Motion to Enforce the Settlement Order of January 25, 1999, and the Order of February 28, 2003, Concerning Dental Services. Case No. 04-7200 was held in abeyance on a motion by defendants and later dismissed on March 15, 2006, based on Defendants' Unopposed Motion to Dismiss Appeal.

In Case No. 98-7106, this case was before this Court on defendants' appeal of the district court's March 12, 1998, Order awarding plaintiffs attorneys' fees. Case No. 98-7106 was held in abeyance and upon a Joint Motion to Dismiss the Appeal, this Court dismissed the appeal on February 24, 1999.

Case No. 97-7094 was before this Court on defendants' appeal from the district court's Amended Remedial Order of May 6, 1997. Case No. 97-7100, in which plaintiffs cross-appealed the Amended Remedial Order of May 6, 1997, and

Case No. 97-7094 were consolidated and stayed. The cases were briefed, but oral argument was not heard, and this Court issued no decision. Upon a joint motion to remand, this Court remanded the cases to the district court on January 14, 1999.

Respectfully submitted,

/s/ *Zenia Sanchez Fuentes*

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May 15, 2017

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GLOSSARY OF ABBREVIATIONS

ACA	Patient Protection and Affordable Care Act
ACEDS	Automated Client Eligibility Determination System
CMS	Centers for Medicare and Medicaid Services
DBr	Brief for the District of Columbia Appellants (Defendants' Brief)
DCAS	District of Columbia Access System
EPSDT	Early and periodic screening, diagnostic, and treatment services
MAGI	Modified Adjusted Gross Income

STATEMENT OF ISSUES

Whether, under the terms of the Settlement Order in a class action and Rule 60(b)(5), the district court properly exercised its equitable discretion to modify the Settlement Order to grant injunctive relief concerning Medicaid applications and renewals to address renewed violations of the statutory and Constitutional rights of the three remaining subclasses when some provisions of the Settlement Order were unquestionably prospective and under active Court oversight.

STATEMENT OF THE CASE

Background

In 1993, plaintiffs filed a class action against defendants to enforce Title XIX of the Social Security Act, 42 U.S.C. 1396, *et seq.*, and accompanying regulations 42 C.F.R. 430, *et seq.*, regarding the District of Columbia's Medicaid program. The plaintiff class was certified to include five subclasses. JA181-182. The claims of two subclasses settled. ECF377. The claims of the three remaining subclasses (III, IV, V) were tried. Plaintiffs alleged that defendants were depriving them of their statutory and constitutional rights by failing to (1) issue decisions and provide Medicaid coverage within 45 days after initial applications were submitted (Subclass III), (2) provide advance notice of termination, discontinuance or suspension of Medicaid benefits and an opportunity for a hearing to contest adverse action at the time of recertification for Medicaid (Subclass IV), (3) provide or arrange for the

provision of early and periodic screening, diagnostic, and treatment (EPSDT) services to children who request these services under the Medicaid program and notify parents about the EPSDT benefit for their children (Subclass V). *Salazar v. District of Columbia*, 954 F. Supp. 278, 280-281 (D.D.C. 1996).

After trial, the district court held that defendants had "denied Plaintiffs' rights under both federal and District of Columbia law, and, in some instances, under the Constitution" with regard to the claims of these three subclasses. 954 F. Supp. at 324. While defendants' appeal was pending, the parties reached a comprehensive settlement. JA251-299 ("Settlement Order").

Settlement Order

The Settlement Order sets forth provisions aimed at providing relief to the plaintiff class to remedy defendants' violations of federal law, the Constitution, and District of Columbia law. Section II required defendants to take specific actions to improve performance in determining applications in 45 days, JA253-260. Section III required defendants to improve performance in ensuring due process protections in the processing of recertifications, now called renewal of Medicaid. JA261-267. Sections II and III enjoined defendants to comply with the federal, Constitutional and District of Columbia standards for processing Medicaid applications and renewals. JA253, para.6; JA261, para.17. Sections II and III set forth detailed provisions for monthly reporting and calculation of compliance with a 95%

performance standard for application and recertification processing. JA254-260, paras. 8-13,16; JA262-266, paras. 19-24,27. Individual class members received no direct relief under Sections II and III of the Settlement Order, but could only assert their rights concerning application and recertification processing by "invoking their right to a fair hearing." JA254, para. 7; JA261-262, para.18. Both Sections II and III had specific criteria for termination which required compliance with the 95% performance standard for three years. JA294-295, para. 74 (application processing), para. 75 (recertification processing).

Sections V and VI enjoin defendants to provide Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services to children up to age 21 on request (para. 36) and to take specific actions to improve the provision of EPSDT services and notice to parents about of the availability of these services. JA271-289, paras. 37-60. The EPSDT services program is a comprehensive child health benefit for children from birth to age 21. EPSDT services include preventive care such as annual well-child visits, blood lead testing, dental services, hearing and vision screens, as well as necessary corrective treatment such as visits to a specialist, physical therapy, and speech-language therapy. The substantive actions required of defendants include, for example, ensuring that the delivery of medical care to each child is tracked (JA271-272, para. 37), that children receive notice in advance of appointments or if an appointment is missed (JA273-274, para. 39), that Medicaid

providers are trained about the EPSDT benefit (JA275, para. 41), that managed care organizations perform well in delivering services to children (JA278-280, para. 45), and that parents and custodians receive notice about the EPSDT benefit for their children (JA286, para. 54). Sections V and VI terminate on compliance with substantive provisions concerning delivery of notice and services to children for three years and meeting a 75% performance standard in the most recent year before termination. JA295-296, para. 77.

Section VII requires defendants to take actions to provide reimbursement to Medicaid beneficiaries "who have incurred out-of-pocket expenses that, but for Defendants' error, should have been paid by Medicaid." JA289-290, para. 61. Those provisions remain in effect and will "conclude at the same time as the last of the Sections identified in paragraphs 74-77." JA296, para. 78.

Over time, some sections of the Settlement Order were terminated by the court. Section II, related to 45-day application processing, remained in force until February 2009, when the district court granted a consent motion to vacate it based on compliance with the performance standard. JA305-310; JA698-699. The Section III provisions related to recertification processing remained in force until October 17, 2013, when the district court granted defendants' motion brought under paragraph 70 of the Settlement Order for termination based on Rule 60(b)(5) on the grounds that the Patient Protection and Affordable Care Act of 2010, Pub. L. No.

111-148, 124 Stat. 119 (2010) ("ACA") was a significant change in law. JA311-321. The court ordered "that Defendants are relieved from complying with Section III…." JA321. However, the Court held that counsel for the plaintiff class could continue to assist individual class members whose due process rights are violated at recertification/renewal: "[M]embers of the plaintiff class can also contact Plaintiffs' counsel, as they have been doing over the years, to obtain legal assistance. Consent Order, ¶ 64." JA319, n.1.

In May 2015, after Section II of the Settlement Order had been vacated (JA698-699) and after defendants had been "relieved from complying with Section III" (JA321), the court described the subclasses that were still in effect and thus, entitled to the protections of the reimbursement procedures in Section VII of the Settlement Order (JA298-290) and related orders (JA237-250; JA300-304). The court cited and explained the Order certifying the plaintiff class (JA181-182), stating that (JA327):

> [I]n order to be a member of the Plaintiff class an individual must meet the criteria of the preamble paragraph above (i.e., be a present, past, or future, Medicaid applicant or recipient) and have claims that fall into one of the five sub-class categories. [emphasis in original]

Only three of the five subclasses certified in 1994 remained in the case in 2015. The court stated (JA339):

> [T]he Salazar class is made up of Medicaid applicants and recipients who fall into one or more of the three remaining sub-classes.

The court stated that the "three remaining sub-classes" are Subclass III which includes those with a "complain[t] of any delay in excess of 45 days in the processing of [a] Medicaid Application;" Subclass IV which "applies to Medicaid recipients whose Medicaid eligibility was terminated without advance notice;" and Subclass V which includes those who "seek EPSDT services." JA339-340. All three remaining subclasses were entitled to reimbursement relief under Section VII of the Settlement Order. JA343-344.

Implementation of the Medicaid Provisions of the ACA by Defendants

Beginning in October 2013, the ACA and its implementing regulations changed the way that Medicaid eligibility determinations were made on applications and renewals (formerly recertifications). *See* 42 U.S.C. 1396a(e)(14); 42 C.F.R. 435.603, 457.315(a). To implement the changes, defendants "took steps to build a new, automated Medicaid application and eligibility determination [computer] system called the DC Access System ('DCAS'), which is intended to eventually entirely replace the District's legacy system, called the Automated Client Eligibility Determination System ('ACEDS')." JA1287. Defendants were also required to adopt a new system of "passive renewal" of Medicaid for existing Medicaid recipients. *Ibid.*; 42 C.F.R. 435.916(a)(passive renewal for MAGI beneficiaries); 42

C.F.R. 435.916(b)("re-determination" for non-MAGI beneficiaries). Passive renewal means that a beneficiary's Medicaid eligibility is extended if defendants can obtain sufficient information of income and residency from federal and local databases and other sources. *See* 42 C.F.R. 435.916(a)(2). If sufficient information is not available, the beneficiary is asked to provide the missing information before Medicaid will be renewed. 42 C.F.R. 435.916(a)(3).

As the district court found: "These changes did not go smoothly." JA1287. Under a timetable approved by the federal government through the Centers for Medicare & Medicaid Services ("CMS"), all Medicaid beneficiaries were to be transitioned into the new eligibility system by late 2014, by which time they would all be passively renewed. JA659. This did not occur in 2014, 2015, or 2016. *Ibid.*; JA833, para. 36; JA836-837, paras. 47, 48; JA839-840, para. 57.[2]

Beginning in mid-2013, due to technical problems, the District sought and obtained numerous extensions and waivers from CMS to implement the ACA's regulations. *Id.* The district court found, and defendants do not dispute, that (JA1287-1288):

> [I]t is clear that thousands of Medicaid beneficiaries were affected by (1) the District's failure to process Medicaid applications within 45 days in violation of 42 C.F.R. §

[2] Passive renewals for the last group of non-MAGI beneficiaries, which comprise about 30% of all Medicaid beneficiaries, is planned to begin in 2018. JA839, para. 57.

> 435.912(c)(3) and D.C. Code§ 4-205.26 (2014); and (2) the District's failure to timely renew Medicaid benefits or to provide adequate notice to Medicaid recipients before terminating their benefits in violation of federal law.

The district court noted that defendants discovered 12,000 applications pending over 45 days in April 2015 (JA1288) and, even accepting all of defendants' qualifications of that figure (JA1289), "approximately 7,000 applications – and people – were affected." The court further noted that a "household with several members will sometimes submit a single application," thus, "the number of individuals affected by the backlog may be larger…." JA1289, n.8.

The court found that the application backlog was 5,263 in August 2015, 5,215 in November 2015, and 4,497 in December 2015. JA1289-1290. The reasons for the backlog included cases with technical glitches, called the "stuck/malformed" group. JA1290. The backlog also included a second "catch-all" category of applications not acted upon because defendants could not verify needed information for the file or due to "other '[computer] system performance issues.'" *Ibid*.

In addition to the backlog identified by defendants in their computer system, "as of August 2015, 'there [wa]s a paper application backlog' as well." JA1290, n.9. The court found that "lost or misplaced paperwork is a substantial problem" with the District Medicaid agency. JA1291 ("documents scanned into the District's document management system cannot always be found and must often be resubmitted"). The court further found that there were "widespread problems with

document processing," and that in a series of site visits to the offices of the Medicaid agency in February and June 2015, Medicaid advocates observed "numerous individuals standing in line to resubmit documentation they had already provided, many now facing denial or termination of benefits due to Defendants' failure to process the paperwork in the first instance." JA1291-1292.

The District also improperly allowed Medicaid recipients' benefits to lapse at renewal. As of June 2015, the District admitted that 1,149 renewal cases were affected by a computer data transfer error. JA1298 (citing JA437). The district court found that "the people who were affected had to wait six months for any benefits." JA1298. "In October 2015, the District discovered a computer error that garbled the mailing addresses of Medicaid recipients from May to October 2015, preventing many recipients from receiving the renewal form." JA1308. Without the renewal form, the Medicaid beneficiary who is not passively renewed does not receive the required advance notice of the need to renew their Medicaid benefits. *See* 42 C.F.R. 435.917. Similar to the computer problem with applications, beneficiaries lost coverage due to the District's inability to process renewals that were "stuck" and "malformed" in the system. JA352. The District was also unable "to accurately redetermine eligibility once a life event [such as birth of a newborn] has been reported due to system defects." JA1300. Although some of these problems, such

as "stuck" renewals, were identified as early as May 2015, defendants could not immediately address them because they had "too much on their plates." JA994.

These technological problems are exacerbated because "the District cannot currently accept renewals submitted on-line," and "[s]ome Medicaid recipients have had difficulty renewing their benefits over the telephone." JA1310. The district court further concluded (*ibid.*): "Thus, the long lines at service centers and paperwork processing issues already discussed are likely to lead to future losses in coverage."

The court further found, based on affidavit testimony of individual Medicaid applicants and beneficiaries (JA1301-1303) and representatives of "several of the District of Columbia's most reliable and experienced legal aid and public health organizations" (JA1301) that defendants' widespread technical difficulties and problems processing paperwork had the consequence of denying many eligible people their needed Medicaid benefits (JA1302-1303):

> Lest the reader be getting exhausted reading all these numbers and examples, s/he must constantly keep in mind that these are real people -- poor and sick people and their children -- who are being denied the health care and the dignity of receiving health care to which they are entitled by law.

The April 4, 2016 Order

After carefully considering the evidence submitted by the parties on plaintiffs' motion for a preliminary injunction (ECF2070; JA348 to 749) and plaintiffs' Motion

for Modification of the Settlement Order (ECF2093), the district court issued a 59-page opinion (JA1275-1333) and an Order (JA1272-1274 - "the April 4 Order"), which granted the relief sought by plaintiffs in their Motion for Modification of the Settlement Order, with some modifications.

The district court found that plaintiffs met each of the requirements for modification of the Settlement Order under paragraph 71 of the Settlement Order, and under Rule 60(b)(5) as set forth by the Supreme Court in *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992), concluding that (JA1280):

> Although the District has made substantial progress since Plaintiffs' initial filing on December 22, 2015, in addressing the problems [in processing Medicaid applications and renewals] ..., it is clear from the Parties' submissions that significant obstacles remain. These obstacles stand between Medicaid eligible individuals and the healthcare to which they are entitled.

To address those obstacles, the court issued injunctive relief under Rule 60(b)(5), which required provisional eligibility for applicants whose Medicaid applications were not decided within 45 days "until a final determination can be made [on the application by defendants]" and continued eligibility for 90 days at Medicaid renewal "unless Defendants have affirmatively determined that the recipient is no longer eligible for Medicaid." JA1272-1274. The April 4 Order allowed defendants to "move to terminate these remedies anytime they can make the demonstration" that technology and processing systems for making eligibility determinations are

functioning as required to ensure the rights of applicants and beneficiaries under applicable laws and regulations. JA1274. Defendants appealed the April 4 Order. ECF2131.

On May 17, 2016, the district court granted defendants' motion to stay the April 4 Order pending appeal. JA1392-1393. On June 2, 2016, the court denied defendants' motion to amend or alter the April 4 Order. JA1414. Defendants appealed the denial of their motion to amend or alter. ECF2146. On July 12, 2016, the district court granted plaintiffs' Motion to Modify the Stay Entered on May 17, 2016. JA1415-1416. The court issued an opinion on July 19, 2016. JA1417-1420. Under the modified stay, Medicaid applicants and beneficiaries who identify themselves to defendants as having an application pending for more than 45 days or being terminated or threatened with termination at renewal without adequate notice or even after having submitted all required paperwork are entitled to continued eligibility while defendants process their case. JA1415-1416. Defendants appealed the July 12, 2016 Order. ECF2174.

STANDARD OF REVIEW

"[T]he district judge, who is in the best position to discern and assess all the facts, is vested with a large measure of discretion in deciding whether to grant a Rule 60(b) motion, and the district court's grant or denial of relief under Rule 60(b), unless rooted in an error of law, may be reversed only for abuse of discretion."

Twelve John Does v. District of Columbia, 841 F.2d 1133, 1138 (D.C. Cir. 1988)(citing, *inter alia*, *Browder v. Director*, 434 U.S. 257, 263, n. 7 (1978)).

SUMMARY OF ARGUMENT

The claims of three certified subclasses were tried in 1996. Those claims involved: defendants' failure to process large numbers of Medicaid applications in the required 45 days; defendants' failure to provide all required due process notices when Medicaid benefits were terminated at Medicaid recertification (now known as renewal); and the failure to provide the comprehensive child health benefit early and periodic, screening, diagnostic and treatment (EPSDT) services to children in the District of Columbia and the failure to provide adequate notice of the benefit to parents and guardians.

Following trial, the parties entered a settlement. The Settlement Order provides for continuing jurisdiction of the court and that the order may be modified on motion by a party. Although the sections of the Settlement Order concerning application processing and recertification processing were terminated in 2009 and 2013, respectively, there is no dispute that in 2015, the Settlement Order continued to have prospective application and be under court oversight because defendants had not met the requirements of the EPSDT sections of the Settlement Order. In addition, in May 2015, the court ruled that members of the subclasses related to untimely application processing, the failure to provide all required notices at

recertification, and the EPSDT benefit, were entitled to relief under the reimbursement section of the Settlement Order and related orders.

The overwhelming evidence in the record showed that by late 2015, after the entry of the Settlement Order in 1999 and the start of the District of Columbia's implementation of the ACA and its regulations in 2013, defendants had returned to violating the constitutional and statutory rights of large numbers of Medicaid applicants and beneficiaries in the processing of applications and renewals. These violations harmed all three certified plaintiff subclasses remaining: applicants, beneficiaries, and children under 21.

Under the terms of the Settlement Order and the federal law governing motions for modifications, including Federal Rule 60(b)(5) and *Rufo v. Inmates of Suffolk County Jail*, the court had the authority and discretion to order relief for all three remaining subclasses. Defendants' renewed violations constituted changed circumstances and the relief awarded by the court was properly tailored to remedy the violations of federal law. Defendants' due process rights were not violated in the adjudication of the motions. Moreover, the court properly denied defendants' motion to alter or amend judgment since the motion was premised on evidence that

could have been, but was not, submitted on the original motion. Therefore, the Court should affirm the April 4 Order.[3]

ARGUMENT

I

THE DISTRICT COURT HAD THE AUTHORITY TO MODIFY THE SETTLEMENT ORDER BY ORDERING INJUNCTIVE RELIEF FOR ALL CERTIFIED SUBCLASSES

A. THE SETTLEMENT ORDER ITSELF PROVIDES FOR CONTINUED JURISDICTION AND AUTHORITY TO MODIFY

1. The Settlement Order Provides for Continuing Jurisdiction of the Court

Defendants state that the "[t]he scope of a consent decree must be discerned within its four corners, and not by reference to what might satisfy the purposes of one of the parties to it." DBr18 (quoting *United States v. Armour & Co.*, 402 U.S. 673, 682 (1971)). Plaintiffs agree. However, here, within the "four corners" of the Settlement Order, the parties agreed to the continuing jurisdiction of the court and that the Settlement Order could be modified on motion. JA294, paras. 71, 72; JA 296, para. 79.

Paragraph 79 of the Settlement Order provides that "[t]he Court shall retain jurisdiction of this matter to make any necessary orders enforcing or construing this

[3] The court properly modified the stay pending appeal in its July 12 Order. JA1415-1416. In any event, once the appeal is decided, defendants' objections will become moot.

Order." JA296. Paragraph 78 of the Settlement Order makes clear that "[a]ll other provisions of this Order shall conclude at the same time as the last of the [exit provision] sections identified in paragraphs 74-77 above" (emphasis added). *Ibid*. Moreover, the Order certifying the class provides that the "five sub-classes" consist of (JA181):

> All persons who have applied, have attempted to apply, or will apply in the future during the pendency of this litigation, for medical assistance pursuant to Title 19 of Social Security Act ("Medicaid"), and all persons who have received, are receiving, or will receive in the future during the pendency of this litigation, Medicaid in the District of Columbia with respect to the following claims:…[emphasis added]

By its terms, the court's Order contemplated continued existence of the subclasses for the entire "pendency of the litigation." *Ibid*.

Even when the court terminated the application processing section of the Settlement Order, it did not decertify the subclass. Minute Order, February 24,2009, JA698. In addition, the court's order relieving defendants from compliance with the recertification processing section of the Settlement Order did not decertify the subclass and, in fact, contemplated continuing monitoring and enforcement of the rights of the recertification subclass by plaintiffs' counsel, stating that members of

the plaintiff class could obtain legal assistance from plaintiffs' counsel pursuant to paragraph 64 of the Settlement Order.[4] JA319, n.1.

In May 2015, the court ruled that all three remaining subclasses (applications, recertification and EPSDT) continued to be entitled to relief under the reimbursement provisions in the Settlement Order. JA344. Subclass members are entitled to reimbursement of out-of-pocket expenses that "but for Defendants' error, should have been paid by Medicaid." JA289-290, paras. 61-63. Subclass members are also entitled to free legal help from plaintiffs' counsel to pursue reimbursement claims. JA344-345.

2. The Settlement Order Provides That It Can Be Modified at Any Time for Any Reason

Defendants claim that (DBr24), the orders terminating Sections II and III "relieved the District from any continuing obligations in this case in the realms of eligibility and renewal determinations."[5] Defendants were relieved from compliance

[4] Paragraph 64 provides for counsel to assist "members of the plaintiff class" and states that such legal assistance is considered "compensable monitoring of this Order." JA290-291.

[5] Defendants cite (DBr20) *King v. Allied Vision, Ltd.*, 65 F.3d 1051, 1058 (2d Cir. 1995) for the proposition that "[b]ecause a decree is the sole source of the parties' rights, a district court may not impose obligations on a party that are not unambiguously mandated by the decree itself." However, *King* concerned contempt proceedings in which a court may compel compliance with a decree, but may not add new requirements. Here, the issue is the propriety of the district court's granting a motion to modify a consent decree when the parties have explicitly agreed that the consent decree may be modified by the court on motion (JA294, para. 71).

with Sections II and III of the Settlement Order and have not become subject to them again. Instead, the court modified the Settlement Order to provide relief to the plaintiff class based on systemic violations of law in the processing of applications and renewals. The court acted in accordance with paragraph 71 which permits any party to move to modify the Settlement Order "at any time and for any reason." JA294. In a previous appeal by defendants, this Court has remarked on the breadth of this provision: "Paragraph 71 of the Settlement Order provides for modification 'at any time for any reason.'" *Salazar v. District of Columbia*, 633 F.3d 1110, 1122 (D.C. Cir. 2011).

Paragraph 72 of the Settlement Order provides that "the general body of federal law governing motions…pursuant to Rule 60(b) of the Federal Rules of Civil Procedure shall apply." JA294. The federal caselaw allows courts flexibility to modify consent decrees based on changed circumstances. *See Rufo v. Inmates of Suffolk County Jail*, *supra*, 502 U.S. at 381:

> The upsurge in institutional reform litigation since *Brown v. Board of Education*, has made the ability of a district court to modify a decree in response to changed circumstances all the more important. Because such decrees often remain in place for extended periods of time, the likelihood of significant changes occurring during the life of the decree is increased….[internal citations omitted]

See also Salazar v. District of Columbia, *supra*, 633 F.3d at 1116 ("Rule 60(b)'s concern with finality…does not carry the same significance in long-running equitable relief as it would in an action where the court's role had ended…"). The broad opportunity to seek modification of the Settlement Order includes the right to seek relief when, as here, facts arise showing that the District has returned to violating aspects of federal law concerning applications and recertification that were part of the Second Amended Complaint (JA202-203, paras. 72-81), for which the defendants were found liable (954 F. Supp. at 324-327), and were part of the Settlement Order (JA253-271, paras. 6-35).

Moreover, "'[t]he power of a court of equity to modify a decree of injunctive relief...is long-established, broad, and flexible'" (internal quotations omitted). *Salazar v. District of Columbia*, *supra*, 633 F.3d at 1116; *see also New York v. Microsoft Corp.*, 531 F. Supp. 2d 141, 167 (D.D.C. 2008)(extending the termination date of the injunctive relief after finding that the district court had modification authority under, *inter alia*, the consent decree's modification clauses and the court's inherent authority).

3. Rule 60(b) Allows for Modification Because the Settlement Order has Prospective Application

Rule 60(b)(5) allows relief from an order if "applying [the judgment] prospectively is no longer equitable." Under this Court's ruling in *Twelve John Does v. District of Columbia*, 841 F. 2d at 1133, 1138 (D.C. Cir. 1998), "an order or

judgment may be modified under…Rule 60(b)(5) only to the extent that it has 'prospective application.'" An order or judgment has prospective application within the meaning of Rule 60(b)(5) if it is "executory or involves the supervision of changing conduct or conditions" (internal quotations and citations omitted). *Id.* at 1139.

Defendants claim (DBr24) that the court erred in the application of Rule 60(b)(5) because it modified previously terminated provisions and that "[w]hatever prospective application those provisions had was lost upon termination, and orders dismissing claims are not prospective within the meaning of the rule."[6] However,

[6] Defendants cite several cases in support of this proposition, none of which are applicable. Two of those cases, *Twelve John Does*, *supra*, 841 F.2d at 1139 and *Maraziti v. Thorpe*, 52 F.3d 252, 254 (9th Cir. 1995), involved Rule 60(b)(5) motions to add parties to the case after those parties had been dismissed. In *Coltec Industries, Inc. v. Hobgood*, 280 F.3d 262, 272 (3d Cir. 2002), the court of appeals held that Rule 60(b)(5) could not be used by plaintiffs to reinstate the very same claims that had been dismissed in a complaint. In *Gibbs v. Maxwell House*, 738 F. 2d 1153, 1155-56 (11th Cir. 1984), the court of appeals found no abuse of discretion in refusing to grant relief under Rule 60(b)(5) to a plaintiff requesting relief from a judgment dismissing his case for failure to pay a sanction because "the judgment of dismissal in this case was not prospective within the meaning of 60(b)(5)." In *Dowell v. Board of Education of Oklahoma City Public Schools*, 782 F. Supp. 574, 577 (W.D. Okla. 1992), the district court denied plaintiffs' Rule 60(b) motion for relief from final judgment because the school district had fully remedied its violation, the decree had been dissolved, and the entire case dismissed. Unlike in those cases, plaintiffs here did not move to add parties previously dismissed, add claims previously dismissed in a complaint, or revive a case that had been entirely dismissed. The modifications granted by the court were based on the prospective application of sections of the Settlement Order.

the relief granted by the court did not rely on the prospective application of the terminated provisions. Instead, the Court found that relief was necessary in order to carry out the EPSDT provisions of the Settlement Order which unquestionably had prospective application (JA1317):

> [T]he Settlement Order has prospective application, and thus may be modified under Rule 60(b)(5), because sections of the Settlement Order relating to early and periodic screening, and diagnostic and treatment services ("EPSDT") very clearly require the supervision of changing conduct or conditions. Id. (citing Settlement Order ¶ ¶ 36, 41, 47, 79)…. The modifications Plaintiffs propose are within the sphere of the Settlement Order's prospectively applicable EPSDT provisions because 'it is common sense that a child cannot obtain any EPSDT service when he or she lacks Medicaid eligibility.' [internal citations omitted]

Defendants do not dispute that the EPSDT Sections of the Settlement Order require the court's "supervision of changing conduct or conditions," as required under *Twelve John Does*, 841 F.2d at 1139. *See* DBr26 ("the prospectively applicable EPSDT provisions"). Indeed, defendants themselves have several times invoked the prospective application of the Settlement Order to request modifications to it. *See e.g.*, ECF 1870, p.14 (Defendants state: "Changes to law or factual circumstances that render continued application of a consent order inequitable or contrary to the public interest justify modification under subsections (b)(5) or (b)(6)").

B. THE SETTLEMENT ORDER CONTEMPLATES CONTINUED RELIEF AND ASSISTANCE FOR THE REMAINING SUB-CLASSES

Defendants argue that the court retained jurisdiction only over the "prospectively applicable EPSDT provisions" and could therefore not provide relief to subclasses III and IV (concerning applications and recertifications), since "[i]ndividuals with [those] claims…do not share anything meaningful in common with the remaining provisions in the Settlement Order concerning EPSDT services." DBr25-26. However, while Sections II and III of the Settlement Order providing specific relief to the applicant and recertification subclasses were terminated, the subclasses were not. As shown below, the subclasses that existed at the time of trial are still certified and continuing to receive relief under the Settlement Order and related orders. Moreover, the court found in 2015 that reimbursement relief was available to a Medicaid applicant or recipient who "fall[s] into one or more of the three remaining sub-classes." JA339. Thus, for example, a child whose Medicaid lapses at renewal without adequate notice may be a member of both the EPSDT subclass and the recertification subclass. As a result, the ability to modify the Settlement Order extends to relief that benefits all remaining subclasses.

1. In 2015, There Were Three Remaining Subclasses in the Plaintiff Class

As we have shown in pp. 1-2 above, in 1994, the district court certified the plaintiff class to consist of five subclasses (JA181-182), three of which remained by

the time of trial (*Salazar v. District of Columbia*, *supra*, 954 F. Supp. at 281). Those same three subclasses remained in the case at the time that the orders at issue were adjudicated. JA343-344. In May 2015, the court found that the "three remaining sub-classes" in the case are Subclass III which includes those with a "complain[t] of any delay in excess of 45 days in the processing of [a] Medicaid Application;" Subclass IV which "applies to Medicaid recipients whose Medicaid eligibility was terminated without advance notice;" and Subclass V which includes those who "seek EPSDT services." JA339-340. The court held that only those in the three remaining subclasses were entitled to the benefits of the reimbursement procedures in the Settlement Order (JA289-290) and related orders (JA212-236, JA237-250). JA340. Defendants did not appeal or object to the court's conclusion in 2015 that there remained three subclasses entitled to relief under the reimbursement aspects of the Settlement Order.

2. The Settlement Order Provides for Continued Assistance to and Relief for the Applications and Recertification Subclasses

Defendants argue that (DBr26) because the "Settlement Order's framework severed the EPSDT provisions from those concerning Medicaid eligibility and renewals" no relief can be provided to the applications and recertification subclasses. However, although the court relieved defendants from compliance with Section III of the Settlement Order in 2013, it did not decertify the subclasses and, in fact, contemplated continuing monitoring and enforcement of the rights of the

recertification subclass by plaintiffs' counsel. JA319, n. 1. As we have seen (p. 23), in 2015, the court explicitly recognized that the application and recertification subclasses had rights to recover reimbursement of their out-of-pocket expenses that should have been covered by Medicaid. *See* JA339-340. Defendants themselves agree that the relief for the EPSDT subclass applies prospectively. DBr26. Therefore, having found that changed circumstances warrant modification of the Settlement Order (JA1321), the court appropriately ordered relief for the benefit of all three certified subclasses, as permitted under paragraphs 71, 72 and 79 of the Settlement Order.

C. DEFENDANTS' ADDITIONAL ARGUMENTS AGAINST MODIFICATION ARE WITHOUT MERIT

1. The April 4 Order Does Not Reimpose Terminated Provisions of the Settlement Order

Defendants claim several times (DBr 16, 19, 20, 21, 23) that the court reimposed the provisions of the Settlement Order that had been terminated regarding applications and renewals. As we show below, the court did not do so. However, defendants never explain why it would have been important to their position if the court had done so.

(a) Application Processing

The portion of the April 4 Order on application processing enjoins defendants to provide relief to individual class members who have applications pending over 45 days without a decision. JA1273. This relief was not part of the Settlement Order.

Instead, the Settlement Order required a class member to file for a fair hearing (*see* 42 U.S.C. 1396a(a)(3)) to obtain any individual relief if their application was pending over 45 days. JA254, para. 7.

The Settlement Order section on application processing was 8 pages long. JA253-260. The application processing portion of the April 4 Order is one paragraph. The Settlement Order included detailed provisions about calculating class-wide statistics on the percentage of applications processed in 45 days. JA254-259, paras. 8-13. No such terms are in the April 4 Order. The Settlement Order required monthly reporting on meeting the 45-day standard for the class. JA260, para. 16. Plaintiffs sought reporting in the modified injunction, but the court denied it. JA1273-1274.

The Settlement Order required notices to the class about their right to a decision in 45 days and to obtain free legal help from plaintiffs' counsel if they do not. JA259-260, paras. 14-15. No such provisions are in the April 4 Order.

Under the Settlement Order, defendants could move to terminate the application processing section of the Settlement Order only after showing three years of compliance with a 95% performance standard. JA254, para. 8, JA256-257, para. 12, JA294, para. 74. In contrast, defendants can move to terminate the April 4 Order at "anytime" if they can show they are in compliance with the federal law applicable to application processing. JA1274.

(b) Renewal – Recertification Processing

The portion of the April 4 Order on renewal processing enjoins defendants to provide relief to individual class members at renewal (formerly called recertification) by providing 90 days of continued eligibility "unless Defendants have affirmatively determined that the recipient is no longer eligible for Medicaid." JA1274. This relief was not part of the Settlement Order. Instead, the Settlement Order required a class member to file for a fair hearing to obtain any individual relief if they did not receive advance notice and an opportunity to be heard and were terminated at recertification. JA261-262, para. 18.

The Settlement Order section on recertification processing was over 6 pages long. JA261-267. The renewal processing portion of the April 4 Order is one paragraph. The Settlement Order included detailed provisions about calculating class-wide statistics on the percentage of recertifications processed with all required notices. JA262-263, paras. 19-21. The Settlement Order also included provisions requiring a study of defendants' recertification processing systems by an outside consultant and next steps depending on the results of the study. JA263-265, para. 22-24, JA266-267, para. 28. No such terms are in the April 4 Order. The Settlement Order required class-wide monthly reporting on processing recertifications with all proper notices to beneficiaries having been given. JA266, para. 27. Plaintiffs sought reporting in the modified injunction, but the court denied it. JA1331, n.17.

The Settlement Order required notices to the class about their right not to be cut off at recertification unless they received all required notices and to obtain free legal help from plaintiffs' counsel if they do not. JA265, paras. 25-26. No such provisions are in the April 4 Order.

Under the Settlement Order, defendants could move to terminate the recertification processing section of the Settlement Order only after showing three years of compliance with a 95% performance standard. JA262, para. 19, JA294-295, para. 75. In contrast, defendants can move to terminate the April 4 Order at "anytime" if they can show they are in compliance with the federal law applicable to the processing of Medicaid renewals. JA1274.

Thus, while the April 4 Order addresses the same violations as the terminated sections of the Settlement Order, it provides entirely different relief. The relief under the April 4 Order is solely and directly to affected members of the plaintiff class. Under the Settlement Order, the remedies set aggregate performance standards, required monthly reporting on progress towards meeting the standards, and required three years of demonstrated compliance before termination. The Settlement Order explicitly provided no direct relief to any affected class member, but required those persons to seek a fair hearing for individual redress. Therefore, defendants' claim that the court "reimposed" the same terminated provisions of the Settlement Order on defendants is not correct.

2. The District Court Did Not Deny Defendants the Benefit of the Bargain

Defendants claim (DBr20) that the court "improperly deprive[d] the District of the benefit of the bargain it negotiated—ending judicial oversight and plaintiffs' enforcement powers in exchange for meeting agreed-upon metrics or otherwise satisfying the requirements of applicable law" by "[p]ermitting a modification to resurrect requirements previously terminated pursuant to the terms of the parties' agreement." The proper course of action, defendants argue would have been for plaintiffs to seek new relief "in the context of a new lawsuit." *Ibid.*

First, the court correctly recognized that part of the bargain negotiated by both parties was the right—explicitly set forth in paragraph 71 of the Settlement Order—to return to the court on motion and seek a modification of the Order "at any time for any reason." JA1315. As we have seen (p. 18), this Court has observed, regarding this very Settlement Order, that the parties have a right to move for modification, even when modification would alter the benefit of the bargain. *Salazar v. District of Columbia*, *supra*, 633 F.3d at 1122 (noting that although defendants were unsuccessful in their Rule 60(b)(6) motion to vacate a related order, "[t]he District government is not without remedies, however. Paragraph 71 of the Settlement Order provides for modification 'at any time for any reason.'").

Second, although any modification of the Settlement Order can alter the bargained-for terms of the agreement, this does not render modification

impermissible. Defendants themselves made use of the provisions of the Settlement Order on two previous occasions to seek relief from their bargained-for obligations. *See Salazar v. District of Columbia*, 671 F.3d 1258 (D.C. Cir. 2012)(dismissing appeal for Rule 60(b) relief from the EPSDT provisions because the underlying order was not immediately appealable); JA321(defendants obtained relief from the recertification provisions under Rule 60(b)(5)). If defendants were correct, plaintiffs could have successfully defeated defendants' previous Rule 60(b)(5) motions by arguing that granting the motion would deny plaintiffs the "benefit of the bargain." Instead, in paragraphs 71 and 72, both parties agreed to be bound by Rule 60(b) and the applicable case law interpreting the Rule in motions to modify the Settlement Order.

Third, we have shown above (pp. 25-28) that the court imposed significantly different relief in the April 4 Order and did not "resurrect requirements previously terminated," as defendants claim. DBr20. Moreover, both cases cited by defendants in support of this argument involve instances in which modification or enforcement was attempted years after the entire consent decree had been terminated and the cases dismissed. *See EEOC v. Local 40*, 76 F.3d 76, 81 (2d Cir. 1996)("If we were to enforce this consent decree against Local 40 twelve years after its expiration, we would be depriving the union of the benefit of its bargain"); *United States v. Overton*, 834 F.2d 1171, 1174 (5th Cir. 1987)(finding that plaintiffs could not enforce consent

decree after entire decree had expired by its own terms). In contrast, here, there is no doubt that the Settlement Order remains in effect prospectively.

3. The Relief Ordered Allows for Prompt Return of Control to the District and is Less Onerous than Termination under the Settlement Order

Defendants argue (DBr21) that the court erred by reinstating vacated portions of the Settlement Order because doing so "defeats the rationale behind terminating segregable portions of a consent decree—to allow a local government to resume control of its political branches from a federal court once a violation is remedied." Defendants further claim that by "reinstating" the Settlement Order provisions, the court disregarded the Supreme Court's guidance under *Horne v. Flores*, 557 U.S. 433, 450 (2009)(internal citations omitted), for district courts "to ensure that 'responsibility for discharging the State's obligations is returned promptly to the State and its officials' when the circumstances warrant." DBr26-27. We have shown in Section C.1 above that the April 4 Order is entirely different from the terminated sections of the Settlement Order which addressed timely application and recertification processing. Thus, the court did not reinstate the terminated provisions.

The court fashioned relief that "provides that '[the District] may move to terminate [these remedies] anytime [it] can make a demonstration" that it is substantially complying with applicable law. JA1325. Defendants contend that

(DBr27) "this grants the District nothing more than what it always had, which is the ability to move to terminate anytime it could demonstrate that it was in compliance with applicable law." But this is not at all what the District "always had."

In order to terminate the application and recertification sections of the Settlement Order, defendants had to demonstrate three years of compliance with a 95% performance standard. JA254, para. 8, JA256-257, para. 12, JA262, para. 19, JA294-295, paras. 74, 75. Defendants claim (DBr35) that the modifications "make the Settlement Order substantially more onerous" because the court "dispens[ed] with the exit criteria." However, to the contrary, under the April 4 Order, there is no lengthy period of compliance or numerical standard that defendants must meet. Instead, defendants may move to terminate at any time they can demonstrate, based on substantial evidence, that their eligibility systems are functioning as required to "ensure and protect the rights of Medicaid recipients and applicants" under applicable law. JA1274. Thus, defendants' ability to achieve termination of the April 4 Order is significantly less onerous than the 3-year compliance period under the Settlement Order. The court properly ordered relief that "is consistent with the goal of restoring responsibility over local management functions as quickly as possible." JA1325.

Moreover, contrary to defendants' claim (DBr27-28), the court's April 4 Order is consistent with the teaching of the Supreme Court in *Horne v. Flores*, 557

U.S. 433, 450 (2009). *Horne v. Flores* states that: "It goes without saying that federal courts must vigilantly enforce federal law and must not hesitate in awarding necessary relief." *Id.* at 450. The Supreme Court explained that "federal-court decrees exceed appropriate limits if they are aimed at eliminating a condition that does not violate [federal law] or flow from such a violation" (internal citation omitted, alteration in original). *Ibid.* "If a [federal consent decree] is not limited to reasonable and necessary implementations of federal law,' it may 'improperly deprive future officials of their designated legislative and executive powers'" (alteration in original). *Ibid.* (quoting *Frew v. Hawkins*, 540 U.S. 431, 441 (2004)). In contrast to the types of orders discussed in *Horne v. Flores*, here, the April 4 Order is directly tailored to remedy federal law and constitutional violations with respect to application processing and protection of due process rights at the time of Medicaid renewal. It goes no further than to provide relief to the victims of defendants' violations of federal law and provides that court oversight will end when defendants demonstrate compliance with federal law protecting Medicaid applicants and recipients. JA1272-1274. Thus, it is consistent with the Supreme Court's ruling in *Horne v. Flores*.

Defendants also rely on *Freeman v. Pitts*, 503 U.S. 467, 489 (1992), a school desegregation case, for the proposition that a court should restore control to local authorities. DBr21. However, the *Freeman* Court explained (*id.* at 489) that a federal

court's "discretion to order…[a] partial withdrawal of its supervision and control…derives both from the constitutional authority which justified its intervention in the first instance and its ultimate objectives in formulating the decree." Retention of judicial control over some areas may be necessary or practicable to achieve compliance with a consent decree if these are (*id*. at 497) "intertwined or synergistic in their relation, so that a constitutional violation in one area cannot be eliminated unless the judicial remedy addresses other matters as well." This is precisely the case here: the court found that defendants were in violation of federal law with respect to the processing of applications and renewals (JA1320-1321) and those violations required remediation to achieve compliance with the remaining EPSDT provisions in the Settlement Order (JA1325-1326).[7]

[7] Defendants cite other cases which are factually distinguishable or inapposite. In *Bobby M. v. Chiles*, 907 F. Supp. 368, 369 (N.D. Fla. 1995), a case involving constitutional violations by the State of Florida at juvenile training school facilities, the district court terminated its supervision over one of the facilities when the State had achieved substantial compliance as to that facility. The district court applied the Supreme Court's test in *Freeman*, and determined that partial termination of the consent decree was warranted because the facility was "independent in all pertinent respects and therefore it is not necessary to subject Dozier [one facility] to the decree in order to ensure compliance therewith at Eckerd [the other facility]." *Id*. at 372. In contrast, here, remedying defendants' violations concerning determinations of Medicaid eligibility is necessary to achieve compliance with the EPSDT provisions in the consent decree because "a child cannot obtain any EPSDT service when he or she lacks Medicaid (internal citations omitted)." JA1326. *Hadix v. Johnson*, No. 80-73581, 2014 WL 4678252, at *2 (E.D. Mich. Sept. 18, 2014), is also unavailing. There, the district court refused to reopen a consent decree, *inter alia*, because the plaintiff prisoner had been transferred and was no longer part of the plaintiff class. Defendants make no such claim here.

4. The Relief Awarded Is Based on the Claims in the Case, Not on Alleged Violations of a New Law

Defendants argue (DBr22) that the new relief "is based not on the systemic failures that gave rise to the Settlement Order some 17 years ago, but on alleged violations of an entirely different law [namely, the ACA]." However, defendants are mistaken. Plaintiffs sought relief for the plaintiff class because defendants had returned to the same widespread violations of federal law concerning the processing of Medicaid applications and renewals that were adjudicated in 1996.

Defendants' core obligations remained the same at the time of plaintiffs' complaint and following the passage of the ACA: they must make determinations on Medicaid applications within 45 days and provide adequate and timely notice to Medicaid recipients before benefits can be terminated. U.S. Constitution, 5th Am.; 42 U.S.C. 1396a(a)(8); 42 C.F.R. 435.912(c)(3),[8] 42 C.F.R. 435.917(a),[9] 42 C.F.R.435.930(b), D.C. Code 4-205.26, 4-205.55(a). The court found that defendants had violated these requirements in 1996. *Salazar v. District of Columbia*, 954 F. Supp. 278, 324-326 (D.D.C. 1996).

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[8] This regulation was set forth at 42 C.F.R. 435.911(a) in 1996.

[9] This regulation was set forth at 42 C.F.R. 435.919 in 1996.

And, in 2016, based on substantial evidence, the court found that defendants had returned to systemic violations concerning the processing of applications and renewals (JA1320-1321):

> [N]umerous Medicaid-eligible residents of the District were denied benefits to which they were entitled due the District's failure to timely process initial applications, failure to deliver adequate and timely renewal notices, and failure to efficiently process renewal requests. These changed circumstances, which violate the Constitution and the ACA, affect members of the Plaintiff class. See Salazar v. D.C., 954 F. Supp. 278, 326 (D.D.C. 1996); 42 C.F.R. 435.912(c)(3); Order [Certifying the Class ECF100] at 1-2….

The relief that the court ordered was closely tailored to the violations found, and not, as defendants claim (DBr22), an effort by "the court…to shoehorn *new* claims that the District is not complying with the ACA into what remains of this lawsuit (emphasis in original)." As we show above (pp. 24-28), relief is provided directly to those Medicaid applicants and beneficiaries who have been harmed by defendants' violations because their application is pending more than 45 days or because they were about to be terminated from Medicaid without an affirmative determination that they were no longer eligible. JA1273-1274.[10]

[10] Defendants cite *Shepard v. Madigan*, 958 F. Supp. 2d 996, 1001 (S.D. Ill. 2013), for the proposition that "a new claim about a new law must be raised in a new suit." DBr22. In *Shepard*, the district court found that new concealed handgun legislation had rendered individual plaintiffs' request for injunctive relief moot and that a new constitutional challenge concerning the established processes under the new legislation required a new lawsuit. *Id*. at 999-1001. In contrast, here, class

5. Defendants' Due Process Rights Were Not Violated in the Adjudication of the Motion to Modify the Settlement Order

Defendants argue (DBr23) that by granting additional new relief, based on new factual circumstances, the "district court significantly expanded the District's obligations under the Settlement Order without any…procedural [due process] protections." Defendants' argument is wholly without merit. First, the District is not a "person" under the Fifth Amendment entitled to due process. *See South Carolina v. Katzenbach*, 383 U.S. 301, 323-324 (1996), *abrogated on other grounds*, *Shelby County, Ala. v. Holder*, 133 S.Ct. 2612 (2013)(holding that States are not persons "in the context of the Due Process Clause of the Fifth Amendment"). Second, defendants were represented by counsel throughout. Third, the court proceeded to decide plaintiffs' motion for a preliminary injunction and their Rule 60(b) motion together, only after consulting with and obtaining the consent of the parties at an on-the-record status call. JA1279. Fourth, defendants did not seek discovery, depositions, or request the court to conduct an evidentiary hearing on any issue. Fifth, defendants filed all the briefing and evidence they desired and even obtained permission to file a sur-reply brief. JA1244-1245. Under these

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members continue to have live claims, which are not rendered moot by any new law, and which are protected under a consent decree. Defendants also cite (DBr22) *Dowell v. Board of Education of Oklahoma City Public Schools, supra*, 782 F. Supp. at 578-579, for the same proposition. As discussed in note 6, that case is also inapplicable.

circumstances, there can be no question that defendants had full procedural protections in the litigation of the Rule 60(b) motion.

Defendants further argue (DBr23), for the first time on appeal, that the court allowed "plaintiffs to raise challenges to the District's implementation of the ACA within the confines of a 1993 lawsuit effectively excus[ing] their compliance with the class action requirements of Rule 23." As a threshold matter, defendants may not press this argument now because they did not raise it below. *Hormel v. Helvering*, 312 U.S. 552, 556 (1941)("Ordinarily an appellate court does not give consideration to issues not raised below"). However, even if defendants had not waived this argument, there was no requirement to certify a new class because the court provided relief to the remaining certified subclasses with active provisions in the Settlement Order. Under the *Rufo* standard, "[o]nce a moving party has met its burden of establishing either a change in fact or in law warranting modification of a consent decree, the district court should determine whether the proposed modification is suitably tailored to the changed circumstances." 502 U.S. at 391. This is what the court did. JA1326-1332. Defendants seek to impose a requirement on the *Rufo* standard for modification of consent decrees that does not exist.

II

MODIFICATION OF THE SETTLEMENT ORDER WAS WARRANTED AND SUITABLY TAILORED TO ADDRESS THE WIDESPREAD VIOLATIONS THAT DEPRIVED THE PLAINTIFF CLASS OF MEDICAID COVERAGE

A. THE DISTRICT COURT PROPERLY FOUND THAT CHANGED CIRCUMSTANCES EXISTED BASED ON EVIDENCE OF NEW AND WIDESPREAD DEPRIVATIONS OF MEDICAID COVERAGE AT APPLICATION AND RENEWAL

Under Rule 60(b)(5), a party seeking modification bears the burden of demonstrating that "a significant change either in factual conditions or in law" warrants revision of the decree. *Rufo v. Inmates of Suffolk County Jail*, *supra,* 502 U.S. at 384.

Plaintiffs' extensive evidence of changed factual circumstances included defendants' own documents (JA350-403, JA412-561, JA659-662, JA666-695, JA712-738, JA750-790, JA989-1028), admissions of defendants (JA822-855, paras. 15,31,57,65,67,71-73,75; JA1132-1140, paras. 6,12,18-20), communications to defendants from CMS noting missed deadlines (JA660) and delayed processing of renewals (JA1301 citing JA468-470), the testimony of Medicaid advocates and medical providers in the District of Columbia, including DC Legal Aid, Whitman-Walker Health, Bread for the City, Legal Counsel for the Elderly, and the D.C. Fiscal Policy Institute (JA562-592, JA598-601, JA608-619, JA1029-1125; JA1143-1214), organizations that collectively represent thousands of Medicaid applicants and

recipients, and the testimony of individual Medicaid applicants and beneficiaries (JA593-597, JA602-607, JA739-749, JA1215-1243).

Testimony describing the irreparable harm to individuals when they erroneously are denied Medicaid benefits was before the court in affidavits from applicants and beneficiaries themselves, as well as from a doctor and staff members at clinics who serve the Medicaid population. One example included the child of Melissa Rizio who had been diagnosed with ADHD, sensory processing disorder, childhood anxiety, eczema, and other environmental allergies. He was unable to obtain necessary care due to an improper lapse in coverage at recertification. The family had "been abruptly cut off from Medicaid benefits so many times that [the mother had] lost count" due to the District "continuously claim[ing] that they did not get [the family's] recertification forms." JA742, paras. 4-5. The mother explained that, "[d]ue to this interruption of Medicaid benefits, I had to cancel [my son's] medical appointments scheduled with his treating physicians and was not able to get medication prescribed by his doctor in October 2015." JA745, para. 23.

The court found that (JA1304):

> [A] significant number of very sick people, or elderly people, or parents of children, are suffering from the time their benefits lapse erroneously until the District can fix the error and make benefits retroactive. In the interim, those people may not be able to buy their cancer medicine, receive necessary mammograms, or continue necessary physical therapy.

The court found, applying the *Rufo* standard, that plaintiffs had met their burden in establishing changed factual circumstances that were causing irreparable harm to Medicaid applicants and beneficiaries (JA1320):

> Based on the extensive evidence submitted by Plaintiffs, it is clear that circumstances have changed significantly since entry of the Settlement Order. Given the numerous case histories presented by Plaintiffs, there is no question that many of the class members are being irreparably harmed by their inability to obtain Medicaid benefits….

Defendants do not challenge that finding on appeal.

Because the court found that the facts constituted significant changed circumstances (JA1320-1326), the relief it ordered—provisional Medicaid for applicants whose applications were pending over 45 days until a determination was made and continued eligibility at renewal for 90 days or until a determination was made (JA1273-1274)—is warranted under *Rufo*. *See* 502 U.S. at 391.

B. THE DISTRICT COURT PROPERLY FOUND THAT THE CHANGED CIRCUMSTANCES WERE NOT ANTICIPATED

Under *Rufo*, "modification [of a consent decree] should not be granted where a party relies upon events that actually were anticipated at the time it entered into a decree" (internal citations omitted). 502 U.S. at 385. "Litigants are not required to anticipate every exigency that could conceivably arise during the life of a consent decree." *Ibid*. Modification is "appropriate when a decree proves unworkable because of unforeseen obstacles." *Id*. at 384. This Court has explained that "[t]he

focus of Rule 60(b)(5) is not on what was possible, but on what the parties and the court reasonably anticipated." *United States v. Western Electric Co., Inc.*, 46 F. 3d 1198, 1205 (D.C. Cir. 1995).

The district court determined, as a fact, that "no one did or could have anticipated, in 1999 when the Settlement Order was entered, the passage of the ACA, no less the complexity and its reforms to our health care." JA1322-1323. Finding that "no one could have predicted the magnitude of the problems that attended the ACA's implementation," the court stated that "as is now clear, the problems facing Medicaid-eligible residents go far beyond renewal procedures and affect initial applications as well as the basic administration of the program." *Ibid*.

Defendants argue that the court "erred [in its determination that renewal problems were unforeseen because] changes in the renewal process brought about by the ACA were anticipated" and that "[w]hile the scope of the problem may not have precisely been known at the time the renewal provisions were terminated, the court and the parties unquestionably anticipated lengthy and significant problems implementing the ACA's new requirements." DBr32-33. The record proves otherwise. It was beyond dispute, that, in 1999, when the consent decree was entered, the parties did not anticipate the passage of the ACA in 2010. Defendants themselves stated, "[i]t is no understatement to say that the ACA has transformed

Medicaid, particularly how states determine eligibility of individuals who initially apply for benefits or during annual renewal of eligibility." ECF2077, p. 5.

Defendants claim (DBr32-33) that the relevant inquiry is whether the problems were anticipated in 2013, when they were relieved from the recertification section of the Settlement Order. In contrast, *Rufo* states that the relevant time to consider whether changed circumstances were anticipated is "the time [when the parties] entered into a decree." 502 U.S. at 385. However, even assuming *arguendo* that 2013 was the correct date to begin the inquiry of whether the changed circumstances were "anticipated," the court concluded that the scope of the changed circumstances after 2013 was something "no one could have predicted." JA1322. Defendants have not shown that the finding was clearly erroneous. While the court acknowledged (JA1276) that it had anticipated lengthy and significant problems with the renewal process when it terminated Section III (JA316), it also explicitly found a lack of evidence to suggest that the due process rights of class members would not be adequately protected under the ACA and its implementing regulations (JA317-319), as has now occurred. Based on defendants' representations in 2013, the court found that there were "multiple safeguards" under the ACA regulations that would protect the due process rights of class members. JA319. Moreover, no anticipated changes to timely application processing were addressed by the Court in the 2013 decision. In 2009, defendants had represented that they were "fully

compliant with federal law and the terms of the Settlement Order of January 22, 1999 in this case as to the timely processing of initial Medicaid applications…." JA309. Therefore, the court acted within its discretion in finding that defendants' widespread violations of Medicaid beneficiaries' statutory and due process rights concerning Medicaid applications and renewals was not anticipated.

A district court's judgment about "what it and the parties contemplated" at the beginning of the consent decree "is entitled to a large measure of respect." *U.S. v. Western Electric Co., Inc.*, *supra*, 46 F.3d at 1205 (citing *Hutto v. Finney*, 437 U.S. 678, 688 (1978)(concerning a 12-year decree). Here, the court has been closely administering the Settlement Order for more than 18 years. Therefore, its determination of what the parties contemplated and what was anticipated concerning defendants' conduct is entitled to deference.

C. THE DISTRICT COURT PROPERLY FOUND THAT CHANGED CIRCUMSTANCES HAVE A DETRIMENTAL IMPACT ON THE EPSDT SUBCLASS

Defendants argue (DBr30) that the court abused its discretion because it "did not find that the changes regarding eligibility determinations and renewals were in fact causing or even contributing to the District's inability to meet the metrics required under the remaining EPSDT provisions…[in] the Settlement Order." Although defendants refer to "metrics" in the plural, there is only one "metric" applicable to defendants in the EPSDT sections of the Settlement Order, namely,

after three years of compliance with the injunction in paragraph 36 and the provisions to improve performance in notice about the benefit and service delivery set forth in paragraphs 37-59, defendants may end court supervision by demonstrating that 75% of children eligible for Medicaid had at least one well-child visit with a doctor in the most recent year. JA295-296, para. 77. This metric is known as the participant ratio. *See* JA295, para. 77. However, even focusing narrowly on this metric of defendants' delivery of well-child visits to Medicaid children, defendants' performance has declined over the same period that the significant problems in processing Medicaid applications and renewals have arisen. Defendants' own data reported to the federal government and the court shows that the participant ratio fell from 69% in fiscal year 2012, the year before the District began implementing the ACA, to 63% in fiscal year 2014, the most recent year in the record at the time of the court's decision. *See* CMS Form 416 Reports, Line 10, JA1126-1127 (FY2012); JA1128-1129 (FY2013); JA322-323 (FY2014).[11]

The EPSDT sections in the Settlement Order set forth an injunction protecting each child in the EPSDT subclass by requiring defendants to "provide or arrange for the provision of early and periodic, screening, diagnostic and treatment services

[11] The fiscal year 2015 report was submitted by defendants after the court's decision was issued on April 4, 2016. However, the well-child visit rate for 2015 remained at 63%. 1349-1350, Line 10.

(EPSDT) when they are requested by or on behalf of children." JA271, para. 36. EPSDT services include screening services to ensure that children are healthy, such as well-child visits, dental examinations, hearing and vision examinations, immunizations, and blood lead testing. 42 U.S.C. 1396a(a)(43)(B); 42 U.S.C. 1396d(r)(1)-(4). EPSDT also includes "corrective treatment" if problems are found during the screening examination. 42 U.S.C. 1396a(a)(43)(C). Corrective treatments include the full range of medical care, treatment, and therapies prescribed for a child: "Such other necessary health care, diagnostic services, treatment, and other measures…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. 1396d(r)(5). The EPSDT notice section in the Settlement Order also requires "[d]efendants…[to] inform all pregnant women, parents, child custodians and teenagers…who have been determined to be eligible for Medicaid benefits…of the availability of…[EPSDT] services…." JA286, para. 54.

When a child's Medicaid eligibility is delayed by an application pending more than 45 days, or is interrupted erroneously at renewal, the child cannot obtain any EPSDT services. If a parent or caregiver is ineligible because of defendants' actions, they will not be provided with the notice about the EPSDT benefit for their child under paragraph 54 of the Settlement Order which requires notice to "parents [and]

child custodians…eligible for Medicaid benefits." Thus, the court properly found that the "issues affecting initial applications and renewals are clearly related to portions of the Settlement Order concerning EPSDT services" and further found that "it is common sense that a child cannot obtain any EPSDT service when he or she lacks Medicaid eligibility" (internal citation omitted)). JA1326.

Aside from the simple logic that a child cannot access any Medicaid benefit (including EPSDT services) when her Medicaid eligibility lapses, the court also relied upon the sworn affidavit testimony with many examples of children who did not have access to EPSDT services due to defendants' failures to timely process applications or Medicaid renewals. *See* JA565-566, para.11; JA575-576, para. 11(a)-11(c); JA579-580, para. 6(b)-(c), 6(e), JA583, para. 15(b); JA593-594, paras. 1-11; JA606-607, paras. 6, 12; JA742, paras. 3,4, JA745, para. 23; JA1145-1147, paras.8, 9, 12; JA1227-1228, paras. 3-7; JA1230-1231, paras. 9-18.[12] The court cited several examples of children with severe disabilities who were impacted by defendants'

[12] Defendants claim that the court only relied on four cases of children not receiving Medicaid services and that (DBr31) "even those examples do not support a finding of widespread, ongoing harm…." However, the court cited specific cases to illustrate the problems caused by the District. The fact that the court described a fewer number of cases of children than those presented in the evidence, does not mean that the court dismissed the declarations concerning those children or the other extensive evidence of systemic problems before it (*see* JA1288-1314). Given the magnitude of the problems created by defendants, the court could not be expected to recount every case presented to it in its 59-page opinion.

application and renewal processing violations to demonstrate the severity of the harm they suffered. *See* JA1303 (citing JA605-607 (lapse in coverage for 14-year-old child with autism due to defendants' failure to timely process renewal form)); JA1301-1302 (JA580, para. 6(e) (lapse in coverage for several children, including one with severe health conditions, due to defendants' failure to process renewal form)); JA1313-1314 (citing JA1239-1243 (child with severe form of epilepsy who received several Medicaid termination notices despite timely submission of renewal form, leaving family unsure of whether they continued to have coverage)). The court cited these and other "narratives of affected District residents," to illustrate "the deeply personal calamity that befell many Medicaid applicants and beneficiaries when they and their children were unable to get the care to which they were entitled." JA1288.

Defendants claim that "the record before the court demonstrated that 97.6 percent of eligible children are enrolled in Medicaid" and that "a recently released study indicates that the District is the first in the nation for continuous Medicaid coverage of children." DBr32. Defendants did not submit either study to the court, but summarized the studies in an affidavit of their representative, Ms. Schlosberg. JA824, para. 9; JA1390-1391, para. 12. We explain the flaws in the studies upon

which defendants' claims are based in a footnote.[13] However, studies about the District of Columbia Medicaid program do not overcome the extensive evidence submitted by plaintiffs upon which the court based its conclusion that "thousands of Medicaid beneficiaries were affected by (1) the District's failure to process Medicaid applications within 45 days in violation of 42 C.F.R. § 435.912(c)(3) and D.C. Code § 4-205.26 (2014); and (2) the District's failure to timely renew Medicaid benefits or to provide adequate notice to Medicaid recipients before terminating their benefits in violation of federal law." JA1287-1288.

[13] The 97.6% figure cited by defendants is from 2014, is based on a survey, not eligibility data, excludes young adults between 19 and 20, and most importantly, does not appear to reflect the number of children who were continuously enrolled, that is, the number of children who did not experience gaps in coverage. *See* ACA Implementation-Monitoring and Tracking Report, Urban Institute, May 2016, pp. 2-4, *available* at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429061 (last visited March 23, 2017). This report is cited as the source material for the graphic map cited in Ms. Schlosberg's affidavit. JA1390, para. 12, n.1.

Second, the "recently released study" is based on data from 2011, *i.e.*, at least two years before the implementation of the ACA in the District (JA1287) and four years before the court found major problems began to occur with applications and renewals (JA1288, JA1298). *See* Continuity of Medicaid Coverage in an Era of Transition, A Working Paper, November 1, 2015, Table 1, available at http://www.communityplans.net/policy/continuity-of-medicaid-coverage-in-an-era-of-transition/ (last visited March 23, 2017).

D. THE RELIEF ORDERED BY THE DISTRICT COURT IS SUITABLY TAILORED TO THE CIRCUMSTANCES

1. The Remedy Ordered is Suitably Tailored to the Violations Found

As a remedy for the violations of federal, constitutional and District of Columbia law found by the court, defendants were ordered to provide relief directly to members of the plaintiff class: to "provisionally approve all Medicaid applications pending over 45 days until a final determination can be made" and to "continue the eligibility of all Medicaid recipients due to be renewed or recertified for 90 days after each recipient's renewal or recertification deadline unless Defendants have affirmatively determined that the recipient is no longer eligible for Medicaid." JA1273-1274.

Defendants argue (DBr34) that even if the court properly concluded that "the changes in initial eligibility processing and renewals made the EPSDT provisions unworkable or inequitable," the remedy fashioned by the court was not suitably tailored because it included adults over whom the court had no oversight. However, we have shown above (p. 22) that the court ruled in 2015 that it continued to have authority over subclasses II (untimely application processing) and III (loss of benefits without adequate notice) with respect to reimbursement for out-of-pocket expenses that should have been covered by Medicaid—those subclasses include adults as well as children. JA327, JA343-344. The remedy in the April 4 Order is closely tailored to address their claims.

Significantly, the court concluded that the problems in the Medicaid program shown by plaintiffs' evidence was systemic (JA1322):

> [A]s is now clear, the problems facing Medicaid-eligible residents go far beyond renewal procedures and affect initial applications, as well as the basic administration of the program.

Defendants do not challenge this factual finding on appeal and it is not clearly erroneous. Therefore, based on a finding of a systemic problem, the court's decision to order relief for all three remaining subclasses was suitably tailored.

Moreover, as the court noted "children make up a substantial proportion of the District's Medicaid population." JA1326. Based on data from defendants, children made up about 40% of the entire Medicaid population in 2014. *Ibid*. (noting there were 98,350 children eligible for Medicaid out of a total population of 247,850); DBr6. If the children's caretakers are added to this number, it would be reasonable to expect that the majority of the District's Medicaid population is composed of children and their caretakers. Importantly, families with children apply for and renew benefits as a unit. 42 C.F.R. 435.110; *see*, *e.g.*, JA1314 (noting the District's admission that a new case should not have been opened for a child when there was already one for the parent). The remedy here is limited to applicants with an application pending over 45 days and beneficiaries whose renewal applications have not been processed to a final determination. Therefore, it is a remedy closely tailored to the violations found.

While the remedy does benefit adults as well as children up to age 21 (the EPSDT subclass), that fact does not invalidate the remedy. As the Supreme Court concluded in *Brown v. Plata*, 563 U.S. 493, 531 (2011): "[T]he [legal] precedents do not suggest that a narrow and otherwise proper remedy for a constitutional violation is invalid simply because it will have [positive] collateral effects." Citing *Board of Trustees of State University of New York v. Fox*, 492 U.S. 469, 480 (1989), the Court stated: "Narrow tailoring requires a "fit' between the [remedy's] ends and the means chosen to accomplish those ends.'" 563 U.S. at 531. Thus, the Court upheld an order reducing prison overcrowding for all prisoners within California's prison system, although class members were limited to those with serious mental and medical conditions. *Id*. at 531-532. Similarly, here, the fact that the April 4 Order assists additional Medicaid beneficiaries who are not in the EPSDT subclass does not render it invalid. This is particularly so when the court has recently held that there are "three remaining sub-classes" (JA339) and only these same three remaining subclasses benefit from the April 4 Order.

2. The District Court Properly Considered the Public Interest

Under the Supreme Court's standard for modification of a consent decree pursuant to Rule 60(b)(5), modification is appropriate "when a decree proves to be unworkable because of unforeseen obstacles or when enforcement of the decree without modification would be detrimental to the public interest" (citations omitted).

Rufo v. Inmates of Suffolk County, *supra*, 502 U.S. at 384-385. A district court should "keep the public interest in mind in ruling on a request to modify based on a change in conditions making it substantially more onerous to abide by the decree." *Id*. at 392.

Defendants claim (DBr35) that the district court abused its discretion in modifying the Settlement Order under Rule 60(b)(5) because it "misinterpreted the public interest, [and] failed to defer to local administrators." However, the court unquestionably considered the public interest by thoroughly addressing the evidence presented by both parties, balancing the equities, and carefully crafting relief. JA1327-JA1332. The Supreme Court has held that, where "federal law is at issue and 'the public interest is involved,' a federal court's 'equitable powers assume an even broader and more flexible character than when only a private controversy is at stake.'" *Kansas v. Nebraska*, 135 S.Ct. 1042, 1053 (2015)(quoting *Porter v. Warner Holding Co*., 328 U.S. 395, 398 (1946)).

Here, the court found that (JA1328) "[p]laintiffs have shown that changed circumstances have led the District to violate its obligations to adjudicate Medicaid applications within 45 days and to renew Medicaid benefits…." Because the changed circumstances, *i.e*., the problems created by the District, include "the denial of coverage of eligible adults as well as children[,]" the court determined that "[i]t is in the public interest to ensure that those children and adults do not lose the vital

services provided by Medicaid coverage under the ACA." JA1327-1328. Defendants provided no evidence to contradict this determination.

3. The District Court Properly Considered Defendants' Claims of Financial Harm

In tailoring a remedy under *Rufo*, "[f]inancial constraints may not be used to justify the creation or perpetuation of constitutional violations, but they are a legitimate concern of government defendants in institutional reform litigation and therefore are appropriately considered in tailoring a consent decree modification." 502 U.S. at 392-393.

Defendants claim that (DBr36) "the court failed to consider the substantial financial costs its April 4 order imposes on the District (and the federal government), a concern that the court should have considered in tailoring the modifications it proposed." However, defendants did not provide any estimates of the financial cost of compliance with the April 4 Order until after the court had issued it. *See* ECF2077, JA822-857; ECF2097, JA1132-1140; ECF2108, JA1246-1269. Defendants only later provided such evidence with their Motion for a Stay (ECF2114 and JA1334-1348) and their Motion to Alter or Amend Judgment (ECF2113 and ECF2113-1).

Despite the lack of evidence from defendants, the court nevertheless considered and addressed their general concerns that plaintiffs' requested relief would cause financial harm to the District's taxpayers (JA1328-1329):

> The first prong [of relief requested by plaintiffs] would simply require provisional approval of Medicaid applications pending longer than 45 days until a final determination can be made. If the District complies with the law by reaching final determinations within 45 days (as it claims to have done in the month of February 2016), this relief will impose no additional burden at all.
>
> …
>
> By contrast, the second prong of relief requested by Plaintiffs, which would indefinitely continue the benefits of all Medicaid benefits of all Medicaid recipients due to be renewed or recertified, does indeed sweep too broadly…. [T]he District notes that Plaintiffs' request to continue the benefits of all Medicaid recipients due to be renewed to continue the benefits of Medicaid recipients whose ongoing eligibility cannot be verified or who are simply no longer eligible for Medicaid. Thus, the requested relief "would virtually eliminate the District's ability to terminate coverage for individuals who are not eligible or entitled to Medicaid benefits at heavy costs to the District's taxpayers." [emphasis added][internal citations omitted].

The court then tailored its remedy to limit the continued eligibility provided to beneficiaries to 90 days unless "Defendants have affirmatively determined that the recipient is no longer eligible for Medicaid." JA1274. Explaining further, the court stated (JA1330-1331):

> Medicaid recipients will maintain the full value of their benefits during the 90-day grace period, rather than lose access to health care for reasons beyond their control. At the same time, the District -- and by extension, the District's taxpayers -- will not be saddled with the burden of indefinitely furnishing benefits to individuals who may no longer be Medicaid eligible.

Thus, the court properly tailored a remedy considering defendants' claims of financial harm.

III

THE DISTRICT COURT DID NOT ERR IN DENYING DEFENDANTS' RULE 59(e) MOTION TO ALTER OR AMEND JUDGMENT

Defendants argue (DBr36) that the court erred in denying defendants' motion to alter or modify the April 4 Order because the court failed to consider that the remedy in the April 4 Order "will cost over $20 million in District funds and almost $80 million in federal funds each year the requirement is in effect."

However, the court properly denied defendants' motion since it was based on evidence of the costs of compliance that could have been, but was not, submitted to the court in any of defendants' submissions on the motions, including a sur-reply brief. ECF2077 and JA822-908; ECF2097 and JA1132-1142; ECF2108 and JA1246-1271. A party seeking to alter or amend a judgment under Rule 59(e) of the Federal Rules of Civil Procedure, must allege a change in applicable law, new evidence, or clear error. *Firestone v. Firestone*, 76 F.3d 1205, 1208 (D.C. Cir. 1996). Because defendants' evidence of the estimated compliance costs with the April 4 Order was presented for the first time in the Rule 59(e) motion (ECF2113), and could have been presented before, it was not an appropriate basis on which the court should have granted relief under Rule 59(e).

CONCLUSION

For the reasons described above, this Court should affirm the district court's orders of April 4 and June 2, 2016.[14]

Respectfully submitted,

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[14] The July 12 Order modifying the stay pending appeal will become moot when this Court resolves the appeal.

CERTIFICATE OF COMPLIANCE WITH RULE 32

I hereby certify that:

(1) this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 12,973 words, excluding the parts of the brief exempted by 32(a)(7)(B)(iii), and

(2) this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the typestyle requirements of Fed. R. App. P. 32(a)(6) because the brief has been prepared in a proportionally spaced typeface using Word 2016 in Times New Roman 14 Point Font.

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May 15, 2017

ADDENDUM

TABLE OF CONTENTS

42 U.S.C. 1396a(a)(3), (a)(8), (a)(43), (e)(14)

§ 1396a. State Plans for Medical Assistance

(a) Contents.

A State plan for medical assistance must—

* * *

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

* * *

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

* * *

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases.

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 1397hh(e) [9] of this title and

(iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title;

* * *

(e) Continuation and extension of eligibility of certain individuals; Express Lane Option for Children

* * *

(14) Income determined using modified adjusted gross income—

(A) Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and

household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on March 23, 2010. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) No income or expense disregards.—
Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) No asset test.—
A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) Exceptions.—

(i) Individuals eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals eligible for medicare cost-sharing. — Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility

for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under subchapter XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of paragraph (3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

* * *

42 U.S.C. 1396d(r)

§ 1396d. Definitions

For purposes of this subchapter—

* * *

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) At intervals which meet reasonable standards medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

(iii) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(iv) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

42 C.F.R. 435.110

§ 435.10 Individuals receiving aid to families with dependent children.

(a) A Medicaid agency must provide Medicaid to individuals receiving AFDC.

(b) For purposes of this section, an individual is receiving AFDC if his needs are included in determining the amount of the AFDC payment. This includes an individual whose presence in the home is considered essential to the well-being of a recipient (see 45 CFR 233.20(a)(2)(vi)) and who could be a recipient under the State's AFDC plan if that plan were as broad as allowed under the Act for FFP.

42 C.F.R. 435.603

§435.603 Application of modified adjusted gross income (MAGI).

(a) *Basis, scope, and implementation*.

(1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(b) *Definitions*. For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver.

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

Tax dependent has the meaning provided in §435.4 of this part.

(c) *Basic rule*. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.

(d) *Household income—*

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) *Income of children and tax dependents*.

(i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

(e) *MAGI-based income*. For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions*. The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from—

(A) Rights of ownership or possession in any lands described in paragraph (e)(3)(ii) of this section; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements—

(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(f) *Household*—

(1) *Basic rule for taxpayers not claimed as a tax dependent*. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

(2) *Basic rule for individuals claimed as a tax dependent*. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this section—

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent*. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

(4) *Married couples*. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

(g) *No resource test or income disregards*. In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not—

(1) Apply any assets or resources test; or

(2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX of the Act, except as provided in paragraph (d)(1) of this section.

(h) *Budget period*—

(1) *Applicants and new enrollees*. Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) *Current beneficiaries*. For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at §435.940 through §435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B-1(e) is below 100

percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e).

(j) *Eligibility Groups for which MAGI-based methods do not apply*. The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in §435.601 and §435.602 of this subpart.

(1) Individuals whose eligibility for Medicaid does not require a determination of income by the agency, including, but not limited to, individuals receiving Supplemental Security Income (SSI) eligible for Medicaid under §435.120 of this part, individuals deemed to be receiving SSI and eligible for Medicaid under §435.135, §435.137 or §435.138 of this part and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act.

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under §435.121, §435.232 or §435.234 of this part or under section 1902(e)(3) of the Act, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group under which long-term care services and supports not covered for individuals determined eligible using MAGI-based financial methods are covered, or for individuals being evaluated for an eligibility group for which being institutionalized, meeting an institutional level of care or satisfying needs-based criteria for home and community based services is a condition of eligibility. For purposes of this paragraph, “long-term care services and supports” include nursing facility services, a level of care in any institution equivalent to nursing facility services; and home and community-based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

(5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis.

(k) *Eligibility*. In the case of an individual whose eligibility is being determined under §435.214, the agency may—

(1) Consider the household to consist of only the individual for purposes of paragraph (f) of this section;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (d) of this section.

(3) Increase the family size of the individual, as defined in paragraph (b) of the section, by one.

42 C.F.R. 457.315

§ 457.315 Application of modified adjusted gross income and household definition.

(a) Effective January 1, 2014, the State must apply the financial methodologies set forth in paragraphs (b) through (i) of § 435.603 of this chapter in determining the financial eligibility of all individuals for CHIP. The exception to application of such methods for individuals for whom the State relies on a finding of income made by an Express Lane agency at § 435.603(j)(1) of this subpart also applies.

(b) In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 457.343, whichever is later.

42 C.F.R. § 435.912(c)(3)

§ 435.912 Notice of agency's decision concerning eligibility.

* * *

(c)(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed—

(i) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(ii) Forty-five days for all other applicants.

* * *

42 C.F.R. 435.916(a), (b)

§ 435.916 Periodic renewal of Medicaid eligibility.

(a) Renewal of individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI).

(1) Except as provided in paragraph (d) of this section, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under §§ 435.948, 435.949 and 435.956 of this part. If the agency is able to renew eligibility based on such information, the agency must, consistent with the requirements of this subpart and subpart E of part 431 of this chapter, notify the individual -

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(a) of this subpart, if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(3) Use of a pre-populated renewal form. If the agency cannot renew eligibility in accordance with paragraph (a)(2) of this section, the agency must -

(i) Provide the individual with -

(A) A renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility.

(B) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 435.907(a) of this part, and to sign the renewal form in a manner consistent with § 435.907(f) of the part;

(C) Notice of the agency's decision concerning the renewal of eligibility in accordance with this subpart and subpart E of part 431 of this chapter;

(ii) Verify any information provided by the beneficiary in accordance with §§ 435.945 through 435.956 of this part;

(iii) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination, or a longer period elected by the State, without requiring a new application;

(iv) Not require an individual to complete an in-person interview as part of the renewal process.

(b) Redetermination of individuals whose Medicaid eligibility is determined on a basis other than modified adjusted gross income. The agency must redetermine the eligibility of Medicaid beneficiaries excepted from modified adjusted gross income under § 435.603(j) of this part, for circumstances that may change, at least every 12 months. The agency must make a redetermination of eligibility in accordance with the provisions of paragraph (a)(2) of this section, if sufficient information is available to do so. The agency may adopt the procedures described at § 435.916(a)(3) for individuals whose eligibility cannot be renewed in accordance with paragraph (a)(2) of this section.

(1) The agency may consider blindness as continuing until the reviewing physician under § 435.531 of this part determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team, under § 435.541 of this part, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

42 C.F.R. 435.917(a)

§ 435.917 Notice of agency's decision concerning eligibility, benefits, or services.

(a) Notice of eligibility determinations. Consistent with §§ 431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must—

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905(b), and

(3) If provided in electronic format, comply with § 435.918(b).

* * *

42 C.F.R. 435.930(b)

§ 435.930 Furnishing Medicaid.

The agency must—

(a) Furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures;

(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

* * *

Fed. R. Civ. P. 59(e)

Rule 59. New Trial; Altering or Amending a Judgment

* * *

(e) Motion to Alter or Amend a Judgment. A motion to alter or amend a judgment must be filed no later than 28 days after the entry of the judgment.

* * *

Fed. R. Civ. P. 60(b)

Rule 60. Relief from a Judgement or Order

(b) Grounds for Relief from a Final Judgment, Order, or Proceeding. On motion and just terms, the court may relieve a party or its legal representative from a final judgment, order, or proceeding for the following reasons:

(1) mistake, inadvertence, surprise, or excusable neglect;

(2) newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move for a new trial under Rule 59(b);

(3) fraud (whether previously called intrinsic or extrinsic), misrepresentation, or misconduct by an opposing party;

(4) the judgment is void;

(5) the judgment has been satisfied, released, or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable; or

(6) any other reason that justifies relief.

* * *

D.C. Code § 4-205.26

§ 4-205.26. Procedure for public and medical assistance application.

Applications for public and medical assistance shall be approved or disapproved by the Mayor with reasonable promptness. Such action shall be taken on applications for public assistance not in excess of 45 days and on applications for medical assistance to people with disabilities not in excess of 60 days from the date the application is received to the date the applicant receives his 1st assistance payment or his Medicaid care or a notice of ineligibility, unless a delay is caused by unusual circumstance beyond the Mayor's control including those which are:

(1) Wholly within the applicant's control;

(2) Beyond his or her control, such as hospitalization or imprisonment; or

(3) An administrative or other emergency that could not be reasonably controlled by the agency.

D.C. Code § 4-205.55(a)

(a) The Mayor shall give timely and adequate notice in cases of intended action to discontinue, withhold, terminate, suspend, reduce assistance, or make assistance subject to additional conditions, or to change the manner or form of payment to a protective, vendor, or 2-party payment.

(1) "Timely" means that the notice is postmarked at least 15 days before the date upon which the action would become effective, except as provided in § 4-205.54(d).

(2) "Adequate" means that the written notice includes a statement of what action the Mayor intends to take, the reasons for the intended action, the specific law and regulations supporting the action, an explanation of the individual's right to request a hearing, and the circumstances under which assistance will be continued if a hearing is requested.

* * *

CERTIFICATE OF SERVICE

I hereby certify that on May 15, 2017, I caused a true copy of the foregoing Initial Brief for Appellees to be delivered electronically via the Court's CM/ECF system to counsel for defendants-appellants, Todd S. Kim, Loren L. AliKhan, and Richard S. Love, counsel for *amicus* Legal Aid Society of the District of Columbia, Jonathan H. Levy, and counsel for *amicus* Children's Law Center, Allen Snyder.

/s/ Zenia Sanchez Fuentes
ZENIA SANCHEZ FUENTES
Counsel for Plaintiffs-Appellees

May 15, 2017