UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

STEPHEN LESSLER, VERONICA EXLEY, PATRICIA BELADE, LORRAINE COOPER, and HARRY VOET, on behalf of themselves and all others similarly situated Plaintiffs, v. SYLVIA MATHEWS BURWELL, Secretary of Health and Human Services, Defendant.	Civil Action No. COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND MANDAMUS RELIEF CLASS ACTION

I. PRELIMINARY STATEMENT

1. The Medicare program's system of administrative review has four levels of appeal. Only the third level, the administrative law judge (ALJ) level, provides the right to an oral hearing before the adjudicator, including witness testimony, allows a beneficiary to present his or her case with more than written evidence and argument, and provides the only opportunity for meaningful review.

2. Because of the crucial role of the ALJ in the review process, Congress has directed that a decision must issue from the ALJ no more than 90 days from the date that the request for an ALJ hearing is received. As of July 2014, the average length of time in which ALJ decisions were issued after the hearing request was received was over five times that statutory limit, 488.8 days.

3. This is an action for declaratory, injunctive, and mandamus relief against the Secretary of Health and Human Services (the Secretary) as the official responsible for

implementing and enforcing the Medicare program. The named plaintiffs are Medicare beneficiaries who have waited more than 90 days to receive an ALJ decision. On information and belief, at present virtually every Medicare beneficiary who requests an ALJ hearing waits more than 90 days for the decision, and, as the statistic in paragraph 2 above and other statistics indicate, usually wait considerably longer.

4. The available information indicates that the time between receipt of the request for an ALJ hearing and issuance of the decision by the ALJ has been increasing dramatically since fiscal year 2009.

5. Plaintiffs challenge this defective administrative review process as in violation of the Medicare statute and the Due Process Clause of the Fifth Amendment. On behalf of themselves and the nationwide class consisting of all other Medicare beneficiaries harmed by this systemic denial of a timely, meaningful, and statutorily mandated review process, plaintiffs seek declaratory, injunctive, and mandamus relief to correct the system of administrative review for the beneficiaries of Medicare.

II. JURISDICTION AND VENUE

6. Jurisdiction is conferred on this Court by 42 U.S.C. § 405(g) as made applicable to and incorporated in the Medicare statute by 42 U.S.C. §§ 1395ff(b)(1)(A), 1395w-22(g)(5), and 1395w-104(h)(1), and by 28 U.S.C. §§ 1331 and 1361. Plaintiffs seek a declaration of rights pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202. Venue is proper in this District pursuant to 28 U.S.C. § 1391(e) and 42 U.S.C. § 405(g).

III. PARTIES

7. Plaintiff STEPHEN LESSLER is a resident of Fairfield, Connecticut. He

is 92 years old. At all relevant times he was a Medicare beneficiary and was enrolled in a Medicare Advantage Plan, Aetna Health, Inc., CT.

8. Plaintiff VERONICA EXLEY is a resident of Baltic, Connecticut. She is 79 years old. At all relevant times she was a Medicare beneficiary.

9. Plaintiff PATRICIA BELADE is a resident of Brooklyn, Connecticut. She is 84 years old. At all relevant times she was a Medicare beneficiary.

10. Plaintiff LORRAINE COOPER is a resident of New York, New York. She is 80 years old. At all relevant times she was a Medicare beneficiary.

11. Plaintiff HARRY VOET is a resident of Kenwood, Ohio. He is 83 years old. At all relevant times he was a Medicare beneficiary.

12. Defendant SYLVIA MATHEWS BURWELL is the Secretary of the Department of Health and Human Services. She is responsible for the overall operation of the Medicare program and in particular for the Office of Medicare Hearings and Appeals, which is a staff division within the Office of the Secretary and includes all the ALJs who decide Medicare appeals. She is sued in her official capacity.

IV. CLASS ACTION ALLEGATIONS

13. Plaintiffs bring this action on behalf of themselves and all others similarly situated, pursuant to Rules 23(a) and (b)(2) of the Federal Rules of Civil Procedure. The class is defined as:

> All Medicare beneficiaries who have pending a timely request, or will have pending a timely request, for an administrative law judge hearing, and for whom an administrative law judge has not rendered, or will not render, a decision on such hearing by the end of the 90-day period

beginning on the date the request for hearing was filed.

14. Joinder is impracticable due to the large number of class members and for other reasons, including, but not limited to, their geographic diversity, their ages and/or disabilities, and their relatively low incomes. Plaintiffs estimate the class to include at least thousands of members.

15. There are questions of law and fact common to the class members. Common facts include that all class members have been or will be denied a statutorily mandated decision within 90 days of requesting an ALJ hearing. The common questions of law include, *inter alia*, whether the Secretary's failure to require the issuance of ALJ decisions within 90 days of their request violates the Medicare statute and the Due Process Clause.

16. The claims of the named plaintiffs are typical of those of the class members in that they are Medicare beneficiaries who were or are parties to ALJ hearings and have not received or will not receive ALJ decisions within 90 days of their request.

17. The named plaintiffs will fairly and adequately protect the interests of the class. They have no interests that are or may be potentially antagonistic to the interests of the class, and they seek the same resolution as the class members: a system that ensures receipt of an ALJ decision within 90 days of requesting a hearing. Moreover, the plaintiffs are represented by competent counsel from an established public interest law firm, the Center for Medicare Advocacy, Inc. The attorneys are experienced in federal litigation involving public benefit programs, especially Medicare, and they have represented classes in numerous other cases involving Medicare and other public benefit programs.

18. The defendant Secretary has acted or refused to act on grounds generally applicable to the class as a whole, thereby making appropriate final injunctive and declaratory relief to the class as a whole, pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure.

V. STATUTORY AND REGULATORY FRAMEWORK

A. Introduction

19. Medicare, which is codified as Title XVIII of the Social Security Act, is the federally funded and administered program of health insurance for those who are 65 and older, or are disabled. Under Part A of Medicare, for which eligibility is automatic for recipients of Social Security old age and disability benefits (Title II of the Social Security Act), beneficiaries are entitled to coverage for hospital care, skilled nursing facility care, home health care, and hospice services. Part B of Medicare establishes a voluntary program of supplemental medical insurance covering physician services, nurse practitioner services, home health care, physical, speech, and occupational therapy, diagnostic services, and durable medical equipment. Under Part C, beneficiaries may opt into private Medicare plans, known as Medicare Advantage plans, in lieu of traditional Medicare. Part D provides for partial coverage of prescription drugs.

20. At the levels of administrative review below the ALJ level there are variations among the different Parts of Medicare, but at the ALJ level and above the process is the same for all four Parts and regardless of the variations at the lower levels of review.

B. Review in Parts A and B

21. The same administrative review process applies to appeals under both

Parts A and B, which are known collectively as "traditional Medicare." That process is authorized by 42 U.S.C. § 1395ff and 42 C.F.R. Part 405, Subparts I (standard) and J (expedited).

22. The standard administrative appeal process for Part A and Part B claims begins with a request for a paper-review redetermination by the contractor that made the initial determination. That decision is supposed to be made within 60 calendar days of the receipt of the request.

23. If dissatisfied with the outcome, the beneficiary may request reconsideration, which is also a paper review and is carried out by an entity that is separate from and independent of the original contractor and is known as the Qualified Independent Contractor (QIC). The reconsideration decision is also supposed to be made within 60 calendar days of the receipt of the request.

24. Over the last five years, the rates at which redetermination and reconsideration decisions have reversed denials of coverage have been falling dramatically and are now usually at 5% or less. For instance, plaintiffs' counsel's employer, the Center for Medicare Advocacy, whose advocates regularly handle 3,000 to 4,000 redeterminations and reconsiderations per year, had a "success" rate for home health care cases in the four calendar years of 2010 through 2013 of 2.41%.

25. Despite the overwhelming likelihood of failure at these first two levels, their completion is a necessary condition to obtaining review at the ALJ level. (The one exception to this rule is that ALJ review is available if the statutory adjudication period for reconsideration has passed without a decision.)

26. At the ALJ level the denial of coverage is generally reversed at least half

the time. For instance, according to the Office of the Inspector General (OIG) of HHS, in fiscal year 2010 62% of all ALJ decisions on home health and hospice claims were fully favorable. OIG (HHS), *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340 (Nov. 2012), at 10.

27. For ALJ review, the beneficiary has the right to a hearing either in-person, by video-teleconference, or by telephone. ALJs conduct *de novo* review, relying on the Medicare statute and regulations, unlike the contractors and QICs who rely on less formal and more restrictive guidelines and directives. Beneficiaries may submit new evidence in support of their appeal to the ALJ, and present and/or question witnesses.

28. Congress directed that an ALJ "shall … render a decision on [the] hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed." 42 U.S.C. § 1395ff(d)(1)(A). The relevant regulation repeats this directive, stating that the ALJ "must issue a decision" within the 90 days. 42 C.F.R. § 405.1016(a). The statute emphasizes the unequivocal nature of this requirement by stating that it may only be breached "in the case of a motion or stipulation by the party requesting the hearing to waive such period." *Id.*, § 1395ff(d)(1)(B).

29. If the beneficiary is dissatisfied with the ALJ decision, review is available from the Medicare Appeals Council (MAC) of the Departmental Appeals Board. MAC decisions are almost always made on the written record. Review by the MAC of an ALJ decision is supposed to be made within 90 days from the date that the request for review of the ALJ decision was filed.

30. If the beneficiary is dissatisfied with the MAC decision, review can then be sought in federal district court.

31. If the ALJ does not meet the 90-day deadline, the party requesting the hearing has the option of requesting direct review by the MAC.

32. If the beneficiary seeks MAC review of an ALJ decision and if the MAC does not make a decision within 90 days, the beneficiary has the option of taking the case directly to federal court.

33. If a beneficiary has sought review by the MAC because the ALJ did not issue a decision within 90 days and if the MAC does not issue a decision within 180 days, the beneficiary has the option of taking the case directly to federal court. In that situation, the federal court is reviewing the paper-review decision of the QIC.

34. When a skilled nursing facility, home health agency, hospice, or comprehensive outpatient rehabilitation facility gives a beneficiary a notice of discharge or termination, the beneficiary has the right to two levels of expedited reviews. The first review is called an expedited determination, which is a paper review by an entity called the Quality Improvement Organization. The appeal from that decision is an expedited reconsideration, also a paper review, to the QIC. The remainder of the review process is the same as in the standard process. There is no expedited ALJ review.

C. Review in Part C and Part D

35. The review process for Part C is authorized by 42 U.S.C. § 1395w-22(g) and 42 C.F.R. Part 422, Subpart M. In a Part C appeal of an initial determination (known as an "organization determination") made by the Medicare Advantage (MA) plan, the first step is reconsideration, which is a paper review by the MA plan, with some rights to expedited review. All partially or fully adverse reconsideration decisions by the MA plan are reviewed automatically by an independent review entity (IRE), which engages in a

paper review. The next step is a hearing before an ALJ, followed by MAC and federal district court review, all of which have the same requirements, policies, and procedures as in the Parts A and B review process.

36. The review process for Part D is modeled on the Part C process, including access to expedited review in selected situations, and is authorized by 42 U.S.C. § 1395w-104(h)(1) and 42 C.F.R. Part 423, Subpart M. An adverse coverage determination entitles the beneficiary to request a paper-review redetermination and then to request a paper review by an IRE. Following that decision are the right to an ALJ hearing, and then MAC and federal district court review, with the same requirements, policies, and procedures as in the review process for the other three Parts.

D. Beneficiaries enrolled in both Medicare and Medicaid

37. The poorest of Medicare beneficiaries are also eligible for Medicaid and are known as dual eligibles. Medicaid, which is codified as Title XIX of the Social Security Act, is a joint federal-state program that provides health coverage for, among others, people 65 and over and people with disabilities who meet income and asset requirements.

38. Medicaid is generally the payer of last resort. A Medicaid state agency that has paid for items or services furnished to a dual eligible may appeal for Medicare coverage of those items or services using the administrative appeal system described above. A Medicaid state agency becomes a party to a Medicare appeal by filing a request at the redetermination level. 42 C.FR. § 405.908. It participates as a statutory subrogee of the beneficiary. 42 U.S.C. § 1396k(a)(1).

39. Dual eligibles are parties to Medicare's initial determination and all levels

of administrative appeal, except when they have assigned their appeal rights to a provider or supplier. 42 C.F.R. § 405.906(a), (b).

VI. FACTUAL STATEMENT

A. Named plaintiffs' situations

Plaintiff Stephen Lessler

40. After hospitalization for hip surgery, plaintiff Stephen Lessler was discharged on October 17, 2013 to a skilled nursing facility where he received Medicare-covered occupational therapy and physical therapy through November 16, 2013.

41. When further coverage for the therapy was denied in an organization determination in November 2013, he sought administrative review, but that request was denied by telephone notification on November 17, 2013. That denial was later put in writing.

42. At the next level of review, the IRE also denied his request, in a written decision dated November 22, 2013. The stated reason was that "you are able to walk 225 feet using a walker, transfer independently and bathe and dress with some assistance. The wounds are healing and the care consists of non-prescription, non-medicated dressings which do not require a licensed clinical person to change. All medications are given by mouth." The conclusion was that he no longer needed skilled care.

43. Although Mr. Lessler continued to receive physical therapy through November 22, it was not covered after November 16, 2013.

44. On November 22, he left the facility. At home he fell and was readmitted to the hospital.

45. On December 19, 2013, Mr. Lessler's request for an ALJ hearing was

mailed to OMHA by his attorney. Although OMHA did not acknowledge receipt of the request by mail, it did acknowledge by telephone in June 2014 in response to a written inquiry from his attorney that the December 19, 2013 request for an ALJ hearing had been received.

46. No date for an ALJ hearing has been set.

Plaintiff Veronica Exley

47. After surgery and hospitalization to repair a fractured hip, plaintiff Veronica Exley was transported by ambulance to a skilled nursing facility on May 20, 2012. She was transferred from her chair in the hospital to the stretcher brought in by the ambulance crew by standing and pivoting with the assistance of a walker and a crew member.

48. Although an Attending Physician Report from her surgeon stated that transportation by ambulance was medically necessary, she received an initial determination dated July 3, 2012 denying coverage on the ground that she was not bedbound and therefore did not need an ambulance. Her appeal of this denial was received on July 9, 2012, and it was affirmed in a redetermination dated August 24, 2012.

49. Her request for reconsideration, mailed on November 6, 2012, also resulted in an adverse decision, dated January 9, 2013.

50. Her representative requested an ALJ hearing by letter dated February 22, 2013.

51. Neither Ms. Exley nor her representative received any written notification from OMHA or an ALJ about receipt of the appeal request, but in response to a telephone inquiry, her representative was informed in April 2013 that the appeal had been assigned

to a specific ALJ.

52. In her representative's most recent correspondence to the ALJ, dated May 6, 2014, the representative stamped on the outside of the envelope and on the letter itself in red capital letters the words "BENEFICIARY APPELLANT".

53. No date for an ALJ hearing has been set.

Plaintiff Patricia Belade

54. In July or August 2012, plaintiff Patricia Belade fell at her nursing home. On August 6, 2012, she was taken by ambulance to a hospital for an MRI. She returned to the nursing home the same day, also by ambulance.

55. She was diagnosed with nondisplaced sacral fracture and was assessed by the physical therapist with whom she was working as having "moderate to severe pain secondary to sacral fracture" and "complaints of pain limiting mobility." The Attending Physician Report stated that Ms. Belade was "unable to get up without assistance" and "was unable to sit without suffering excruciating pain," which would have made transportation other than by ambulance not bearable and contraindicated.

56. Nevertheless, coverage for the ambulance trips was denied. Requests for redetermination led to affirmance of the denials, on January 17 and 18, 2013.

57. Requests for reconsideration for coverage of both transports were denied in one decision, dated April 25, 2013. The stated reason was that transportation by ambulance was not medically necessary because "other methods of transport could have been used without endangering the patient's health," such as "a wheelchair van or stretcher."

58. A request for an ALJ hearing was made on May 28, 2013, with follow-up

letters asking for a hearing sent on April 29, 2014 and July 30, 2014. By letter dated August 5, 2014, OMHA acknowledged in writing that the request for a hearing was received on May 30, 2013 and that the appeal had been assigned to a specific ALJ.

59. In all correspondence to OMHA regarding the appeal, the words "BENEFICIARY APPELLANT" have been stamped on the envelope and the letter.

60. No date for an ALJ hearing has been set.

Plaintiff Lorraine Cooper

61. On January 5, 2014, plaintiff Lorraine Cooper was admitted to the intensive care unit of a hospital in Miami Beach, Florida. She was diagnosed with shortness of breath, left lower extremity deep vein thrombosis, and antiphospholipid syndrome. She moved out of the ICU on January 17, 2014, and on January 22, 2014 she was transferred to the hospital's intense rehabilitation unit.

62. Ms. Cooper's coverage under Medicare was terminated on February 19, 2014 on the ground that "care could be provided in a less acute setting." The hospital took the position that she was no longer improving and therefore was not entitled to coverage.

63. On her behalf, her husband sought expedited review of the proposed discharge on February 17, 2014, but the redetermination request was denied on February 18, 2014. The request for expedited reconsideration, submitted on February 19, 2014, was denied on February 21, 2014, without explanation. No information was provided as to the timeline of 60 days for seeking ALJ review.

64. Because of her severe health problems, she remained in the hospital's acute rehabilitation unit until March 14, 2014 and is responsible for the hospital bill of

approximately $38,000, covering the period from February 19 to March 14, 2014.

65. Ms. Cooper was readmitted to the hospital's intensive care unit on March 31, 2014 following a fall that resulted in a fractured neck.

66. On May 14, 2014 her attorney sent in a request for an ALJ hearing, both by mail and by fax. It included a statement explaining that, because of her two hospitalizations and the lack of notice in the reconsideration decision, she had good cause for not requesting an ALJ hearing within 60 days of the reconsideration decision.

67. On the envelope holding the request, and on the request itself, were the typed words "ATTENTION: BENEFICIARY MAIL STOP." Added to the envelope in handwriting were the words: "BENEFICIARY APPEAL, DO NOT OPEN IN MAILROOM."

68. Neither Ms. Cooper nor her attorney has received confirmation from OMHA of receipt of the hearing request.

69. No date for an ALJ hearing has been set.

Plaintiff Harry Voet

70. In 2011, plaintiff Harry Voet went for a routine dental visit. The dentist noticed an infection and performed a biopsy incision. A pathology report showed cancer of the upper gum. Mr. Voet's dentist referred him to an oral surgeon.

71. Mr. Voet's oral surgery was performed at a Cincinnati hospital. The surgery involved removal of some teeth, part of his gum and part of the upper palate. The surgery was covered by Medicare.

72. After the surgery, Mr. Voet's regular dentist placed a permanent prosthesis in Mr. Voet's mouth to replace the upper palate.

73. In 2011, Mr. Voet appealed for Medicare coverage of the dental services related to the initial biopsy, pathology report, and the placement of the permanent prosthesis, for which he paid approximately $5500.

74. Mr. Voet first had to appeal up to the ALJ level to prove that he had good cause for filing his claim outside the initial appeals period. Then, after receiving a denial on the merits from the QIC, Mr. Voet requested an ALJ hearing on his own behalf on December 27, 2013.

75. Mr. Voet followed up his request with calls to OMHA. He also requested assistance from his U.S. Representative. In April 2014 he received an acknowledgement from OMHA that his request had been received.

76. Mr. Voet's ALJ hearing was held on July 30, 2014. He has not yet received a decision.

B. <u>The time frame for issuing ALJ decisions is increasing and is invariably well beyond 90 days.</u>

77. Documents compiled by the Office of Medicare Hearings and Appeals (OMHA) depict the increasing length of time that elapses between the request for an ALJ hearing and the ALJ decision. According to a chart prepared by OMHA for distribution at the Medicare Appellant Forum held on February 12, 2014, the "Average Processing Time by Fiscal Year" (referring to the fiscal year in which the ALJ decision was issued) for the full fiscal years since 2009 was as follows:

FY09	94.9 days
FY10	109.6 days
FY11	121.3 days
FY12	134.5 days

FY13 220.6 days

78. The posting on the OMHA website on August 25, 2014 [http://www.hhs.gov/omha] gave an average processing time for the first ten months of FY2014 of 398.1 days. For the most recent month for which figures are available, July 2014, the average processing time was 488.8 days.

79. The numbers in the preceding paragraphs do not tell the full story, however, as they are geared to decisions issued in past and present fiscal years and largely do not take into account the future impact of increasing delays during the course of the review process. Other OMHA documents indicate that future delays will be much longer. The most recent average processing time of 488.8 days will soon be far surpassed.

80. There are four steps between receipt of a hearing request and issuance of a decision: docketing of the hearing request, assignment to an ALJ, scheduling of the hearing by the ALJ, and preparing the decision. *Each* of the four steps now takes considerably longer than the 90-day requirement for the entire process. First, the OMHA website states that there is now a "20-24 week delay in entering ('docketing') new requests into our case processing system." Second, as explained in subsequent paragraphs, assignment of most appeals to an ALJ has been deferred for an estimated two years. Third, a document prepared by OMHA and issued at a conference in December 2013 stated that "there is an **average** wait time of 7 months to obtain a hearing after assignment to an ALJ" and that the "[p]ost-assignment wait time to obtain a hearing is expected to continue to exceed 6 months." Fourth, the same document states that the number of days to make the decision averaged 201 in fiscal year 2013, and, for fiscal year

2014, a "**significant** increase [is] expected."

81. In a "Memorandum to OMHA Medicare Appellants" dated December 24, 2013, OMHA's Chief ALJ, Nancy J. Griswold, summarized the situation. As of that date, there was a backlog of appeals involving over 460,000 claims for services and entitlement, with requests for hearings on the rise and averaging over 15,000 per week in November 2013. Chief ALJ Griswold stated that "OMHA's average wait time for a hearing before an Administrative Law Judge has risen to 16 months and is expected to continue to increase as the backlog grows."

82. Chief ALJ Griswold further stated that, "effective July 15, 2013, OMHA temporarily suspended the assignment of most new requests for an Administrative Law Judge hearing …." Furthermore, "with the current backlog we do not expect general assignments to resume for at least 24 months …."

83. According to postings on the OMHA website during 2014, assignment of hearing requests made after April 1, 2013 are being deferred; appellants have been informed that the delay in assignment to an ALJ may be as long as 28 months.

84. The memorandum from Chief ALJ Griswold sets out one exception: "Although assignment of most new requests for hearing will be temporarily suspended, OMHA will continue to assign and process requests filed directly by Medicare beneficiaries …." This exception does not apply to dual eligibles.

85. A letter dated April 1, 2014 from Eileen McDaniel, Director of OMHA's Office of Programs, to the niece-representative of a Medicare beneficiary, stated that, "[f]or beneficiary-initiated appeals received in August 2013, the average case processing time is currently 112 days, with 33% of beneficiary-initiated appeals received during that

time still pending a decision."

86. In a follow-up letter to the same representative dated April 24, 2014, Ms. McDaniel stated that "[o]ur case management system indicates that as of April 22, 2014, we have 2,537 pending appeals that were initiated by beneficiaries or representatives of beneficiaries."

87. OMHA has suggested on its website and in other documents that appellants consider escalating to the MAC. The Centers for Medicare & Medicaid Services (CMS), the division within the Secretary's Department of Health & Human Services that proposed and promulgated the regulations governing the administrative review process, warned in its comments about those regulations that appellants should "carefully consider" escalation to the MAC. 67 F.R. 69312, 69329 (Nov. 15, 2002). CMS pointed out that escalating would deprive the appellant of an oral hearing, would cause the forfeiture of the 90-day deadline for the MAC's decision-making, and would result in a less well-developed record, thereby requiring the MAC to take more time to reach a decision. *Id.*; see also 70 F.R. 11420, 11454-11455 (March 8, 2005). Moreover, like OMHA, the MAC is not meeting its statutory deadline for making decisions, a fact noted in a document provided by OMHA at its Medicare Appellant Forum on February 12, 2014: "The [Medicare Appeals] Council is unlikely to meet the 90-day deadline for issuing decisions in most appeals."

88. Furthermore, even if escalation to the MAC could be a reasonable choice for the occasional appellant willing to give up the right to an ALJ hearing, escalation was not intended to be and could not be a wholesale solution for thousands of appellants. The document referred to in paragraph 77 notes that, in fiscal year 2014, the MAC had

received "a total of 19 escalations from OMHA" by the February 2014 date of the Forum.

VII. INADEQUACY OF REMEDY AT LAW AND PROPRIETY OF ISSUANCE OF A WRIT OF MANDAMUS

89. Plaintiffs and the class are suffering and will continue to suffer irreparable injury by reason of defendant's actions complained of herein. Plaintiffs and the class are and will be deprived of their right to a timely hearing decision on their claims for Medicare coverage, and the denial of that coverage will adversely affect their well-being and health.

90. Plaintiffs and the class have no adequate remedy at law. Only the declaratory, injunctive, and mandamus relief that this Court can provide will fully redress the wrongs done to them.

91. Plaintiffs and the class have a clear right to the relief sought. There is no other adequate remedy available to correct an otherwise unreviewable defect not related to a claim for benefits. The defendant has a plainly defined and nondiscretionary duty to provide the relief that plaintiffs and the class seek.

VIII. FIRST CAUSE OF ACTION: VIOLATION OF THE MEDICARE STATUTE AND REGULATIONS

92. By her widespread and increasing failure to enforce the unequivocal requirement that ALJs issue decisions within 90 days of the timely filing of a request for a hearing, the Secretary violates the Medicare statute and regulations, 42 U.S.C. § 1395ff(d)(1)(A) and 42 C.F.R. § 405.1016(a).

IX. SECOND CAUSE OF ACTION: VIOLATION OF THE DUE PROCESS CLAUSE

93. By her widespread and increasing failure to require ALJs to issue decisions within 90 days of the timely filing of a request for a hearing, the Secretary

countenances illegal delays and creates unwarranted deprivation of a legal right to a timely and meaningful hearing for Medicare beneficiaries in violation of the Due Process Clause.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs respectfully pray that this Court:

1. Assume jurisdiction over this action.

2. Certify at an appropriate time that this suit is properly maintainable as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure.

3. Declare that defendant's policy of failing to require that ALJs issue decisions on beneficiaries' appeals within 90 days of the timely filing of a request for an ALJ hearing violates the Medicare statute and regulations and the Due Process Clause of the Fifth Amendment.

4. Grant and issue a permanent injunction, and/or an order of mandamus,

a. prohibiting defendant, her successors in office, her agents, employees, and all persons acting in concert with her, from continuing to implement and authorize a system of administrative review for plaintiffs and the class members that deprives them of a decision by an ALJ within 90 days of their timely filing a request for a hearing; and

b. ordering defendant, her successors in office, her agents, employees, and all persons acting in concert with her immediately to take any and all steps to ensure that each plaintiff and class member receive decisions from an ALJ on their appeals of denials of Medicare coverage within 90 days of their timely filing a request for a hearing.

Plaintiffs pray in addition:

5. For costs of the suit herein.

6. For reasonable attorneys' fees.

7. For such other and further relief as the Court deems just and proper.

DATED: August 26, 2014

Respectfully submitted,

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