UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

RUTH SHERMAN, on behalf of herself and all others similarly situated, Plaintiff, v. ERIC D. HARGAN, Acting Secretary of Health and Human Services, Defendant.	Civil No. 3:15-cv-1468 (JAM)

NOTICE OF PROPOSED SETTLEMENT OF CLASS ACTION AND OF FAIRNESS HEARING

Notice is hereby given to certain Medicare beneficiaries that a settlement on behalf of a nationwide class has been proposed in the above-referenced case filed in the United States District Court for the District of Connecticut. This notice contains information about:

A. The Nature and History of the Lawsuit

B. The Proposed Settlement of the Lawsuit

C. The Reasons for the Settlement

D. The Fairness Hearing and the Process for Filing Objections to the Settlement

E. Additional Information

PLEASE READ THIS NOTICE CAREFULLY.
YOUR RIGHTS MAY BE AFFECTED BY THESE PROCEEDINGS.

A. Nature and History of Lawsuit

The plaintiff is the widow of a Medicare beneficiary who was denied coverage of home health services and was unsuccessful at the first two levels of appeal in the Medicare administrative appeal system. Plaintiff filed this lawsuit on October 9, 2015 against Defendant Sylvia Mathews Burwell, who was then the Secretary of the U.S. Department of Health and Human Services.[1] Plaintiff alleged that defendant was imposing policies or practices that denied Medicare beneficiaries meaningful review of their home health claims until they reached the third level of appeal: a hearing with an Administrative Law Judge (ALJ). Citing statistics, plaintiff alleged that the virtual certainty of denial at the first two levels of appeal violated the Medicare statute and the Due Process Clause of the Fifth Amendment. Plaintiff sought an injunction ordering the defendant to correct the appeal system by taking actions such as revising the internal guidelines for decision-makers involved in the first two levels of appeal, and by providing education on the procedures for decision-making required by Medicare law.

Plaintiff filed a motion for certification of a nationwide class action on October 23, 2015, and the Court certified the class on August 8, 2016. The class is defined as:

> All Medicare beneficiaries (1) who have received, are receiving, or will receive home health care services, (2) whose claims for coverage of those services under Medicare Part A or Part B (a) have been or will be denied at the initial determination stage, in whole or in part, or who have received or will receive a notice of termination of coverage and (b) have been or will be denied, in whole or in apart, at the two levels of review below the Administrative Law Judge level, and (3) for whom the initial determination or termination of coverage was dated on or after January 1, 2012.

[1] When the original named plaintiff died, his wife, Ruth Sherman, was substituted as the representative of his estate. The current defendant, Eric D. Hargan, is the Acting Secretary of Health and Human Services.

Ruling Denying Motion to Dismiss and Granting Motion for Class Certification (ECF # 55) at 14.

B. The Proposed Settlement of the Lawsuit

Following negotiations that occurred from July 2017 through October 2017, the parties have reached a settlement of this matter, subject to Court approval. In exchange for class members dismissing any claims they brought or could have brought, defendant has agreed that the Centers for Medicare & Medicaid Service (CMS) will transmit the language contained in four memoranda (attached to the settlement agreement as Exhibits A-D) to the contractors that handle decisions at the first two levels of home health appeals. One transmittal is to Medicare Administrative Contractors (MACs), which handle the first level of standard appeals; one is to Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs), which handle the first level of expedited appeals; and two are to Qualified Independent Contractors (QICs), which handle the second level in standard and expedited appeals.

The memoranda reinforce important principles that should be followed by reviewers of home health appeals and cite the regulations whose principles are summarized. For example, the transmission to the MACs lists certain required elements in decisions that are affirmations (*i.e.*, uphold denials of coverage), such as an explanation of how pertinent laws, regulations, coverage rules, and CMS policies apply to the facts of the case, and a summary of the rationale for the decision that is clear and understandable. 42 C.F.R. § 405.956(b). The transmission to the BFCC-QIOs reminds those contractors that in expedited appeals, the burden of proof rests with the provider to demonstrate that coverage should terminate, not with the beneficiary to prove s/he is

entitled to coverage. *Id.* § 405.1202(d). The transmission also states that the reviewer must consider and give appropriate weight to evidence submitted by the beneficiary, which may include statements from doctors who are not connected to the provider proposing to terminate the coverage in question. *Id.* § 405.1202(b)(3).

Defendant will certify to class counsel that the transmittals have been disseminated within 100 days of the settlement receiving final approval from the Court. Plaintiff will then file a stipulation of dismissal, dismissing her individual claims as well as the class members' claims. Each party has agreed to bear its own fees and costs.

B. The Reasons for the Settlement

Plaintiff contended in this lawsuit that defendant has failed to provide meaningful review of Medicare beneficiaries' home health appeals at the two lowest levels of administrative appeal because plaintiff believed that there is virtually no chance of success at those levels. In the Complaint, plaintiff cited statistics to support her position that that the success rate of appeals declined after the appeal system was modified pursuant to two laws. Defendant has responded that, among other things, contrary to plaintiff's contention, CMS maintains no policies or practices to improperly deny home healthcare claims and that the low success rate at those levels is primarily the result of an increase in the submission of presumptively uncovered claims (called demand bills) by certain state Medicaid agencies.

While the parties continue to disagree with some of each other's contentions, if this action were to continue, it is uncertain which side would prevail and it would likely take at least six months for the parties to brief and the Court to resolve motions for summary judgment. Although plaintiff prevailed in part on defendant's Motion to Dismiss, which contended that the Court lacked jurisdiction over plaintiff's claims,

defendant could appeal that decision. Furthermore, even if plaintiff prevailed before both the trial court and the appellate courts, the nature and extent of the relief that the class could obtain is unknown. Class counsel believes that the principles expressed in the transmittals are key to fair decision-making and will reinforce compliance with beneficiaries' due process protections in the administrative appeal system.

The Agreement will reinforce important procedural requirements for decision-makers at the first two levels of appeal. Given the uncertainty for both parties and the amount of time that would be consumed by the additional work in the trial court and a possible appeal, the parties believe that settlement is the best resolution of the matter and that the proposed Settlement Agreement is fair, adequate, and reasonable.

D. Settlement Fairness Hearing

The Court has preliminarily approved the settlement, but will hold a hearing ("Fairness Hearing") to determine whether to permanently approve the proposed settlement as fair, adequate, and reasonable. The Fairness Hearing will take place at 3:00 PM on February 26, 2018 at the United States District Court for the District of Connecticut, 141 Church Street, New Haven, Connecticut 06510. The Fairness Hearing may, from time to time and without further notice to the Class, be continued or adjourned by order of the Court. If you wish to attend the Fairness Hearing, you should confirm the date and time with Class Counsel at the Center for Medicare Advocacy (contact information below). Class Members do not need to appear at the Fairness Hearing or take any other action to indicate their approval of the settlement or to obtain the benefits of the settlement.

If you wish to object to the settlement, you must do so in writing via letter or card (e-mail cannot be accepted). Written objections must be received by class counsel, Center for Medicare Advocacy (address below), no later than twenty-one days before the date of the Fairness Hearing. Class counsel will forward all objections to counsel for the defendant promptly after they are received and will file all objections with the Court no later than five days before the Fairness Hearing.

E. Additional Information

The pleadings and other records in this litigation may be examined and copied during regular office hours at the office of the Clerk of the Court, United States District Court for the District of Connecticut, 141 Church Street, New Haven, Connecticut 06510. You may also view the entire proposed Settlement Agreement at the website of the Center for Medicare Advocacy (www.medicareadvocacy.org).

Dated: December 12, 2017

Respectfully submitted,

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