EXHIBIT A:

PROPOSED SETTLEMENT AGREEMENT

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 U.S. Department of Health and Human Services, Defendant.	Civil Action No. 15-CV-1468 (JAM)

SETTLEMENT AGREEMENT

I. INTRODUCTION

WHEREAS the parties desire to resolve amicably all claims raised in this suit without admission of liability;

WHEREAS the parties have agreed upon mutually satisfactory terms for the complete resolution of this Federal Rule of Civil Procedure 23(b)(2) class action litigation;

NOW THEREFORE, the parties, by and through their undersigned counsel, hereby enter into this Settlement Agreement with the following terms.

II. DEFINITIONS

The following definitions shall apply:

1. "Action" means Civil Action 15-CV-1468 in the District of Connecticut.

2. "Approval Date" means the date upon which the Court approves this Settlement Agreement after having determined that it is adequate, fair, and reasonable to the Class as a

whole, after: (i) notice to the Class; (ii) an opportunity for Class members to submit timely objections to the Settlement Agreement; and (iii) a hearing on the fairness of the Settlement Agreement.

3. "Class Counsel" means the Center for Medicare Advocacy, Inc.

4. The "Class" or "Class Members" means the class that was certified by order of the Court in this Action on August 8, 2016 (ECF #55).

5. "Complaint" means the complaint filed in this Action on October 9, 2015 (ECF #1).

6. "Court" means the United States District Court for the District of Connecticut.

7. "Defendant" means the Secretary of Health and Human Services, in his or her official capacity.

8. "Parties" refers to the Plaintiff, the Class, and Defendant.

9. "Plaintiff" means the named plaintiff in this Action.

III. ENTIRE AGREEMENT

The terms of this Settlement Agreement and any attachments thereto are the exclusive and full agreement of the Parties with respect to all claims for relief in the Complaint and any claims for attorney's fees and costs. No representations or inducements or promises to compromise this Action or enter into this Settlement Agreement have been made, other than those recited or referenced in this Settlement Agreement.

IV. APPROVAL

This Settlement Agreement is expressly conditioned upon its approval by the Court. The terms of this Settlement Agreement are fair, reasonable, and adequate. The entry of this Settlement Agreement is in the best interest of the Parties and the public.

V. FINAL JUDGMENT

Within 100 days of the Approval Date, Defendant will certify to Class Counsel that it has transmitted to the relevant Medicare contractors the language contained in Exhibits A – D of the Settlement Agreement. The certification is attached as Exhibit E to this agreement. Within 5 days of receiving this certification, Plaintiffs shall file attached stipulation of dismissal with prejudice (attached as Exhibit F). .

VI. TRANSMISSIONS TO CONTRACTORS

The language in Exhibits A – D is meant to reinforce important principles that should be followed by reviewers of home health appeals. Defendant agrees to disseminate this language to the relevant Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs), via Technical Direction Letters (TDLs), and to the relevant Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs), via Health Care Quality Improvement System (HCQIS) memoranda.

VII. RELEASE

1. In consideration of the promises of Defendant as set forth in this Settlement Agreement, the Plaintiff and all Class Members, and their heirs, administrators, successors, or assigns (together, the "Releasors"), hereby release and forever discharge Defendant and the United States Department of Health and Human Services (HHS), along with Defendant's and HHS's administrators, successors, officers, employees, and agents (together the "Releasees") from any and all claims and causes of action, whether presently known or unknown, that have been asserted or could have been asserted in this Action (ECF # 1).

2. The release contained in paragraph 1 of section VII shall not affect, create, or alter in any way the right of any Class Member to pursue any claim in an individual administrative appeal for home health benefits that has not been waived by paragraph 1.

VIII. ADDITIONAL PROVISIONS

1. Defendant denies liability and any wrongdoing as to each of the claims that was raised, or that could have been raised, in the Complaint in this Action.

2. The Parties agree that each party shall bear its own fees and costs.

3. This Settlement Agreement may be modified only in writing upon agreement of the Defendant and Plaintiff.

4. The Plaintiff and Defendant acknowledge that they have reviewed this Settlement Agreement, had an opportunity to consult with legal counsel regarding this Settlement Agreement, and are bound by its terms. Further, the parties consent to execution of this Settlement Agreement by their undersigned counsel and agree that their undersigned counsel have authority to execute this Settlement Agreement on the Parties' behalf.

5. This Settlement Agreement is not intended to create, and does not create, any third-party beneficiary rights or any other kind of right or privilege for any person, group, or entity.

6. This Settlement Agreement shall be considered a jointly drafted agreement and shall not be construed against any party as the drafter.

7. This Settlement Agreement may be executed in counterparts and is effective on the Approval Date.

DATED: December 12, 2017

CHAD READLER
Acting Assistant Attorney General

JOEL McELVAIN
Assistant Director, Federal Programs Branch, Civil Division

JUSTIN M. SANDBERG

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[EXHIBIT A TO SETTLEMENT AGREEMENT]

TO BE PROVIDED TO MEDICARE ADMINISTRATIVE CONTRACTORS:

SUBJECT: Important principles regarding the review of standard home health appeals

As part of a settlement of a lawsuit, CMS is reinforcing important principles contained in the Medicare regulations that must be followed by reviewers of home health appeals.

Home health redeterminations that are affirmations must contain an *individualized* statement regarding the rationale for the decision.

The Medicare regulation at 42 C.F.R. § 405.956(b) requires the following information, among other things, for decisions that are affirmations in whole or in part.

- A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;
- An explanation of how pertinent laws, regulations, coverage rules, and CMS policies apply to the facts of the case;
- A summary of the rationale for the redetermination in clear, understandable language;
- A statement of any specific missing documentation that must be submitted with a request for a reconsideration, if applicable.

[EXHIBIT B TO SETTLEMENT AGREEMENT]

TO BE PROVIDED TO QUALIFIED INDEPENDENT CONTRACTORS

SUBJECT: Important principles regarding the review of standard home health appeals

As part of a settlement of a lawsuit, CMS is reinforcing important principles contained in the Medicare regulations that must be followed by reviewers of home health appeals.

Home health reconsiderations that are affirmations must contain an *individualized* statement regarding the rationale for the decision.

The Medicare regulation at 42 C.F.R. § 405.976(b) requires the following information, among other things, to be contained in reconsideration decisions:

- A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the reconsideration;
- An explanation of how pertinent laws, regulations, coverage rules, and CMS policies, apply to the facts of the case, including, where applicable, the rationale for declining to follow an LCD, LMRP, or CMS program guidance;
- In the case of a determination on whether an item or service is reasonable or necessary under section 1862(a)(1)(A) of the Act, an explanation of the medical and scientific rationale for the decision;
- A summary of the rationale for the reconsideration.

[EXHIBIT C TO SETTLEMENT AGREEMENT]

TO BE PROVIDED TO BENEFICIARY AND FAMILY CENTERED CARE – QUALITY IMPROVEMENT ORGANIZATIONS:

SUBJECT: Important principles regarding the review of expedited home health appeals

As part of a settlement of a lawsuit, CMS is reinforcing important principles contained in the Medicare regulations that must be followed by reviewers of home health appeals.

In home health expedited determinations, 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.

The reviewer must consider and give appropriate weight to evidence submitted by the beneficiary, and such evidence may include statements from the beneficiary's doctors who are not connected to the provider proposing to terminate the coverage in question.

These requirements are contained in the Medicare regulations at 42 C.F.R. §§ 405.1202(b)(3), 405.1202(d), which state the following:

- The beneficiary may, but is not required to, submit evidence to be considered by a QIO in making its decision.
- When a beneficiary requests an expedited determination by a QIO, the burden of proof rests with the provider to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies.
    - The beneficiary may submit evidence to be considered by a QIO in making its decision.

[EXHIBIT D TO SETTLEMENT AGREEMENT]

TO BE PROVIDED TO QUALIFIED INDEPENDENT CONTRACTORS

SUBJECT: Important principles regarding the review of expedited home health appeals

As part of a settlement of a lawsuit, CMS is reinforcing important principles contained in the Medicare regulations that must be followed by reviewers of home health appeals.

> In home health expedited reconsiderations, the reviewers must consider and give appropriate weight to evidence submitted by the beneficiary, and such evidence may include statements from the beneficiary's doctors who are not connected to the provider proposing to terminate the coverage in question.
>
> These requirements are contained in the Medicare regulations at 42 C.F.R. §§ 405.1204(b)(3), 405.1204(c)(2), which state the following:
>
> - The beneficiary may, but is not required to, submit evidence to be considered by a QIC in making its decision.
> - The QIC must offer the beneficiary and the provider an opportunity to provide further information.

[EXHIBIT E TO SETTLEMENT AGREEMENT]

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

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CERTIFICATION

Defendant hereby certifies that, by [DATE], it transmitted to the relevant Medicare contractors the language contained in Exhibits A – D of the Settlement Agreement approved by the Court on [DATE].

DATED: [Month, Day], 201[X]

Respectfully,

CHAD READLER
Acting Assistant Attorney General

JOEL McELVAIN
Assistant Director, Federal Programs Branch, Civil Division

JUSTIN M. SANDBERG
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[EXHIBIT F TO SETTLEMENT AGREEMENT]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

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STIPULATION OF DISMISSAL

Pursuant to Federal Rules of Civil Procedure 23 and 41(a)(1)(A)(ii), Plaintiff, by and through class counsel, hereby dismisses the Complaint in this action. This dismissal is with prejudice as to the named Plaintiff and all class members. Each party shall bear its own fees and costs.

Dated:

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