UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

MARCELLA RYAN, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:14-cv-00269
	)	
ERIC D. HARGAN, Acting Secretary of Health and Human Services	)	
	)	
Defendant.	)	
	)	

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 Plaintiffs and Defendant hereby consent to the entry of this Settlement Agreement with the following terms.

II. DEFINITIONS

1. "Approval Date" means the date upon which the Court approves this Settlement Agreement, after having determined that it is adequate, fair, reasonable, equitable, and just 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.

2. "Beneficiary" and "Beneficiaries" means individuals claiming entitlement to Medicare benefits.
3. "Class Counsel" or "Plaintiffs' Counsel" means the Center for Medicare Advocacy, Inc. or Vermont Legal Aid, Inc.
4. The "Class" or "Class Members" means the class that was certified by order of the Court in this action on June 10, 2015 (ECF # 67).
5. "Court" means the United States District Court for the District of Vermont.
6. "Defendant" or "the Secretary" means the Secretary of Health and Human Services, in his or her official capacity.
7. "Parties" refers to Plaintiffs and Defendant.
8. "Plaintiffs" means the named plaintiffs 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 declaratory and injunctive relief, and attorney's fees and costs, as set forth in this Settlement Agreement and in the Complaint. No representations, 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

1. This Settlement Agreement is expressly conditioned upon its approval by the Court.

2. The Parties agree that the terms of this Settlement Agreement are fair, reasonable, and adequate and that entry of this Settlement Agreement is in the best interest of the Parties and the public.

V. FINAL JUDGMENT

If, after the Fairness Hearing, the Court approves this Settlement Agreement as fair, reasonable, and adequate, the Parties will ask that the Court to direct entry of Final Judgment dismissing this action with prejudice (the "Final Judgment"), pursuant to the terms of this Settlement Agreement and Fed. R. Civ. P. 41., and that the Final Judgment incorporate and be subject to the terms of the Settlement Agreement.

VI. INJUNCTIVE RELIEF

1. Review Relief

Under this Settlement Agreement, Class Members will receive, only as set forth in this paragraph, Review of Eligible Claims either: (a) by Medicare Administrative Contractor (MAC), National Government Services (NGS) for cases not currently pending in the Medicare administrative claims appeals process, or (b) by the Medicare appeals adjudicator with jurisdiction over the pending appeal containing the Eligible Claim, for cases currently pending in the Medicare administrative claims appeals process. Specifically, for each Eligible Claim submitted by a Class Member who identifies himself or herself to the Centers for Medicare & Medicaid Services (CMS) within the specified timeframe for Review as set forth in § VI.2.a, NGS, or the Medicare appeals adjudicator with jurisdiction over the pending appeal, will Review the Eligible Claim and apply the "great weight" review

criteria as previously found in § 6.2.1 (B) of the Medicare Program Integrity Manual to determine whether the beneficiary meets the homebound requirement under the Medicare home health benefit. If NGS or the Medicare appeals adjudicator with jurisdiction over the pending appeal determines that the Eligible Claim satisfies the homebound requirement after applying this criteria, NGS or the Medicare appeals adjudicator will process the appeal under existing Medicare regulations.

2. Procedural Requirements for submission for Review of Eligible Claims by Class Members:

   a. Class Members seeking Review of an Eligible Claim will be required to identify themselves and their eligible claim to CMS no later than one year after the settlement application process is published on CMS.gov. The application will specify the cut-off date for submissions under this Settlement Agreement.

   b. Class Members who seek Review of Eligible Claim denials will be required to complete and submit a form to be developed by CMS, in consultation with counsel for the Plaintiffs, along with any supporting documentation called for by the form. The form will collect all of the information required to evaluate whether the Class Member is eligible for Review under this Settlement Agreement, and the Class Member seeking Review will be required to certify that the information included on the form is accurate to the best of his or her knowledge. The form will be

made available on CMS.gov, https://vtlawhelp.org, and medicareadvocacy.org.

c. Upon receipt of the completed form and documentation in § VI.2.b, CMS or its designee will make reasonable efforts to identify and obtain the relevant prior favorable appellate homebound decision.

3. Class Members: Only Class Members are entitled to Review Relief set forth above in § VI.1. Class Members must meet all of the following criteria:

a. The Class Member must be a beneficiary of Medicare Part A or B, in Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island or Vermont;

b. The Class Member must have received a "favorable final appellate decision" that he or she was "confined to home," i.e., homebound, in the appeal of a home health nursing or therapy claim denial;

c. The Class Member must have subsequently been denied, or will be denied, coverage for additional service on the basis of not being homebound, on or after January 1, 2010;

d. The Class Member must have had a non-lapsed, viable appeal of the subsequent denial for coverage of additional home health services as of March 5, 2015; and

e. The Class Member must have had a claim for Medicare home health coverage filed on his or her behalf on or before August 2, 2015.

4. Eligible Claims: A claim must meet all of the following criteria in order to qualify as an Eligible Claim under this Settlement Agreement:
   a. The claim is for Medicare home health benefits under Parts A or B, not Part C;
   b. The claim is for services provided to a Medicare beneficiary located in Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, or Vermont at the time the claim received the initial determination from the MAC;
   c. The claim was denied on the basis that the beneficiary was not homebound;
   d. The claim was denied on or between January 1, 2010 through August 3, 2015;
   e. The claim is for services provided to a Medicare beneficiary who received a favorable final appellate decision that he or she was homebound at any of the four levels of Medicare administrative appeal prior to the denial date for that claim;
   f. The appeal of that claim denial: (a) was pending at any of the four levels of Medicare appeal as of March 5, 2015; or (b) was within the time period for appeal at any of the four levels of Medicare administrative appeal as of March 5, 2015, and an appeal of the initial denial was timely filed;
   g. Claims other than of the Named Plaintiffs that are currently the subject of any lawsuit pending in an Article III United States Court,

or have been the subject of a final, non-appealable judgment by such courts, are not eligible for re-review;

h. The appeal of that claim denial is pursued by a beneficiary on his or her own behalf, or through a representative other than a provider, supplier, or Medicaid State Agency. Appeals of claim denials pursued by providers or suppliers or Medicaid State agencies are excluded. No provider or supplier or Medicaid State Agency is permitted to receive re-review on behalf of or by assignment from a class member;

i. Claim for services must not have been covered or paid for by Medicare or by any third-party payor or insurer except in the case of an individual Medicare beneficiary whose services were paid in full or part by Medicaid; and

j. For cases not currently pending in the Medicare administrative claims appeals process, there must not have been a determination by the last Medicare adjudicator to review the claim (MAC, Qualified Independent Contractor (QIC), Administrative Law Judge (ALJ), or Medicare Appeals Council (Appeals Council)) that there was a separate and independent basis for denial of the claim other than failure to meet the homebound requirements of the Medicare home health benefit.

5. Appeal Rights: Class Members with Eligible Claims will be afforded the following appeal rights:

a. For Eligible Claims that are not currently pending in Medicare administrative claims appeals process:

i. If NGS's application of the "great weight" provision to the Eligible Claim results in a determination that the beneficiary met the homebound requirement for Medicare coverage of home health services, and all other requirements for Medicare payment for home health benefits are met, NGS will effectuate payment of the home health claim. There will be no appeal rights for this determination.

ii. If NGS's application of the "great weight" provision to the Eligible Claim results in a determination that the beneficiary met the homebound requirement for Medicare coverage of home health services, but that there is some other requirement for payment that has not been met such that the Class Member receives a partially favorable determination or fully unfavorable determination, the MAC will either effectuate payment accordingly or give notice of the denial or partial denial of the claim. Appeal rights will attach to such partially favorable and fully unfavorable determinations.

iii. If this application of the "great weight" provision to the Eligible Claim results in a determination that the beneficiary did not meet the homebound requirements for Medicare coverage of home health services, NGS will provide notice to the beneficiary or beneficiary's representative that the disposition of the claim will not change. Appeal rights from such a determination and notice will attach solely to review whether NGS properly applied the "great weight" provision in

determining whether the beneficiary met the homebound requirement.

iv. If the determination on appeal is that NGS did not properly apply the "great weight" provision, the Medicare appeals adjudicator will determine whether the beneficiary satisfies the homebound requirement under the "great weight" provision. If the Medicare appeals adjudicator determines that the beneficiary is homebound under the "great weight" provision, the Medicare appeals adjudicator will process the appeal under existing Medicare regulations, and all usual appeal rights will attach to any adverse determination.

b. For cases currently pending in the Medicare administrative claims appeal process, all usual appeal rights that apply to decisions by the Medicare appeals adjudicator making the decision are available.

c. All eligible appeals under § VI.5 are subject to all procedural requirements and limitations applicable to each level of Medicare appeal.

6. Report to Plaintiffs' Counsel: Defendant, through counsel, will provide an interim status report to Plaintiffs' counsel regarding the Review process specified in the Settlement Agreement within 90 days of the conclusion of the period for submitting class claims for Review under § VI.2.a and a final report once all Review under this Settlement Agreement is complete.

7. No Guaranteed Results: The Parties recognize that Defendant's obligations are met under the Settlement Agreement once it has complied

with the terms of the Settlement Agreement, and that Defendant is not guaranteeing to Plaintiffs that favorable results will be achieved once the steps set forth in this Settlement Agreement have been implemented.

VII. ATTORNEY'S FEES

Defendant agrees to pay sixty thousand dollars and zero cents ($60,000.00) to Plaintiffs' Counsel in full resolution of all claims for attorney fees and costs that Plaintiffs' Counsel might have incurred in this litigation, including future work. Defendant will make best efforts to issue payment to Plaintiffs' Counsel within 60 days of the Approval Date.

VIII. RELEASE

1. In consideration of the promises of Defendant as set forth in this Settlement Agreement, the Plaintiffs 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 "Releases") from any and all claims and causes of action that have been asserted or could have been asserted in this action by reason of, or with respect to, Plaintiffs' allegations as set forth in the Complaint in this litigation.
2. The above release shall not affect in any way the right of any Class Member to seek any and all individual relief that is otherwise available in satisfaction of an individual claim against Defendant for Medicare benefits that is not based upon the allegations set forth in the Complaint in this litigation.

IX. SAVING CLAUSE

Nothing in this Agreement is intended to create a right to review, reopening, or reconsideration of any Medicare appeal not otherwise provided for by statute, regulation, or this Agreement.

The undersigned representatives of the Parties certify that they are fully authorized to consent to the Court's entry of the terms and conditions of this Settlement Agreement.

Dated: October 11, 2017.

Respectfully submitted,

/s/ Michael Benvenuto, Esq.

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