UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

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| CAROLYN HULL, PEGGY KNOX, ROSANN STENGER, and ERMA THOMPSON, on behalf of themselves and all others similarly situated,<br><br>Plaintiffs,<br><br>v.<br><br>KATHLEEN SEBELIUS, Secretary of Health and Human Services,<br><br>Defendant. | ) | Civil Action No. |

**MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL**

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## I. INTRODUCTION

The plaintiffs, who represent a statewide class of elderly and disabled Medicare beneficiaries needing home health care services, challenge the Secretary's administrative review process as essentially no review at all. The existing review process has become a stacked deck against beneficiaries, with a combined denial rate at the first two levels of review of about 98% -- or a "success rate" (if it can be called that) of about 2%.

For all practical purposes, Medicare beneficiaries' only chance for reversing a coverage denial is to go to the third level of review, the administrative law judge (ALJ) level. In addition to the extraordinary time that that action adds to the process – ALJs are so backlogged that they are taking years to decide cases – the reality is that most beneficiaries cannot utilize the ALJ level because they lack the time, resources, or advocacy support to go that far. As a consequence, the second level of review largely acts as the final decision of the Secretary. Not only is that decision invariably adverse, but because it does not technically represent exhaustion of administrative remedies, beneficiaries are precluded from seeking relief in court.

The four named plaintiffs' experiences typify the problem. Although their situations are such that any rational reviewer would recognize immediately that their home health care services should be covered, they have each received adverse decisions both at the first level of review, redetermination, and at the second level, reconsideration. Whatever happens at the ALJ level,[1] the fact remains that the first two levels of review are a waste of time and effort, a classic rubber-stamping of the initial determination. These first two levels of review are actually counter-productive because beneficiaries

[1] The named plaintiffs have hearings pending at the ALJ level, but none of them have had a hearing scheduled yet.

must jump through those two meaningless hoops in order to have the theoretical opportunity for access to the level where a meaningful review is carried out. This result is especially ironic because Congress overhauled the review process several years ago with the express purpose of giving beneficiaries a better chance to obtain coverage at the lowest levels of review and therefore to avoid having to proceed to the ALJ level.

Accordingly, the plaintiffs seek declaratory and injunctive relief to correct this policy, on the ground that it violates the Medicare statute and the Due Process Clause. Through this motion, they request certification of a class defined as:

> All Medicare beneficiaries in Connecticut (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 B (a) have been or will be denied at the initial determination stage, in whole or 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 part, at the two levels of review below the Administrative Law Judge level, and (3) for whom the initial determination or notice of termination of coverage was dated on or after January 1, 2012.

## II. LEGAL AND FACTUAL BACKGROUND OF THE CASE

### A. Medicare's administrative review process was changed in the first decade of this century.

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 over 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, extended care, home health care, and hospice services. 42 U.S.C. § 1395d(a). Part B of Medicare establishes a voluntary program of supplemental medical insurance providing outpatient coverage of physician services, nurse practitioner services, home health care, physical, speech and occupational therapy, diagnostic services, and durable medical equipment. *Id.*, § 1395k(a). [2]

As the Complaint sets out in detail (see ¶¶ 19-42), the system of review that was previously in effect differed for Parts A and B. For Part A claims, the beneficiary was entitled to a paper review by the contractor that had made the initial determination and, if that decision was also adverse, the beneficiary could go directly to the ALJ level for a de novo hearing and then to a paper-review of that decision by the Medicare Appeals Council (MAC) (if the amount in controversy requirement was satisfied). See 67 F.R. 69312, 69313 (Nov. 15, 2002); 70 F.R. 11420, 11421 (March 8, 2005); 74 F.R. 65296, 65297 (Dec. 9, 2009). For Part B claims, there was an additional level of review between the carrier's review and the ALJ: a "carrier hearing" before a hearing officer. From the hearing officer's decision the beneficiary could appeal to an ALJ and then to the MAC. See 67 F.R. at 69313; 70 F.R. at 11421-22; 74 F.R. at 65297.

In 2000 and 2003 Congress made changes to the system, including creating a review mechanism applicable to both Parts A and B. The Secretary gradually implemented the changes beginning in 2005, with claims processed prior to January 1, 2006 adjudicated pursuant to the old system. As of May 16, 2012, the Secretary

[2] Under Part C, beneficiaries may opt to enroll in a managed care plan in lieu of the traditional fee-for-service approach under Parts A and B. *Id.*, § 1395w-21(a). Part D provides for coverage of prescription drugs through private insurance plans. *Id.*, § 1395w-101 *et seq.* Neither Part C nor Part D is at issue in this case.

determined that all such claims had been resolved and declared obsolete the old regulatory provisions, subparts G and H of 42 C.F.R. part 405. 77 F.R. 29002, 29016-18 (May 16, 2012.)

The new system applicable to both Part A and Part B claims included provisions for standard review, and, in certain circumstances, expedited review. The standard review process, which was designated as subpart I of 42 C.F.R. part 405, provides for a paper-review redetermination of the initial determination by the same contractor, followed by a paper-review reconsideration by a different contractor known as the Qualified Independent Contractor (QIC), de novo review via a hearing before an ALJ, and finally the MAC's paper review (assuming the amount in controversy is met). See 70 F.R. at 11447-48.

The paper-review reconsideration stage thus represented an additional level to be navigated for Part A claims, and it replaced the carrier hearing for Part B claims. 67 F.R. at 69324; 70 F.R. at 11448; 74 F.R. at 65310. As in the old system, ALJ review is only available if the beneficiary has proceeded through the lowest levels of review, with the one exception that ALJ review is available in the absence of a reconsideration decision if the 60-day adjudication period for reconsideration has elapsed. See 42 U.S.C. §§ 1395ff(a)(3)(B)(i), 1395ff(b)(1)(A), 1395ff(c)(3)(C)(ii), and 1395ff(d)(1); 42 C.F.R. §§ 405.940, .960, and .1000(a).

Congress also created an "expedited determination" and an "expedited reconsideration" when certain providers, including home health agencies, plan to terminate services to a beneficiary. 42 U.S.C. § 1395ff(b)(1)(F). The regulations implementing this provision, subpart J of 42 C.F.R. part 405, provide for a paper review

(by an entity called the Quality Improvement Organization (QIO)) of a planned termination of services; it is equivalent to a redetermination and must be made within 72 hours of the request. 42 C.F.R. §§ 405.902, .1202. If dissatisfied with the QIO's decision, the beneficiary may obtain a paper-review reconsideration from the QIC, also within 72 hours. *Id.*, § 405.1204.

As in the standard review process, a beneficiary may obtain ALJ review only by first completing the expedited determination and reconsideration process (unless the QIC fails to issue a decision within 72 hours). *Id.*, § 405.1204(c)(5). There is no expedited ALJ review.

The Secretary views the statutory changes as intended to "introduce[ ] greater efficiency and accuracy into the Medicare appeals system." 67 F.R. at 69316. In creating the new reconsideration stage, she "attempted to use [her] discretion to design a process that will prove to be impartial, efficient, and accurate." *Id.* at 69324. Furthermore, the Secretary believed that "these new procedures will lead, over time, to significant reductions in the need to pursue appeals at the later stages of the appeal system, such as ALJ hearings and MAC reviews." 70 F.R. at 11424. As the next section of this brief explains, these reflections have turned out to be wildly inaccurate.

### B. Under the review process now in place, the rates of denial at the pre-ALJ level are so high as to render these reviews not just useless but counter-productive.

In an e-mail in December 2012 the Acting Director of CMS' Medicare Enrollment and Appeals Group stated that in calendar year 2011 the contractor responsible for initial determinations and redeterminations for home health claims in Connecticut issued redeterminations reversing the initial determinations (*i.e.*, a successful

redetermination for the beneficiary) 0.61% of the time. That is, the denial rate for redeterminations was a staggering 99.39%. The "success rate" for the first ten months of 2012 was only slightly higher, 0.79%. Similarly, at the reconsideration stage, the "success rate" for home health claims adjudicated by the QIC was 2.2% in calendar year 2011 and 1.1% in calendar year 2012.

This information was provided to plaintiffs' counsels' employer, the Center for Medicare Advocacy (CMA), because that organization brought to CMS' attention CMA's internal statistics that revealed an increasingly low "success rate" as the new administrative review process took effect. In responding by e-mail to that inquiry, the Acting Director, referring to the statistics in the previous paragraph, stated "that the reversal rates for these specific services are in-line with the appeals rate for CMA's appeals." In other words, CMS' statistics confirmed the accuracy of CMA's statistics.

CMA's advocates handled home health cases resulting in a total of 35,184 redetermination and reconsideration decisions from 1993 through 2001 and 2010 through 2013, an average of 2,706 per year.[3] The two periods coincide with the old review process and the new one; the differences are startling. In the first period, the "success rate" (counting both partially and fully favorable decisions as success) ranged from a high of 37.00% in 1993 to a low of 15.83% in 2000. The average "success rate" for those nine years was 23.36%. After implementation of the new process – which was allegedly intended to give beneficiaries a better opportunity for effective review at the pre-ALJ

[3] The years 2002 through 2009 are not included because a demonstration project was in effect during those years that drastically reduced the number of decisions. There were a total of only 1,164 in that eight-year period, and in five of the eight years there were ten or fewer decisions.

stages – the "success rates" from 2010 through 2013 were 4.34%, 0.61%, 2.87%, and 2.58%, respectively, an overall average for the four years of 2.41%.

These numbers were corroborated by the HHS Office of the Inspector General (OIG) in a report issued in October 2013. Table A4 of OIG's *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness,* OEI-01-12-00150 (Oct. 2013), reflected that, as the number of home health redeterminations increased over eight-fold in that five-year period, the "success rate" dropped from 22% to 3%:

2008: 13,385 redeterminations, 22% fully favorable, 76% unfavorable

2009: 17,116 redeterminations, 35% fully favorable, 61% unfavorable

2010: 46,037 redeterminations, 9% fully favorable, 89% unfavorable

2011: 58,713 redeterminations, 6% fully favorable, 94% unfavorable

2012: 112,844 redeterminations, 3% fully favorable, 95% unfavorable.

These extraordinary statistics at the two lowest levels of review are rendered more distressing by the fact that, at the ALJ level, there exists a realistic possibility of actually prevailing. The Acting Director of CMS' Medicare Enrollment and Appeals Group informed plaintiffs' counsel at a meeting on February 25, 2013 that the reversal rate at the ALJ level for all types of services in Parts A and B was about 70%. According to another OIG report, in fiscal year 2010 62% of ALJ decisions on home health and hospice issues together were fully favorable. *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340 (Nov. 2012), at 10.

Most beneficiaries, especially the overwhelming majority who are without advocates and therefore lack knowledge of how the system works and how their chances

of success greatly improve at the ALJ level, cannot pursue their claims beyond reconsideration. As a practical matter, the reconsideration level represents the final decision, and, as the numbers above demonstrate, beneficiaries almost always lose at that level.

Some beneficiaries can go to the ALJ level, however, and, because of the growing number of claims resolved adversely at the lowest levels, the need to take more claims to the ALJ level has added to the dramatic increase in the number of cases that ALJs handle. This result has contributed to a backlog that denies beneficiaries a speedy hearing and review. According to a Memorandum dated December 24, 2013 from the Chief Administrative Law Judge of the Office of Medicare Hearings and Appeals (OMHA), OMHA's workload grew by 184% from 2010 to 2013. The Memorandum explained that the backlog of almost 357,000 claims led to the suspension of assignment of new claims to ALJs effective July 15, 2013. Even if, as the Memorandum contends, the suspension will not affect claims filed by beneficiaries (as opposed to providers), the fact is that beneficiaries usually wait at least 1-1/2 to two years from the date a request for ALJ review is filed until they receive a decision – and often longer. These delays for ALJ review stand in stark contrast to Congress' directive that an ALJ must issue a decision (not just hold a hearing) within ninety days of the filing of the hearing request. See 42 U.S.C. § 1395ff(d)(1)(A); 42 C.F.R. § 405.1016(a).

The ironies of the existing situation are obvious. Despite a legislative intent to give Medicare beneficiaries a faster and more efficient system for challenging coverage denials, the new process of administrative review has resulted in such a vastly diminished "success rate" at the lowest levels that there is virtually no chance of overturning

decisions. Coupled with the fact that most beneficiaries cannot go to the ALJ level and that, even if they can, that step alone will last years, the minuscule "success rate" at the two lowest levels effectively denies beneficiaries a realistic opportunity to challenge coverage denials. Not only is the overall result exactly the opposite of what Congress intended, but the new system, as implemented by the Secretary, is far inferior to its predecessor.

### C. The named plaintiffs' situations

Carolyn Hull, a Clinton, Connecticut resident who was 78 and 79 years old during the period at issue (March 4 through December 28, 2012), lives alone in a trailer, where she is homebound. She suffers from severe orthopedic problems in her lower extremities. Her right hip is chronically dislocated as a result of an unsuccessful hip replacement. During the period at issue she suffered from continuous pain due to severe degenerative joint disease and arthritis of the knee and hip. She was non-ambulatory, using a wheelchair to move about in her home and a walker to transfer between her wheelchair and her bed or a chair. She was limited in endurance and chronically incontinent. She left home only for medical care, which is not a qualifying absence under the Medicare statute. See 42 U.S.C. § 1395f(a). This took considerable and taxing effort due to her very limited mobility and poor endurance.

During the period at issue, Ms. Hull received intermittent skilled nursing services at her home from Middlesex Hospital Homecare, a Medicare-certified home health agency. Her physician ordered skilled nursing visits one to three times per week to observe and assess many aspects of her health, including checking cardiopulmonary status, observing for signs and symptoms of fluid retention, assessing and managing her

pain, and evaluating, treating, and managing her chronic wounds. The doctor also ordered home health aides to assist Ms. Hull with activities of daily living such as bathing, dressing, grooming, and toileting.

The visits from skilled nurses were particularly critical for Ms. Hull's wound care. She had several stasis ulcers on her legs, which can result in serious infections of the skin (cellulitis) or bone (osteomyelitis). During their visits, the nurses measured Ms. Hull's wounds, noted color and any drainage, and checked for signs and symptoms of infection. The wounds were not stable, and the nurses cleansed them and applied dressing and compression bandages.

The nurses also measured and assessed Ms. Hull's edema (swelling) in her legs, gauging the effectiveness of the wound treatment. They auscultated her lung sounds. The nurses also taught Ms. Hull energy conservation and fall prevention techniques, pressure reduction techniques, and techniques to reduce the swelling in her legs. Ms. Hull's wound care protocols and oral medications were changed several times during the period at issue, as nurses evaluated the effectiveness of these changes.

In the initial determination, a Medicare contractor determined that five claims of home health care, covering the period of March 4 to December 28, 2012, were not covered by Medicare. Ms. Hull is a beneficiary of both Medicare and Medicaid (a "dual eligible"). This allowed the Connecticut Department of Social Services (DSS), the state's Medicaid agency, to appeal for Medicare coverage of the services for which it had paid, as a subrogee of the rights of the beneficiary. 42 C.F.R. § 405.908. Standing in the shoes of the beneficiary, DSS requested redetermination of the initial determination and then reconsideration.

The Medicare contractors charged with making those decisions had the medical records from the home health agency as evidence. The records reflected Ms. Hull's medical condition and the services that she received. Nevertheless, despite her medical condition, the redetermination decision of July 9, 2013 denied coverage of the services in question, finding that she was not homebound because she "goes out to attend the wound care clinic." The reconsideration decision of December 10, 2013 denied coverage because "[t]he documentation submitted for review did not support that the beneficiary was homebound. There was no evidence that the beneficiary's condition was such that there was a normal inability to leave the home and, consequently, leaving home would require a considerable and taxing effort. We have, therefore, determined that the home health services at issue were not reasonable and medically necessary. As a result, Medicare cannot cover the home health services at issue." A request for an ALJ hearing submitted on January 17, 2014 is still pending.

Peggy Knox, a resident of Torrington, Connecticut, was 63 years old during the period at issue, June 8, 2011 through February 2, 2012. She lives alone in an apartment, where she is homebound. Ms. Knox's primary diagnosis is venous insufficiency, meaning that the veins in her legs are impaired in their ability to send blood back to the heart. This leads to lower extremity edema, intractable pain, and stasis ulcers or wounds on her lower extremities. Ms. Knox is also diagnosed with myalgia and myositis (muscle pain and swelling), gastroparesis (impairment of the stomach muscles), asthma, and diabetes.

During the period at issue, Ms. Knox had prescriptions for over twenty medications, as well as supplemental oxygen to be taken as needed for dyspnea

(shortness of breath). She experienced dyspnea with minimal exertion, such as talking or any change of position, and therefore used the supplemental oxygen frequently, sometimes continuously. Even though she was taking morphine, she consistently rated her pain at level 9 or 10 on the numerical pain scale, where "0" represents no pain and "10" represents the worst pain imaginable. She suffered from abdominal cramping and severe joint pain.

Ms. Knox spent most of her days in bed or a wheelchair. She was unable to stand for more than a few minutes and could take only a few steps, with supervision and assistance. She was required to keep her legs elevated as much as possible for her lower extremity edema. Absences from her home were infrequent and required considerable and taxing effort. During the period at issue, Ms. Knox was evaluated for a different wheelchair to increase elevation of her legs, with the goal of spending more time in the wheelchair and less time in bed.

Ms. Knox received intermittent skilled nursing services at her home from Visiting Nurses Services of Connecticut, a Medicare-certified home health agency. Her physician ordered skilled nursing visits once per week to observe and assess many aspects of her health, including her cardiovascular, gastrointestinal, and respiratory statuses, pain management, and evaluation, treatment, and management of her wounds. New wounds developed and worsened during the period. Upon being informed of these developments by the nurses, her doctor instituted wound care orders and increased the frequency of skilled nursing visits. Ms. Knox's diabetic status slowed the healing process and increased her risk of wound infection and further ulceration.

The nurses carefully assessed Ms. Knox's lower extremity edema and wounds, noting the development of new wounds and informing her doctor of them. During their visits, the nurses measured the wounds, noted color and drainage (which was significant), and checked for signs and symptoms of infection. They provided instruction to Ms. Knox on wound care, particularly after the doctor's orders changed in August 2011 when the wounds were actually getting worse. A particularly large wound developed that at one point extended almost completely around her lower leg.

The nurses also evaluated Ms. Knox's respiratory status, sometimes detecting adventitious lung sounds, wheezing, and coughing. Ms. Knox experienced fevers and episodes of nausea and vomiting during the period, which the nurses also documented and assessed.

In the initial determination, a Medicare contractor determined that four claims of home health care, covering the period of June 8, 2011 to February 2, 2012, were not covered by Medicare. Ms. Knox is a dual eligible. DSS appealed for Medicare coverage of the services for which it had paid, requesting a redetermination of the initial determination and then reconsideration.

The Medicare contractors that performed the redetermination and reconsideration had the medical records from the home health agency as evidence. The records reflected the medical condition of Ms. Knox and the services she received. Nevertheless, despite her medical condition, the redetermination decision of August 7, 2013 denied coverage of the services in question, finding that Ms. Knox was not homebound. The reconsideration decision of May 15, 2013 found that she was homebound, but it stated that Ms. Knox was receiving "chronic custodial care" and was "capable of self-managing her care needs."

The contractor therefore found that the home health services she received were not reasonable and necessary and could not be covered by Medicare. A request for an ALJ hearing on coverage of the services in question was submitted on July 2, 2013.

Rosann Stenger, a resident of East Hartford, Connecticut, was 80 years old during the period at issue (May 6, 2011 through March 4, 2012). Ms. Stenger has been disabled and essentially bedbound for over 30 years. Since suffering a stroke in the 1980s she has had left-side hemiparesis (weakness or inability to move).

During the period at issue Ms. Stenger required a Hoyer lift plus the assistance of two people to get out of bed. Unable to walk, she generally spent about one hour per day sitting in her wheelchair and was otherwise in bed. She was normally unable to leave her home, and when she did it required considerable and taxing effort due to her extremely impaired mobility.

Ms. Stenger was dependent on a caregiver and home health aides for all self-care, including bathing, grooming, and toilet care. She was also diagnosed with diabetes, morbid obesity, edema, and, just prior to the period at issue, had been hospitalized for gastroenteritis. Since she was diabetic and incontinent of bladder and bowel, she was at high risk for developing skin breakdown and bacterial and fungal infections.

Ms. Stenger received intermittent skilled nursing services as well as home health aide services at her home from Interim Healthcare, a Medicare-certified home health agency. Her physician ordered skilled nursing visits once per week to observe and assess many aspects of her health, including her cardiovascular, gastrointestinal, and endocrine status, as well as for assessing skin integrity and edema. The doctor also ordered home health aides to assist with her activities of daily living.

Ms. Stenger experienced gastrointestinal problems during the period at issue. She had recently been diagnosed with gastroenteritis and prescribed an antibiotic. In May 2011, the nurses noted that she was still experiencing vomiting and had an elevated temperature. A nurse alerted her doctor. In late May Ms. Stenger was still complaining of diarrhea and nausea. She went to the emergency room and was diagnosed with diarrhea. She was eventually referred to a gastroenterologist. The nurses continued to note diarrhea symptoms in June.

In July 2011 the nurses observed the development of respiratory issues that led to a hospitalization. Ms. Stenger was reporting dizziness along with her chronic diarrhea. On July 15 the nurse noted that she was struggling to breathe while talking. The nurse auscultated her lungs and measured the oxygen saturation of her blood, which was below normal. Two days later a nurse visited again because an aide had reported shortness of breath. The nurse observed and assessed Ms. Stenger's respiratory status. On July 19 a nurse contacted the doctor's office about the respiratory problems, and Ms. Stenger was sent to the emergency room. At the hospital Ms. Stenger was diagnosed with pleural effusion (a build-up of fluid between tissues lining the lungs and chest) and underwent thoracentesis, an invasive procedure to remove the fluid. When Ms. Stenger returned from the hospital, the home health services resumed. She was started on supplemental oxygen at home, and skilled nursing services were needed to carefully observe and evaluate her respiratory function.

Another issue that arose during the period was chronic edema and leg pain, which raised concerns that she might have a blood clot. The nurses assessed her edema and pain, and, when her doctor grew concerned about a clot, provided instruction on signs

and symptoms to watch for, and when to seek medical help. Nurses called her doctor twice in January 2012 to report on the status of her leg.

The nurses also provided continuous assessment of Ms. Stenger's skin, which was at high risk for breakdown and infection. They noted issues such as a rash and skin tears. When some wounds developed from the use of a bedpan, the nurses evaluated the wounds, provided instruction on wound care, and alerted Ms. Stenger's doctor when appropriate.

Ms. Stenger was evaluated by a physical therapist in January 2012 after complaining of left leg discomfort. The therapist devised an exercise plan to assist with the leg pain.

A Medicare contractor determined that five claims of home health care services that Ms. Stenger received from May 6, 2011 to March 4, 2012 were not covered by Medicare. Ms. Stenger is a dual eligible. DSS appealed for Medicare coverage of the services for which it had paid, requesting a redetermination of the initial determination, and subsequently, reconsideration.

The Medicare contractors that performed the redetermination and reconsideration had the medical records from the home health agency as evidence. The records reflected Ms. Stenger's medical condition and the services she received. Nevertheless, despite her medical condition, the redetermination decision of January 16, 2013 denied coverage of the services in question, stating that Ms. Stenger was "chronic, stable, and…safe within her environment. Consequently, no skilled needs were identified." The reconsideration decision of October 18, 2013 found that Ms. Stenger was homebound but that she "was medically stable with no changes in clinical status, plan of care or medication regimen to

support the medical necessity for skilled nursing visits." The contractor therefore found that the home health services she received were not reasonable and necessary and could not be covered by Medicare. A request for an ALJ hearing on coverage of the services in question was submitted on December 6, 2013.

Erma Thompson, an East Hartford, Connecticut resident who was 96 years old during the periods at issue, April 29, 2012 through August 21, 2012, and October 20, 2012 through December 18, 2012, is homebound and lives on the first floor of a house with family members. She has diabetes and associated neuropathy, hypertension, rheumatoid arthritis, and asthma. She is limited in endurance and ambulation and experiences dyspnea with minimal exertion. She is incontinent of bladder. During the period at issue she had a drug regimen of over 15 medications and used a walker to ambulate when she was able to walk. She also used a wheelchair.

Ms. Thompson received intermittent skilled nursing services at her home from Interim Healthcare, a Medicare-certified home health agency. Her physician ordered two skilled nursing visits per month to observe and assess her respiratory, endocrine, and genitourinary systems, as well as provide ongoing assessment of her risk for falls with safety instruction. Ms. Thompson also received home health aide services for assistance with activities of daily living such as bathing, grooming, and dressing.

At the beginning of the first period at issue a nurse saw the need for additional pain management for Ms. Thompson, and requested a pain assessment from her doctor, who prescribed Percocet. The nurse also noted congestion with expiratory wheezes, which developed into a upper respiratory infection. Ms. Thompson was prescribed an antibiotic (Augmentin), which in turn caused gastrointestinal distress with diarrhea. The

nurse instructed Ms. Thompson to halt the Augmentin until she heard from her doctor. Once the diarrhea resolved the nurse noted that Ms. Thompson was experiencing constipation. The nurse explained how the narcotic pain medication can cause constipation and provided instruction on relieving symptoms. During this time the nurses were also monitoring a left eye infection, which was eventually diagnosed as shingles and treated with medication.

In July 2012 the nurses documented and monitored pitting edema in Ms. Thompson's legs as well as an itching rash on her arms, legs, and back. The following month her health declined precipitously, necessitating more frequent skilled nursing visits. Ms. Thompson's rash was worsening and she complained of feeling ill, weak, and unsteady. A nurse discovered that Ms. Thompson was making errors in her dosage of Lasix (a diuretic used to treat edema) and consulted with her doctor. Since the dosage error created a risk of dehydration, the nurse provided instruction to Ms. Thompson on increasing her fluids. Later, in August 2012 the nurses documented that Ms. Thompson was weak, shaking, and having difficulty walking. They also noted the development of a pressure wound, which was measured, documented, and treated.

During the second period at issue (October 20 – December 18, 2012), the nurses continued to carefully monitor Ms. Thompson for additional complications, which were highly likely given her very advanced age, overall condition, and recent adverse health events. The nurses noted that Ms. Thompson's legs were still edematous and "weeping" fluid. The chronic pressure wound was noted to be in a state where it would heal and then reopen. Nurses monitored and assessed these conditions and provided instruction on reducing symptoms.

In the initial determination, a Medicare contractor determined that three claims for home health care, covering April 29 to August 21, 2012 and October 20 to December 18, 2012, were not covered by Medicare. Ms. Thompson is a dual eligible, and Medicaid covered the services in question. DSS appealed for Medicare coverage, requesting a redetermination of the initial determination and, later, reconsideration.

The Medicare contractors that performed the redetermination and reconsideration had the medical records from the home health agency as evidence in the appeal. The records reflected the medical condition of Ms. Thompson and the services she received, as described above. Nevertheless, despite her medical condition, Medicare's redetermination decision of October 10, 2013, denied coverage of the services in question, finding that Ms. Thompson was "chronic and stable" and did not require skilled services. The reconsideration decision of May 22, 2014 similarly found that the services provided did not require the unique skills of a licensed nurse and therefore could not be covered by Medicare. A request for an ALJ hearing on coverage of the services in question was submitted on May 29, 2014.

## III. BECAUSE THE NAMED PLAINTIFFS SATISFY THE REQUIREMENTS OF RULE 23(a) AND RULE 23(b)(2), THE CLASS SHOULD BE CERTIFIED.

### A. Introduction

Class actions are a significant and effective tool in the litigation process, for both courts and litigants, as they advance "the efficiency and economy of litigation which is a principal purpose of the procedure." *General Telephone Co. of Southwest v. Falcon*, 457 U.S. 147, 159 (1982) (internal quotation marks and citation omitted); see also, *e.g.*, *U.S. Parole Commission v. Geraghty*, 445 U.S. 388, 402-403 (1980). Furthermore, in cases

seeking to correct the improper administration of government benefit programs, they are particularly useful in securing effective relief to everyone harmed by the challenged practice. See, *e.g.*, *Matyasovszky v. Housing Authority of City of Bridgeport*, 226 F.R.D. 35, 40 (D.Conn. 2005) (quoting *Newberg on Class Actions* for propriety of class certification in cases brought by participants in government benefit programs).

In another Social Security Act case, the Supreme Court stated that

> class relief for claims such as those presented ... in this case is peculiarly appropriate. The issues involved are common to the class as a whole. They turn on questions of law applicable in the same manner to each member of the class .... It is unlikely that differences in the factual background of each claim will affect the outcome of the legal issue. And the class-action device saves the resources of both the courts and the parties by permitting an issue potentially affecting every social security beneficiary to be litigated in an economical fashion under Rule 23.

*Califano v. Yamasaki*, 442 U.S. 682, 701 (1979). In a later decision, Chief Justice Rehnquist repeated and approved the *Yamasaki* language: "[A]s the litigation history of this case demonstrates, 'the class-action device save[d] the resources of both the courts and the parties by permitting an issue potentially affecting every [class member] to be litigated in an economical fashion.'" *Gratz v. Bollinger*, 539 U.S. 244, 268 n.17 (2003). Accordingly, judges in this district have consistently employed the class certification device in Medicare cases that seek relief for classes of beneficiaries.[4]

[4] See, *e.g.*, *Landers v. Leavitt*, 232 F.R.D. 42 (D.Conn. 2005) (nationwide class certified in challenge to Medicare condition of coverage); *Wilson-Coker v. Shalala*, 2001 WL 930770 (D.Conn. 2001) (statewide class certified in case involving Medicare beneficiaries who are also eligible for Medicaid); *Conn. State Dept. of Social Services v. Shalala*, 2000 WL 436616 (D.Conn. 2000) (statewide class certified in another case involving Medicare beneficiaries who are also eligible for Medicaid); *Healey v. Shalala*, No. 3:98CV00418 (DJS) (D.Conn. Nov. 19, 1998) (nationwide class certified in challenge to Secretary's failure to require home health agencies to provide procedural rights to beneficiaries, discussed in appeal of merits *sub nom*. *Lutwin v. Thompson*, 361 F.3d 146, 148 (2d Cir. 2004)); *Fox v. Bowen*, 656 F.Supp. 1236, 1238 n. 2 (D.Conn.

Recognizing that "Rule 23 is given liberal rather than restrictive construction and courts are to adopt a standard of flexibility," *Marisol A. v. Giuliani*, 126 F.3d 372, 377 (2d Cir. 1997) (internal quotation marks and citation omitted), the Court should certify this case to proceed as a class action.

### B. Plaintiffs meet the requirements of Rule 23(a).

The party seeking certification must satisfy the "four threshold requirements" set out in Rule 23(a) and also must demonstrate that the action is maintainable under one of the three subdivisions of Rule 23(b). *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 613-614 (1997); see also, *e.g., Comer v. Cisneros*, 37 F.3d 775, 796 (2d Cir. 1994). The district court must determine that plaintiffs meet each of the requirements of Rule 23 by considering all the relevant evidence to establish whether the preponderance of the evidence standard is satisfied.[5] If the factors are satisfied, plaintiffs are entitled to have the class certified. *Shady Grove Orthopedic Associates, P.A. v. Allstate Ins. Co.*, 559 U.S. 393, 398 (2010) (Rule 23 "creates a categorical rule entitling a plaintiff whose suit meets the specified criteria to pursue his claim as a class action"). In this case, as in similar challenges to the Secretary's policies in implementing Social Security Act benefit programs, the right to certification is easily demonstrated.

#### 1. "Numerosity" or "impracticability": The size of the class and other factors demonstrate that joinder is impracticable.

The first factor for consideration is known as numerosity or the impracticability of

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1987) (statewide class certified in challenge to Secretary's application of Improvement Standard to Medicare beneficiaries).

[5] See, *e.g., Comcast Corp. v. Behrend*, 133 S.Ct. 1426, 1432 (2013); *Wal-Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541, 2551 (2011); *Teamsters Local 445 Freight Div. Pension Fund v. Bombadier, Inc.*, 546 F.3d 196, 202 (2d Cir. 2008); *In re Initial Pub. Offerings Sec. Litig.*, 471 F.3d 24, 41-42 (2d Cir. 2006).

joinder. See, *e.g.*, *Robidoux v. Celani*, 987 F.2d 931, 935 (2d Cir. 1993); see also, *e.g.*, Wright, Miller & Kane, 7A *Federal Practice and Procedure*, § 1762 at 171 (3d ed. 2005). Its resolution depends

> on all the circumstances surrounding a case, not on mere numbers. Relevant considerations include judicial economy arising from the avoidance of a multiplicity of actions, geographic dispersion of class members, financial resources of class members, the ability of claimants to institute individual suits, and requests for prospective injunctive relief which would involve future class members.

*Robidoux*, 987 F.2d at 936 (citations omitted); see also, *e.g.*, *Matyasovszky*, 226 F.R.D. at 40; *Raymond v. Rowland*, 220 F.R.D. 173, 179 (D.Conn. 2004); . Furthermore, "[i]mpracticable does not mean impossible." *Robidoux*, 987 F.2d at 935 (citations omitted).

In this case, the numbers alone are sufficient to resolve the matter. Although there is no magic number, see *Petrolito v. Arrow Financial Services, LLC*, 221 F.R.D. 303, 308-309 (D.Conn. 2004), "numerosity is presumed at a level of 40 members." *Consol. Rail Corp. v. Town of Hyde Park*, 47 F.3d 473, 483 (2d Cir. 1995) (citation omitted). Although no known information exists specifically detailing how many Connecticut Medicare beneficiaries seeking coverage for home health care are harmed by the defective administrative process, the available information indicates that the class has well over the forty members at which the presumption of impracticability adheres.

Statistics compiled by CMA based on its practice provide the necessary core information. From 2010 through 2013 (the four years after the conclusion of the demonstration project), CMA advocates handled home health claims that resulted in fully unfavorable decisions at both the redetermination and reconsideration levels for 3,763 Connecticut beneficiaries, an average of 941 per year. Declaration of Shaun Harrington

(filed with this Motion), ¶ 5 and attached exhibit. Although both unfavorable decisions were not always issued in the same calendar year, the fact remains that, during the four-year period, an unfavorable redetermination decision was followed by an unfavorable reconsideration decision for 3,763 beneficiaries. Even putting aside the fact that these figures do not include decisions obtained by other advocates in the state or by Connecticut beneficiaries acting on their own, the numbers are more than enough (*i.e.*, well over 40) to meet the numerosity requirement.

"[C]ourts may make common sense assumptions to support a finding of numerosity." *Raymond*, 220 F.R.D. at 178 (internal quotation marks and citation omitted). The available information demonstrates that the class is sufficiently large to preclude joinder as a practical possibility. See *Robidoux*, 987 F.2d at 935 (plaintiffs need not present "evidence of exact class size or identity of class members to satisfy the numerosity requirement"); see also, *e.g.*, *Clark v. Astrue*, 274 F.R.D. 462, 471 (S.D.N.Y. 2011) (inferring satisfaction of numerosity requirement from agency statistics); *State of Conn. Office of Protection and Advocacy for Persons with Disabilities v. State of Connecticut*, 706 F. Supp. 2d 266, 287 (D.Conn. 2010) ("permissible for the plaintiffs to rely on reasonable inferences drawn from the available facts") (internal quotation marks and citation omitted). Certainly, there can be no doubt that at any given time, more than forty beneficiaries in Connecticut are receiving adverse decisions at the two lowest levels of the Medicare administrative review system on their home health care claims. On that basis alone, subsection 23(a)(1) is met.

Furthermore, the other indicia of impracticability leave no doubt that the subsection is met. First, it would be extraordinarily inefficient to have numerous lawsuits

on this issue, as they would all focus on the same point: the ridiculously low "success rate" for Medicare beneficiaries seeking home health care coverage. It "serves judicial economy" to allow this case to proceed as a class action. *Robidoux*, 987 F.2d at 936.

Second, the difficulty for individuals to bring suit or to join in this one is real. By definition, the class members are elderly and disabled and are physically in poor condition. Most are not financially well off, thus making "individual suits difficult to pursue." *Id*. Also, they reside throughout the state, thus further exacerbating the difficulty of joinder. *Id.* ("potential class members are distributed over the entire area of Vermont"). These practical impediments inherent in the membership of the class render it virtually impossible for most class members to file individual cases or otherwise to participate. See, *e.g.*, *Raymond*, 220 F.R.D. at 179.

Finally, as plaintiffs seek declaratory and injunctive relief for both present and future members of a class whose composition is constantly fluctuating, classwide relief is particularly appropriate. *Robidoux*, 987 F.2d at 936.

The available information indicates that, at any given time, at least hundreds of Medicare home health beneficiaries around the state are subject to the challenged system. Even if the class were considerably smaller, it would be more than sufficient. *Matyasovszky*, 226 F.R.D. at 41 n. 4. Numbers alone are sufficient to satisfy this first component of Rule 23(a)(1), and the other indicia of impracticability lend further support to that conclusion.

**2. Rule 23(a)(2) and (3): Common questions of law and fact exist, and the claims of the named plaintiffs are typical of the claims of the class members.**

The next two factors, commonality and typicality,

> tend to merge into one another, so that similar considerations animate analysis of Rules 23(a)(2) and (3). The crux of both requirements is to ensure that maintenance of a class action is economical and [that] the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence.

*Marisol A.*, 126 F.3d at 376 (internal quotation marks and citations omitted); see also *Wal-Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541, 2551 n. 5 (2011).

"Courts have found that the test for commonality is not demanding ...." *Raymond*, 220 F.R.D. at 179 (internal quotation marks and citation omitted), and that general guideline has not been altered by the decision in *Wal-Mart*. See, *e.g., Linsley v. FMS Investment Corp.*, 288 F.R.D. 11, 15 (D.Conn. 2013). "The commonality requirement is met if plaintiffs' grievances share a common question of law or fact." *Marisol A.*, 126 F.3d at 376 (citations omitted).

> Rule 23(a)(2) requires only that common questions exist at the core of the cause of action alleged. Where the question of law involves standardized conduct of the defendant toward members of the proposed class ... the commonality requirement of Rule 23(a)(2) is usually met.

*Easterling v. Connecticut*, 265 F.R.D. 45, 52 (D.Conn. 2010) (internal quotation marks and citations omitted). "Minor factual differences will not preclude class certification if there is a common question of law." *State of Conn. Office for Protection and Advocacy for Persons with Disabilities*, 706 F. Supp. 2d at 287 (citation omitted). A single common question, of law or fact, satisfies the commonality standard. *Wal-Mart*, 131 S.Ct. at 2556; *Marisol A.*, 126 F.3d at 376.

The *Wal-Mart* decision reminded courts to ensure "that the class members have suffered the same injury" and that their claims "depend upon a common contention ... of such a nature that it is capable of classwide resolution – which means that determination

of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Id.* at 2551 (citation and internal quotation marks omitted). The Court added: "What matters to class certification … is not the raising of common questions – even in droves – but, rather the capacity of a classwide proceeding to generate common *answers* apt to drive the resolution of the litigation." *Id.* (citation and internal quotation marks omitted). Judges in this district have recognized these points as the crux of the Supreme Court's commonality analysis in *Wal-Mart*. See, *e.g.*, *Haddock v. Nationwide Fin. Services*, 293 F.R.D. 272, 279 (D.Conn. 2013); *Morrison v. Ocean State Jobbers, Inc.*, 290 F.R.D. 347, 353 (D.Conn. 2013); *Linsley*, 288 F.R.D. at 15; *Amara v. Cigna Corp.*, 925 F. Supp. 2d 242, 262 (D.Conn. 2012); *Maziarz v. Housing Authority of the Town of Vernon*, 281 F.R.D. 71, 81-82 (D.Conn. 2012).

In this case, as in others involving the failure of a government agency to meet its obligations, there can be little doubt that commonality is satisfied. As noted in a Second Circuit decision involving another benefit program, "the questions of law, which predominantly focus on whether the behavior of the defendants violated the [relevant statute and provisions] of the Constitution, are, by necessity, common to the class because they do not depend on the plaintiff-variable but on the defendants, who are a constant." *Comer*, 37 F.3d at 796-797.

Here, there are common questions of both law and fact that are central to the validity of the claims and that will generate common answers to provide a classwide resolution. The common question of law is whether the Secretary violates the Medicare statute and the Due Process Clause by implementation and imposition of an administrative review process that almost invariably results in adverse decisions at the

lowest levels of review, thus forcing beneficiaries to waste time and effort at those levels and discouraging them from obtaining review at the ALJ level, where there is a legitimate opportunity to obtain coverage. These are "common issue[s] the resolution of which will advance the litigation." *Petrolito*, 221 F.R.D. at 309 (internal quotation marks and citation omitted). A determination that the Secretary has imposed an illegal system of administrative review will allow resolution of the litigation for all class members, which is the focus in *Wal-Mart*. See, *e.g.*, *Shahriar v. Smith & Wollensky Restaurant Group, Inc.*, 659 F.3d 234, 252 (2d Cir. 2011) (finding commonality because plaintiffs' class claims derive from the same policies and practices and arise under the same statutes and regulations).

The common question of fact is that all the class members are Medicare beneficiaries who have received adverse decisions from the Secretary at the two lowest levels of review on their claims for coverage of home health care services regardless of the merits of their claims. "[T]he lawsuit focuses on the behavior of the defendants and not that of the plaintiffs." *Comer*, 37 F.3d at 797. Accordingly, the class members have all suffered the same injury, and correction of that injury is the purpose of the lawsuit.

Commonality is met.

The "typicality requirement is satisfied when each class member's claim arises from the same course of events and each class member makes similar legal arguments to prove the defendant's liability." *Robidoux*, 987 F.2d at 936 (citations omitted); see also, *e.g.*, *Marisol A.*, 126 F.3d at 376; *Maziarz*, 281 F.R.D. at 82; *Perkins v. So. New England Tel. Co.*, 669 F. Supp. 2d 212, 223 (D.Conn. 2009). "In government benefit class actions, the typicality requirement is generally satisfied when the representative plaintiff is

subject to the same statute, regulation, or policy as class members." *Matyasovszky*, 226 F.R.D. at 42 (internal quotation marks and citation omitted). Again, this standard is easily satisfied, as the claims of the named plaintiffs and the class members all arise from the Secretary's policy of denying virtually all claims for home health coverage at the lowest levels of review regardless of the merits. Furthermore, the named plaintiffs and the class members are making the same arguments to demonstrate that the Secretary's policy is illegal.

"When it is alleged that the same unlawful conduct was directed at or affected both the named plaintiff and the class sought to be represented, the typicality requirement is usually met irrespective of minor variations in the fact patterns underlying individual claims." *Robidoux*, 987 F.2d at 936-937 (citations omitted); see also, *e.g.*, *Maziarz*, 281 F.R.D. at 82; *Matyasovszky*, 226 F.R.D. at 42. By proving their claims, the named plaintiffs will necessarily prove the class members' claims as well. Typicality is therefore met.

### 3. Rule 23(a)(4): The named plaintiffs will protect the interests of the class.

The adequacy of representation requirement "is motivated by concerns similar to those driving the commonality and typicality requirement, namely, the efficiency and fairness of class certification." *Marisol A.*, 126 F.3d at 378 (citation omitted); see also *Wal-Mart*, 131 S.Ct. at 2551 n. 5 (adequacy of representation requirement tends to merge with the commonality and typicality requirements). The standard

> entails inquiry as to whether: 1) plaintiff's interests are antagonistic to the interest of other members of the class and 2) plaintiff's attorneys are qualified, experienced and able to conduct the litigation. The focus is on uncovering conflicts of interest between named parties and the class they seek to represent. In order to defeat a motion for certification, however,

the conflict must be fundamental.

*In re Flag Telecom Holdings, Ltd. Sec. Litig.*, 574 F.3d 29, 35 (2d Cir. 2009) (internal quotation marks and citations omitted); see also, *e.g.*, *Marisol A.*, 126 F.3d at 378; *Maziarz*, 281 F.R.D. at 82; *State of Conn. Office for Protection and Advocacy for Persons with Disabilities*, 706 F. Supp. 2d at 288.

With respect to the first prong, the named plaintiffs' interests are not antagonistic to those of the class members because all suffer from the same policy of the Secretary, the deprivation of a meaningful administrative review process at the lowest levels. They seek relief requiring the Secretary to take corrective measures that would benefit the class members as well as the named plaintiffs. *Accord*, *Marisol A.*, 126 F.3d at 378. "[B]ecause there are legal issues common to the class, the plaintiffs ... will be protecting the interests of the class by advancing their own legal interests in the case ...." *Doe v. Bridgeport Police Dept.*, 198 F.R.D. 325, 333 (D.Conn. 2001); see also, *e.g.*, *Maziarz*, 281 F.R.D. at 82 ("As all tenants were subject to this policy, [the named plaintiff's] interests align with those of the proposed class."). The class members' rights will be fully protected and enforced by providing the relief requested by the named plaintiffs.

On the second prong, plaintiffs' counsel have demonstrated their ability to handle this litigation by vigorously representing Medicare beneficiaries, as well as beneficiaries of other Social Security Act programs, for many years.[6] Because of this extensive

[6] A representative sample of reported Medicare decisions on which plaintiffs' counsel have acted as lead or co-counsel includes *Machado v. Leavitt*, 542 F. Supp. 2d 185 (D.Mass. 2008); *Situ v. Leavitt*, 240 F.R.D. 551 (N.D.Cal. 2007); *Landers v. Leavitt*, 2006 WL 2560297 (D.Conn. 2006), aff'd, 545 F.3d 98 (2d Cir. 2008); *Gray Panthers Project Fund v. Thompson*, 273 F. Supp. 2d 32 (D.D.C. 2002); *Healey v. Thompson*, 186 F. Supp. 2d 105 (D.Conn. 2001), aff'd in part, vacated and remanded in part *sub nom.*

relevant experience, plaintiffs' counsel are usually not questioned on the issue of adequacy of representation.[7]

### C. Plaintiffs meet the requirements of Rule 23(b)(2).

"In addition to satisfying Rule 23(a)'s prerequisites, parties seeking class certification must show that the action is maintainable under Rule 23(b)(1), (2), or (3)." *Amchem Products, Inc.*, 521 U.S. at 614. Under (b)(2), "[c]lass certification is appropriate where the defendant has acted or refused to act on grounds generally applicable to the class, thereby making injunctive or declaratory relief appropriate." *Marisol A.*, 126 F.3d at 378. "Rule 23(b)(2) applies only when a single injunction or declaratory judgment would provide relief to each member of the class." *Wal-Mart*, 131 S.Ct. at 2557; see also, *e.g.*, *Maziarz*, 281 F.R.D. at 83. "The entire purpose behind Rule 23(b)(2) is to resolve disputes concerning the existence of a policy and practice of discrimination against a broad class of individuals." *State of Conn. Office for Protection and Advocacy for Persons with Disabilities*, 706 F. Supp. 2d at 289 (internal quotation marks and citation omitted).

Again, there can be little doubt that plaintiffs meet this standard. This case presents the paradigm of a Rule 23(b)(2) class action, as "plaintiffs seek injunctive relief and they predicate the lawsuit on the defendants' acts and omissions with respect to" the class, *Comer*, 37 F.3d at 796, namely, the Secretary's policy of almost always denying

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*Lutwin v. Thompson*, 361 F.3d 146 (2d Cir. 2004); *Fox v. Bowen*, 656 F.Supp. 1236 (D.Conn. 1987).

[7] Accordingly, and in order to avoid unnecessary filings, they are not filing declarations in support of their stated experience. See, *e.g.*, *Raymond*, 220 F.R.D. at 180 (court relies on pleadings to conclude that plaintiffs' counsel are competent to handle the litigation); *Doe*, 198 F.R.D. at 333 (same). If deemed necessary, however, plaintiffs' counsel will further document their experience with declarations.

coverage at the lowest levels of review regardless of the merits. Since the "deficiencies ... stem from central and systemic failures" by the Secretary, class certification under Rule 23(b)(2) is the appropriate vehicle for resolving the matter. *Marisol A.*, 126 F.3d at 378; see also *Yamasaki*, 442 U.S. at 700-701 ((b)(2) class appropriate in challenge to procedures used in Social Security Act case); *Raymond*, 220 F.R.D. at 181 ("Cases of this nature, alleging systemic failure of governmental bodies to properly fulfill statutory requirements, have been held to be appropriate for class certification under Rule 23(b)(2).").

## IV. PLAINTIFFS' COUNSEL SHOULD BE APPOINTED AS CLASS COUNSEL.

Rule 23(g) requires a court to appoint "class counsel" when a class is certified. F.R.Civ.P. 23(g)(1). An applicant for class counsel must satisfy subsections (1) and (4) of Rule 23(g) if there is only one applicant, as is the case here. F.R.Civ.P. 23(g)(2).

Closely tracking the language of Rule 23(a)(4), Rule 23(g)(4) requires that an attorney serving as class counsel "fairly and adequately represent the interests of the class." Plaintiffs have already shown how their attorneys, based on their histories of experience with Medicare and other Social Security Act programs, will fairly and adequately represent the class.

Rule (g)(1)(A) directs the Court to consider

> (i) the work counsel has done in identifying or investigating potential claims in the action; (ii) counsel's experience in handling class actions, other complex litigation, and claims of the type asserted in the action; (iii) counsel's knowledge of the applicable law; and (iv) the resources that counsel will commit to representing the class.

The Court may also consider "any other matter pertinent to counsel's ability to fairly and adequately represent the interests of the class." F.R.Civ.P. 23(g)(1)(B). The Advisory

Committee Notes to the 2003 amendments that added subsection (g) state that "[i]n evaluating prospective class counsel, the court should weigh all pertinent factors. No single factor should necessarily be determinative in a given case."

Considering these factors, it is clear that plaintiffs' counsel have fully and completely identified the legal issues, as they have raised claims under the Medicare statute and the Due Process Clause. Their experience, as reflected in the sample of decisions listed in footnote 6, shows that they have extensive backgrounds in class actions, in the legal and factual issues raised by this case, and in Medicare law. Furthermore, the individual attorneys will have behind them the resources of a national public interest organization that for many years has specialized in the rights of the elderly and disabled and advocated aggressively on their behalf. There can be little doubt that they will meet the goal set out in the Advisory Committee Notes of "ensur[ing] adequate representation for the class."

Plaintiffs' attorneys' experience, dedication, and knowledge are fully reflected in their lengthy careers on behalf of the elderly and disabled. Conversely, no reason presents itself as to why they should not be appointed as class counsel. A fair weighing of the factors set out at Rule 23(g) leads to the conclusion that plaintiffs' counsel should be appointed as class counsel.

## V. CONCLUSION

As plaintiffs meet all the requirements of Rule 23(a) and subdivision (2) of Rule 23(b), the Court should certify the class.

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Respectfully submitted,

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