UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT

GLENDA JIMMO, KR by her guardian KENNETH ROBERTS, MIRIAM KATZ, EDITH MASTERMAN, MARY PATRICIA BOITANO, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, NATIONAL MULTIPLE SCLEROSIS SOCIETY, PARKINSON'S ACTION NETWORK, PARALYZED VETERANS OF AMERICA, and AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION, on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

KATHLEEN SEBELIUS, Secretary of Health and Human Services,

Defendant.

Civil Action No. 5:11-CV-17

**MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL**

Pursuant to Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure, all plaintiffs move that the Court certify this case to proceed as a class action. The class is defined as follows:

> All beneficiaries of Medicare Parts A, B, or C who have had or will have coverage for health care or therapy services, as an outpatient, in a hospital, in a skilled nursing facility, or in a home health care setting,

denied, terminated, or reduced due to the application of the Improvement Standard, on or after January 1, 2006.

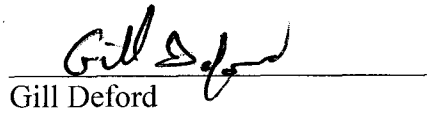
Furthermore, pursuant to Rule 23(g), plaintiffs move that their counsel, Gill Deford, Judith A. Stein, Margaret Murphy, Wey-Wey Kwok, Nancy V. Gifford, Toby Edelman, Michael Benvenuto, and Devon Green be appointed class counsel.

Plaintiffs base this motion upon the Complaint, the accompanying Memorandum of Points and Authorities in Support of Class Certification and Appointment of Class Counsel, and the other papers and pleadings filed in this action.

Plaintiffs' counsel have not been able to obtain the Defendant's agreement that the class should be certified, because, due to the simultaneous filing of this Motion and the Complaint, they do not know who will be representing the Defendant. Based on past experience in cases involving the Medicare program, however, plaintiffs' counsel believe it is highly unlikely that Defendant would agree to class certification.

DATED: January 13, 2011

Respectfully submitted,



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**CERTIFICATE OF SERVICE**

This is to certify that, on January 18, 2011, I caused to be mailed, by first class, postage prepaid mail, Motion for Class Certification and Appointment of Class Counsel, and Memorandum in Support of Motion for Class Certification and Appointment of Class Counsel, to:

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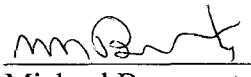

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GLENDA JIMMO, KR by her guardian KENNETH ROBERTS, MIRIAM KATZ, EDITH MASTERMAN, MARY PATRICIA BOITANO, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, NATIONAL MULTIPLE SCLEROSIS SOCIETY, PARKINSON'S ACTION NETWORK, PARALYZED VETERANS OF AMERICA, and AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION, on behalf of themselves and all others similarly situated,

Plaintiffs,

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Defendant.

Civil Action No. 5:11-CV-17

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

## I. INTRODUCTION

In this case plaintiffs challenge an illegal condition of coverage employed by the defendant Secretary of Health & Human Services (the Secretary) in her administration of the Medicare program, which provides health insurance for 47 million Americans. As a covert rule of thumb that also deprives most affected beneficiaries of the right to review, the Improvement Standard causes termination, reduction, or denial of coverage for thousands of Medicare beneficiaries annually, of whom many have chronic diseases and can least afford the loss of care and services. This largely clandestine policy, which has been implemented without notice-and-comment rulemaking, has no support in the Medicare statute, is directly contradicted by the implementing regulations, and has been repeatedly repudiated by court decisions, none of which the government has appealed.

Different terms are employed in applying the Improvement Standard. These include that the beneficiary needs "maintenance services only," has "plateaued," or is "chronic," "stable," or "not improving." All have the same meaning and impact, however: that the beneficiary is not getting better as a consequence of the care or services at issue and therefore is not entitled to coverage for skilled care. Although federal regulations preclude application of such a standard, employees of the decision-making entities, especially at the lower levels of the Medicare administrative review process, heed carefully to the phraseology that effects the Improvement Standard. Furthermore, because the Standard is recited as Medicare policy and its application appears to be "correct," most beneficiaries do not even attempt to seek review at a higher level.

The named plaintiffs are Medicare beneficiaries who have had coverage terminated or denied due to application of the Improvement Standard and

organizations that assist their members and others who are subject to the Standard. They seek declaratory and injunctive relief to correct this policy, contending that it is prohibited by the Medicare statute, the Administrative Procedure Act (APA), the Freedom of Information Act, and the Due Process Clause. Because it is applicable to beneficiaries around the country, they seek to represent a nationwide class of Medicare beneficiaries who have suffered or will suffer from the application of the Improvement Standard. Specifically, they request certification of a class defined as:

> All beneficiaries of Medicare Parts A, B, or C who have had or will have coverage for health care or therapy services, as an outpatient, in a hospital, in a skilled nursing facility, or in a home health care setting, denied, terminated, or reduced due to the application of the Improvement Standard, on or after January 1, 2006.

## I. LEGAL AND FACTUAL BACKGROUND OF THE CASE

### A. Medicare and its coverage rules.

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, extended care (nursing homes), home health, 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 physicians, nurse practitioners, home health, physical, speech and occupational therapy, diagnostic services, and durable medical equipment. *Id.*, § 1395k(a). Under Part C (the Medicare Advantage program), beneficiaries may opt to enroll in a managed care plan in lieu of the traditional fee-for-service approach provided

in Parts A and B. *Id.*, § 1395w-21(a).[1]

The threshold for Medicare coverage is codified in its medical necessity requirement, which states that

> no payment may be made … for any expenses incurred for items or services which … are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

42 U.S.C. § 1395y(a)(1)(A). In other words, full coverage must flow when the service is reasonable and necessary. *Hays v. Sebelius*, 589 F.3d 1279, 1283 (D.C. Cir. 2009).

Except for the discrete and limited reference in subsection 1395y(a)(1)(A) to "improv[ing] the functioning of a malformed body member," the Medicare statute nowhere establishes or refers to improvement as a condition of coverage. Indeed, the regulations state just the opposite. Thus, for coverage of skilled nursing care,

> [t]he restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.

42 C.F.R. § 409.32(c); see also *id.*, § 409.44(b)(1) (incorporating that standard for home health care coverage). The home health care regulations emphasize that the "reasonable and necessary" determination depends on "the unique medical condition of the individual beneficiary," *id.*, § 409.44(a), and expressly preclude consideration of "whether the illness or injury is acute, chronic, terminal, or expected to last a long time." *Id.*, § 409.44(b)(3)(iii). And, with respect to physical, speech, and occupational therapy in the home health context, the regulations are framed in the alternative, with improvement

[1] The fourth part of Medicare, Part D, provides for coverage of prescription drugs through private insurance plans. See 42 U.S.C. § 1395w-101 *et seq.* The Improvement Standard is not implicated in Part D.

being only one of three possible grounds for coverage. *Id.*, § 409.44(c)(2)(iii). Furthermore, the Medicare Benefit Policy Manual (MBPM) emphasizes the need for assessing the totality of the individual's need for care, expressly precluding reliance on "rules of thumb." IOM 100-02, MBPM, ch. 7, §§ 20.3, 40.2, 40.1.1. Just two months ago, CMS reiterated and emphasized this point:

> "Rules of thumb" in the Medicare medical review process are prohibited .... Any "rules of thumb" that would declare a claim not covered solely on the basis of such elements, such as, lack of restoration potential ... or degree of stability, is [*sic*] unacceptable without individual review of all pertinent facts to determine if coverage may be justified.

75 F.R. 70372, 70395 (Nov. 17, 2010).

### B. The administrative review process and application of the Improvement Standard.

Medicare administrative review is a multi-step process. For Parts A and B, it includes an opinion from the provider that Medicare will not or will no longer authorize coverage of the care or services at issue, an "initial determination" from the Medicare administrative contractor, a redetermination either by the contractor or, if expedited review has been requested, by a separate entity called the Quality Improvement Organization (QIO), reconsideration by the Qualified Independent Contractor (QIC), de novo review by an administrative law judge (ALJ), and on-the-record review by the Medicare Appeals Council (MAC). The process is largely the same for Part C claims, but with slightly different terminology and with the reconsideration determination made by an external organization known as the Independent Review Entity (IRE).

As a general rule (though with important exceptions), failure to timely seek review at the next step in the sequence terminates the beneficiary's right to seek further administrative or judicial review. This is so despite the fact that, under Parts A and B,

beneficiaries may only proceed through the administrative process after they have received the care or services at issue and obligated themselves to pay for it. That is, a Part A or B beneficiary cannot obtain an advisory coverage decision. See, *e.g., Heckler v. Ringer*, 466 U.S. 602, 621 (1984).

Despite the regulatory prohibition against a policy like the Improvement Standard, lower level decision-makers – that is, employees of providers, contractors, Medicare Advantage plans, QICs, QIOs, and IREs – largely ignore the regulations. Following in-house directives and Local Coverage Determinations (LCDs), which are created by individual contractors to provide guidance in the jurisdictions in which they operate, they consistently deny coverage on the ground that the beneficiary has "plateaued" or is not improving. Provider reliance on the Improvement Standard can result in a beneficiary being unable to obtain the initial determination that provides the entrée into the administrative process.

Even when beneficiaries do formally seek coverage, only a tiny percentage of those who are denied initially seek further review, see *infra* at 15, despite the greater likelihood of success at either the ALJ level, where LCDs are not binding, 42 C.F.R. § 405.1062(a), or upon judicial review.[2] The overall rate of review by ALJs of Part A and B reconsiderations is under 38%.[3] Given that cases involving the Improvement Standard

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[2] The courts have regularly rejected application of the Improvement Standard. See, *e.g., Anderson v. Sebelius*, 2010 WL 4273238 (D.Vt. 2010); *Papciak v. Sebelius*, --- F. Supp. 2d ---, 2010 WL 3885605 (W.D.Pa. 2010); *Smith v. Shalala*, 855 F.Supp. 658 (D.Vt. 1994); *Rizzi v. Shalala*, 1994 WL 686630 (D.Conn. 1994) (challenge to Improvement Standard claim rejected because Secretary's change to manual rendered claim moot); *Folland v. Sullivan*, 1992 WL 295230 (D.Vt. 1992); *Fox v. Bowen*, 656 F.Supp. 1236 (D.Conn. 1987).

[3] In FY 2008, the number of Medicare claims taken to ALJs under all four Parts of Medicare was 185,665 in 36,585 appeals. Office of Medicare Hearings and Appeals

appear to involve the simple application of a rule to undisputed facts (rather than a dispute about the facts or application of the rule to those facts), it stands to reason that an even smaller percentage of those who are denied coverage because of the Improvement Standard seek ALJ review.

The bottom line is that the Improvement Standard has a twofold impact on beneficiaries. First, it denies them coverage to which they are entitled. Second, it discourages review to such an extent that beneficiaries are effectively deprived of the ability to obtain review. This case seeks to correct that situation.

### C. The named plaintiffs' situations

The individual plaintiffs

The five individual plaintiffs have all been denied coverage because of application of the Improvement Standard. Glenda Jimmo, who is a resident of Bristol, Vermont and was 71 at the time of the coverage denial, suffers from serious medical problems, including diabetes and angina. As a consequence of these conditions, her physician prescribed intermittent skilled nursing and home health aide nursing services, but the defendant Secretary's Medicare contractor denied coverage for the home health services received from January 14, 2007 to January 8, 2008, noting that "[h]er condition was stable with no acute changes." At the next level, the QIC affirmed on the basis of

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website, at http://www.hhs.gov/omha/resources/index.html. The total claims figure for ALJ appeals (185,665) represents 38% of the Part A and B reconsideration decisions made in 2008 (482,989). See CMS, "Fact Sheet: Original Medicare (Fee-For-Service) Appeals Data – 2008," at http://www.cms.gov/OrgMedFFSAppeals/Downloads/Feeshet2008.pdf. Since the claims figure includes an unknown number of Parts C and D claims as well, the percentage of Parts A and B claims that are taken to the ALJ level is something less than 38%, probably considerably less.

similar reasoning: "The likelihood of a change in the patient's condition requiring skilled nursing services was not supported in the documentation." The ALJ also applied the Improvement Standard: "Observation and assessment of the Beneficiary was not necessary as the Beneficiary was stable .... The Beneficiary's condition did not significantly changes [*sic*] during the period at issue and the plan of care did not undergo changes." The MAC affirmed the ALJ and expressly adopted his conclusions. Complaint, ¶¶ 45 - 51.

Plaintiff KR, who lives in Bennington, Vermont, was, at the relevant time, 48 years old. She is severely disabled, suffering from congenital quadriplegia, patellofemoral syndrome, and epilepsy; she also has significant cognitive impairments, including mental retardation. She needs either a wheelchair or a walker to get around, and requires assistance from others when she goes outside. Accordingly, her physician ordered skilled physical therapy beginning September 26, 2008, but her claim for coverage of this therapy was denied at both the initial and redetermination levels of review. On reconsideration, the QIC affirmed on the basis of the Improvement Standard, holding that the "submitted documentation did not support that the beneficiary had experienced an acute episode or exacerbation of chronic condition resulting in a complex functional deficit to warrant skilled therapy intervention." Her appeal to an ALJ fared no better, as the ALJ, in his decision of November 16, 2010, parroted the classic Improvement Standard language as the basis for his holding: "The services must be provided with the expectation that the condition of the patient will improve materially in a reasonable and generally predictable period of time." As a consequence of that application, he denied coverage because "[t]he submitted documentation does not support

that [KR] had experienced an acute episode or exacerbation of chronic condition resulting in a complex functional deficit to warrant skilled intervention." KR appealed that decision to the MAC on December 22, 2010. Complaint, ¶¶ 52-60.

After hospitalization for a high grade intestinal obstruction and metastatic cancer, David Katz, who was 90 years old and a resident of Bloomfield, Connecticut when he died, went to a skilled nursing facility. Although the first part of his stay there was covered, his wife Miriam Katz, who was named as the executor in his will, was notified on November 26, 2010 that coverage for his SNF stay would end effective November 30. Expedited review resulted in denials from the QIO and then from the QIC on December 3, on the ground that the "care you are currently receiving is considered custodial and could be performed by unskilled aides, who are trained in maintenance care." Complaint, ¶¶ 61-65.

Edith Masterman is 79 years old and lives in Wilton, Maine. She has been a paraplegic since she was injured in a farming accident over sixty years ago. She was receiving home health care, on her doctor's orders, because of pressure sores. After she returned home from a hospital and then a SNF because of the need for a skin graft to repair a sore, however, her home health care agency, which is the only Medicare-certified agency in the area, refused to provide further care, contending that "Medicare will not pay for a chronic problem." She now receives limited home health services through the Medicaid program. She also has to visit the wound care clinic on a weekly basis, which would not be necessary if she had the more comprehensive care that she previously received. Because her former home health agency has determined that she would not be covered for Medicare, she cannot gain access to the administrative review process and

challenge the very policy that the agency is applying to her. Complaint, ¶¶ 66 - 74.

Mary Patricia Boitano, who lives in Narragansett, Rhode Island, is 83 years old. She is enrolled in United HealthCare's Part C Medicare Advantage program. After being hospitalized this past fall, she was transferred to a SNF, for which her care was originally covered by Medicare. United HealthCare denied Coverage after November 22, 2010, however, and her fast-track appeal decision affirmed that denial because "[t]herapy services must … be reasonable in relation to the expected improvement in your condition." A different skilled nursing facility to which she moved determined that she needed skilled care and therapy, but United HealthCare continued to contend that she was not entitled to Medicare coverage. At her own expense, however, she stayed at that SNF, receiving skilled care and therapy, until January 3, 2011, when she again had to be hospitalized. Complaint, ¶¶ 75 - 83.

The organization plaintiffs[4]

The five national organizations that are co-plaintiffs with the individual beneficiaries represent a cross-section of organizations that seek to assist Americans who have chronic illnesses and disabilities in obtaining coverage for their necessary treatment and care. They include an organization that represents Medicare beneficiaries, three organizations that advocate on behalf of individuals with specific chronic conditions, and the organization that represents the nation's physiatrists, who specialize in physical medicine and rehabilitation. All are devoted to the ending of the Improvement Standard

[4] An organization may act as a class representative when its underlying purpose is to represent the interests of the class. *See, e.g., Communities for Equity v. Michigan High School Athletic Ass'n*, 192 F.R.D. 568, 573 (W.D.Mich. 1999); *Nat'l Org. for Women, Inc. v. Scheidler*, 172 F.R.D. 351, 362 (N.D.Ill. 1997); *Upper Valley Ass'n for Handicapped Citizens v. Mills*, 168 F.R.D. 167, 171 (D.Vt. 1996); *Mass. Ass'n of Older Americans v. Spirito*, 92 F.R.D. 129, 135 (D.Mass. 1981).

with the goal of guaranteeing the right to Medicare coverage for those whom the organizations serve and seek to protect.

The National Committee to Preserve Social Security and Medicare (the National Committee) has 3.2 million members and supporters throughout the country, almost all of whom are Medicare beneficiaries. As its full name indicates, the National Committee is focused in large part on protecting the Medicare program and making it work for its members and other beneficiaries. Complaint, ¶¶ 84 - 90.

The National Multiple Sclerosis Society (MS Society) has a 50-state network of chapters that work with the national office to provide care and support for those suffering from multiple sclerosis. The Medicare program is one of the MS Society's four key points of focus, and many of the people whom it serves are Medicare beneficiaries. Complaint, ¶¶ 91- 99.

The Parkinson's Action Network (PAN) works with other Parkinson's organizations and its grassroots network of advocates throughout the country to improve the lives of those with Parkinson's disease. One crucial aspect of PAN's effort is to ensure that those with the disease receive the benefits to which they are entitled, including Medicare. Complaint, ¶¶ 100 - 107.

The Paralyzed Veterans of America (PVA) is a nationwide, congressionally chartered organization that assists veterans who have spinal chord injury or dysfunction. Obtaining quality health care is a critical component of this effort. With thousands of its 20,000 members receiving Medicare, PVA is devoted to insuring that they obtain the coverage to which they are entitled. Complaint, ¶¶ 108 - 115.

The American Academy of Physical Medicine and Rehabilitation (AAPM&R)

advocates on behalf of its more than 7,500 members and has as its core purpose to enhance its members' ability to serve patients with temporary or permanent disabilities. As part of that purpose it advocates on public policy issues related to persons with disabling conditions, and ensuring that those patients receive Medicare coverage without interference from the Improvement Standard is a key focus of that advocacy. Complaint, ¶¶ 116 - 122.

## III. SINCE 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); 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 recipients of government benefits).

In another Social Security Act case, the Supreme Court stated over thirty years ago 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). Writing for the Court, 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 have not hesitated to employ the class certification device in Medicare cases that seek relief for classes of beneficiaries.[5]

Accepting the allegations in the complaint as true,[6] and 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) (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

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[5] See, *e.g.*, *Landers v. Leavitt*, 232 F.R.D. 42 (D.Conn. 2005) (nationwide class certified in challenge to Medicare condition of coverage); *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)); *Grijalva v. Shalala*, 946 F.3d 1115, 1118 (9th Cir. 1998) (nationwide class certified in due process challenge to Part C procedures), vacated in light of intervening legislation and decision, 526 U.S. 1096 (1999); *Fox v. Bowen*, 656 F.Supp. 1236, 1238 n. 2 (D.Conn. 1987) (statewide class certified in challenge to Secretary's application of Improvement Standard to Medicare beneficiaries).

[6] See, *e.g.*, *Shelter Realty Corp. v. Allied Maintenance Corp.*, 574 F.2d 656, 661 n.15 (2d Cir. 1978); *Alleyne v. Time Moving & Storage Inc.*, 264 F.R.D. 41, 47 (E.D.N.Y. 2010); *Matyasovszky*, 226 F.R.D. at 39.

the three subdivisions of Rule 23(b). *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 613 (1997); see also, *e.g., Comer v. Cisneros*, 37 F.3d 775, 796 (2d Cir. 1994); *Brown v. City of Barre, Vermont*, 2010 WL 5141783 at *3 (D.Vt. 2010). 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.[7] If the factors are satisfied, the Court must certify the class. *Shady Grove Orthopedic Associates, P.A. v. Allstate Ins. Co.*, 130 S.Ct. 1431, 1437-38 (2010). 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 is the impracticability of joinder. See, *e.g., Comer*, 37 F.3d at 796; *In Re Drexel Burnham Lambert Group, Inc.*, 960 F.2d 285, 290 (2d Cir. 1992). Although this is frequently referred to as the "numerosity requirement," it is more properly subsumed under the rubric of "impracticability." See, *e.g.*, Wright, Miller & Kane, 7A *Federal Practice and Procedure*, § 1762 at 171 (3d ed. 2005); *Anderson v. Dept. of Public Welfare*, 1 F.Supp.2d 456, 461 (E.D.Pa. 1998). Accordingly, the Second Circuit has made clear that 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

[7] See, *e.g., Teamsters Local 445 Freight Div. Pension Fund v. Bombadier, Inc.*, 546 F.3d 196, 202 (2d Cir. 2008); *In re Pub. Offerings Sec. Litig.*, 471 F.3d 24, 41-42 (2d Cir. 2006); *Brown*, 2010 WL 5141783 at *3; *Easterling v. Connecticut*, 265 F.R.D. 45, 50 (D.Conn. 2010).

which would involve future class members.

*Robidoux v. Celani*, 987 F.2d 931, 936 (2d Cir. 1993) (citations omitted); see also, *e.g.*, *Matyasovszky*, 226 F.R.D. at 40; *McGee v. Gold*, 2006 WL 2975752 at *3 (D.Vt. 2006); Alba Conte and Herbert B. Newberg, 1 *Newberg on Class Actions*, § 3:6 at 249-253 (4th ed. 2002). Furthermore, "[i]mpracticable does not mean impossible." *Robidoux*, 987 F.2d at 935; *Brown*, 2010 WL 5141783 at *4.

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); see also, *e.g.*, *McGee*, 2006 WL 2975752 at *2. Although there exists no known information specifically detailing how many decisions are based on the Improvement Standard, the available information indicates that the class has well over the forty members at which the presumption of impracticability adheres.

First, plaintiffs have alleged that the class is estimated to include "at least tens of thousands of members," Complaint, ¶ 21, and unrefuted allegations may suffice to satisfy the standard. See, *e.g.*, *Haddock v. Nationwide Financial Services*, 262 F.R.D. 97, 116 (D.Conn. 2009). Moreover, this allegation is a reasonable one. In 2008, in Part A, 15.4 million claims were denied, and, of these, 265,000 were appealed to the redetermination level. Centers for Medicare & Medicaid Services, "Fact Sheet: Original Medicare (Fee-For-Service) Appeals Data – 2008," at 2 (available at http://www.cms.gov/OrgMedFFSAppeals/Downloads/factsheet2008.pdf).[8] Of those

[8] The Part B figures are available at the same website, but plaintiffs believe that Part

denied at that stage, 76,051 Part A claims were appealed to the next level, reconsideration. *Id.* at 6.

Thus, at the three lowest levels of Part A decision-making – initial determination, redetermination, and reconsideration – there were, respectively, millions, hundreds of thousands, and tens of thousands of claims at issue in a year. Even if only 1% of these denials relied on the Improvement Standard, the numbers for the respective levels would be 154,000, 2,650, and 760 in a year. In fact, though, because the 1% figure is unrealistically low, and because these numbers do not include claims denied under Parts B and C, the number of Medicare beneficiaries affected in a given year by the Improvement Standard must be considerably higher. In any event, it is clear that, at any given time, tens of thousands of Medicare beneficiaries have their Part A claims denied because of the Improvement Standard.

A "court may make common sense assumptions to support a finding of numerosity." *Brown*, 2010 WL 5141783 at *4 (citation and internal quotation marks omitted); see also, *e.g., 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). 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

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A accounts for the great majority of the claims involving the Improvement Standard, and, accordingly, even though there are many more Part B claims and denials, plaintiffs will refer to the Part A claims to simplify the discussion. Plaintiffs have been unable to locate any comparable statistics for Part C claims.

class size or identity of class members to satisfy the numerosity requirement"). On that basis alone, subsection 23(a)(1) is met.

In any event, though, the "other indicia of impracticability," *Jordan v. County of Los Angeles*, 669 F.2d 1311, 1319 (9th Cir.), vacated on other grounds, 459 U.S. 810 (1982), 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 illegal application of the Improvement Standard. It would "serve judicial economy" to allow this case to proceed as a class action. *Robidoux*, 987 F.2d at 936. Second, the Secretary's determination not to allow her challenged policy to be corrected by individual cases illustrates the need for class certification. The government can continue to apply the standard, lose the occasional decision in an individual case, and not appeal, thereby insulating the policy from effective review. It would serve the interests of justice for this case to proceed as a class action. *Accord, Brown*, 2010 WL 5141783 at *6 (unknowable individuals in the future will benefit from a successful outcome and should be included in the numerosity analysis).

Third, 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. Many, probably most, are not financially well off, thus making "individual suits difficult to pursue." *Robidoux*, 987 F.2d at 936. Furthermore, they reside throughout the country, thus further exacerbating the difficulty of joinder. *Id.* at 936 ("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.

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. The numerosity requirement has generally been relaxed in that context. *Robidoux*, 987 F.2d at 936; *Brown*, 2010 WL 5141783 at *5.

The available information indicates that, at any given time, thousands of Medicare beneficiaries around the country are subject to the challenged policy. Numbers alone are sufficient to satisfy this first component of Rule 23(a)(1), but 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 (citations and quotation marks omitted); see also *Amchem Products, Inc.*, 521 U.S. at 626 n. 20. Moreover, when, as here, "a plaintiff seeks injunctive and declaratory relief, there is a presumption that both commonality and typicality are present." *Brown*, 2010 WL 5147183 at *6 (citation omitted).

"Courts have found that the test for commonality is not demanding ...." *Raymond v. Rowland*, 220 F.R.D. 173, 179 (D.Conn. 2004) (quotation marks and citation omitted). "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*, 265 F.R.D. at 52 (citations and internal quotation marks omitted). "Commonality is established so long as the plaintiffs can identify some unifying thread among the members' claims." *Haddock*, 262 F.R.D. at 116 (citations and internal quotation marks 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).

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 796-97.

Here, there are common questions of both law and fact. The common questions of law are whether application of the Improvement Standard violates the Medicare statute and regulations, whether the policy has been carried out in violation of the APA, the Medicare statute's procedural requirements, and the Freedom of Information Act, and whether it runs afoul of the Due Process Clause. In the most basic sense, these are "common issue[s] the resolution of which will advance the litigation." *Petrolito*, 221 F.R.D. at 309 (quotation marks and citation omitted). The common question of fact is that all the class members are Medicare beneficiaries who are in need of health care and

who have had their Medicare coverage denied or terminated by application of the Improvement Standard.

In short, "the lawsuit focuses on the behavior of the defendants and not that of the plaintiffs." *Comer*, 37 F.3d at 797. Commonality is easily 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., Caridad v. Metro-North Commuter R.R.*, 191 F.3d 283, 293 (2d Cir. 1999); *Marisol A.*, 126 F.3d at 376. "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 (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 applying the Improvement Standard in the face of regulations to the contrary. 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). 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; see also *Amchem Products, Inc.*, 521 U.S. at 626 n. 20 (adequacy of representation requirement tends to merge with the commonality and typicality requirements). The requirement

> 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. Securities Lit.*, 574 F.3d 29, 35 (2d Cir. 2009) (citations and internal quotation marks omitted); see also, *e.g., Marisol A.*, 126 F.3d at 378.

With respect to the first prong, the named plaintiffs suffer from having the Improvement Standard applied to them just as it is and will be applied to the class members. They seek relief requiring the defendant 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). There is no antagonism or conflict between the named plaintiffs and the class members, and the latter's rights will be fully protected and enforced by provision of 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.[9] Because of this extensive relevant experience, plaintiffs' counsel are usually not questioned on the issue of adequacy of representation.[10]

### 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. "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 288 (internal quotation marks and citation omitted).

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[9] A representative sample of reported Medicare decisions on which plaintiffs' counsel have served 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), *cert. denied*, 129 U.S. 2878 (2009); *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. Lutwin v. Thompson*, 361 F.3d 146 (2d Cir. 2004); *Fox v. Bowen*, 656 F.Supp. 1236 (D.Conn. 1987).

[10] 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 it is deemed necessary, however, plaintiffs' counsel will further document their experience with declarations.

Again, there can be little doubt that plaintiffs meet this requirement. 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 defendant's acts and omissions with respect to the class, namely, her policy of applying the Improvement Standard in the face of contrary regulations. 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 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, the APA, the Freedom of Information Act, and the Due Process Clause. Their experience, as reflected in the sample of decisions listed in footnote 9, 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 both state and national organizations that for many years have 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."

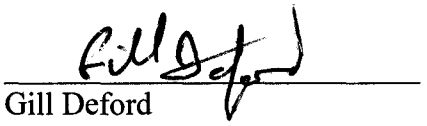
Plaintiffs' attorneys' experience, dedication, and knowledge are fully reflected in their lengthy careers on behalf of the elderly and disabled. Conversely, no reason presents itself as to why they should not be appointed as class counsel. A fair weighing of the factors set out at Rule 23(g) leads to the conclusion that plaintiffs' counsel should be appointed as class counsel. See, *e.g.*, *Landers*, 232 F.R.D. at 48 (appointing several attorneys from the Center for Medicare Advocacy, Inc. as class counsel in a Medicare class action).

## 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.

DATED: January 13, 2011

Respectfully submitted,



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