UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT

GLENDA JIMMO, et al., Plaintiffs, vs. KATHLEEN SEBELIUS, Secretary of Health & Human Services, Defendant.	No. 5:11-CV-17

NOTICE OF PROPOSED SETTLEMENT OF CLASS ACTION AND OF FAIRNESS HEARING

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

A. The Nature and History of the Lawsuit

B. The Proposed Settlement of the Lawsuit

C. The Reasons for the Settlement

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

E. Additional Information

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

A. Nature and History of Lawsuit

Plaintiffs filed this lawsuit on January 18, 2011 against Defendant Kathleen Sebelius, the Secretary of Health and Human Services, alleging that the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS) (the agency that administers the Medicare program), has violated its obligations under the law by applying what Plaintiffs call "the Improvement Standard." "Improvement Standard" refers to a standard that Plaintiffs have alleged, but that Defendant denies, exists under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care or services in question. Plaintiffs sought an injunction ordering HHS to stop applying the alleged Improvement Standard in the future and to correct past denials or terminations of coverage based on the Improvement Standard.

Plaintiffs filed a motion for certification of a nationwide class action at the same time as their original Complaint. Certification of the class has been agreed to by the Defendant as part of the proposed settlement. The class is defined as

> All Medicare beneficiaries who:
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> a. received skilled nursing or therapy services in a skilled nursing facility, home health setting, or outpatient setting; and
> b. received a denial of Medicare coverage (in part or in full) for those services described in the previous paragraph based on a lack of improvement potential in violation of SNF [skilled nursing facility], HH [home health services], or OPT [outpatient therapy services] maintenance coverage standards as defined above in Sections IX.6 and IX.7 [of the Settlement Agreement] and that became final and non-appealable on or after January 18, 2011; and
> c. seek Medicare coverage on his or her own behalf; the definition of class members specifically excludes providers or suppliers of Medicare services or Medicaid State Agency.

B. The Proposed Settlement of the Lawsuit

Following extensive settlement negotiations, including in-person meetings, numerous conference calls, and regular exchanges of e-mails and draft positions from December 2011 through October 16, 2012 (when the proposed Settlement Agreement was filed), the parties have reached a settlement of this matter, subject to Court approval. In exchange for class members dismissing their claims, Defendant has agreed that CMS will do the following:

- Revise relevant portions of the Medicare Benefit Policy Manual, after considering input from Plaintiffs' Counsel, to clarify the coverage standards for the SNF, HH, and OPT benefits when a patient has no restoration or improvement potential but when that patient needs skilled SNF, HH, or OPT services to maintain his or her condition or prevent or slow further deterioration.

- Engage in a nationwide educational campaign using written materials, prepared after considering input from Plaintiffs' Counsel, and interactive forums and National Calls with providers, suppliers, contractors, and adjudicators to communicate the clarified coverage standards.

- Develop protocols for reviewing random samples of certain QIC decisions for consistency with the clarified coverage standards, provide updates to Plaintiffs' Counsel of the results of the sampling, work with the QIC to determine if errors were made and to correct any errors, review up to 100 individual claims brought to CMS' attention by Plaintiffs' Counsel, and meet with Plaintiffs' Counsel to discuss implementation of the Settlement Agreement five times on a bi-annual basis.

- Allow certain class members who received or will receive a final and non-appealable denial that is based on a violation of the coverage standards for the SNF, HH, and OPT benefits when a patient has no restoration or improvement potential but when that patient needs skilled SNF, HH, or OPT services to maintain his or her current condition or to prevent or slow further deterioration as set forth in the Settlement Agreement up to the date of the end of the educational campaign (which will last up to one year after the approval date of the Settlement Agreement) the opportunity for a re-review of their denied claim.

- Pay Plaintiffs' Counsel reasonable and appropriate attorney's fees, costs, and expenses under the Equal Access to Justice Act for their work on the

> case through the approval date of the Settlement Agreement, and pay reasonable fees, costs, and expenses under the Equal Access to Justice Act for their work on the case after the approval date up to $300,000.

In addition, the Court will maintain jurisdiction over the case for either two or three years after the end of the educational campaign (the time period dependent on whether Defendant issues a CMS Ruling communicating the clarified standards for the SNF, HH, and OPT benefits when a patient has no restoration or improvement potential but when that patient needs skilled SNF, HH, or OPT services to maintain his or her condition or prevent or slow further deterioration, which she has the option to do). During that period, either party may, through counsel, ask the Court to enforce one or more provisions of the Settlement Agreement if the party believes that the other party is not carrying out the terms of the Settlement Agreement.

C. The Reasons for the Settlement

Plaintiffs contend in this lawsuit that the Defendant has failed to follow the law in applying the Improvement Standard throughout the years. The Defendant vigorously disagrees with that assessment, and contends in fact that there is no Improvement Standard. If the case were to continue, it is uncertain which side would prevail. Moreover, because of Plaintiffs' intention to seek answers to discovery, it would be at least a year, and probably more, before the case could be brought to the Court for resolution. Also, although Plaintiffs largely prevailed on the Defendant's Motion to Dismiss, which contended that the Court lacked jurisdiction over Plaintiffs' claims, Defendant could appeal that decision as well. Furthermore, even if Plaintiffs prevailed before both the trial court and the appellate courts, the nature and extent of the relief that they could obtain is unknown. Given the uncertainty for both parties and the amount of

time that would be consumed by the additional work in the trial court and a likely appeal, the Plaintiffs and Defendant believe that settlement is the best resolution of the matter and that the proposed Settlement Agreement is fair, adequate, and reasonable and will result in appropriate Medicare coverage determinations consistent with the law.

D. Settlement Fairness Hearing

The Court has preliminarily approved the settlement, but will hold a hearing ("Fairness Hearing") to determine whether to grant final approval of the proposed settlement as fair, adequate, and reasonable. The Fairness Hearing will take place at 10:00am on January 24, 2013 at the United States District Court for the District of Vermont, 151 West Street, Rutland, Vermont 05701. The Fairness Hearing may, from time to time and without further notice to the Class, be continued or adjourned by order of the Court. If you wish to attend the Fairness Hearing, you should confirm the date and time with Class Counsel at Center for Medicare Advocacy, Inc. or Vermont Legal Aid (contact information below). Class Members do not need to appear at the Fairness Hearing or take any other action to indicate their approval of the settlement or to obtain the benefits of the settlement.

If you wish to object to the settlement, you must do so in writing via letter or card (e-mail cannot be accepted). Written objections must be sent to Class Counsel, either the Center for Medicare Advocacy, Inc. or Vermont Legal Aid (addresses below), no later than fourteen days before the date of the Fairness Hearing, or by January 10, 2013. Class Counsel will forward all objections to Counsel for the Defendant and will file all objections with the Court no later than January 18, 2013.

If the Court grants final approval of the proposed Settlement Agreement, class members will be subject to the settlement and bound by the judgment, including the release of claims described in Section XIII of the Settlement Agreement.

E. Additional Information

The pleadings and other records in this litigation may be examined and copied during regular office hours at the office of the Clerk of the Court, United States District Court for the District of Vermont, 151 West Street, Rutland, Vermont 05701. You may also view the entire Settlement Agreement at the website of the Center for Medicare Advocacy, Inc. (http://www.medicareadvocacy.org) or Vermont Legal Aid (http://www.vtlawhelp.org).

Dated: November 29, 2012

Respectfully submitted,

*/s/ Gill Deford*____
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