IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

CAROL WINKLER; ILENE R. BELL and RUBY MAYES, by their next friend, Vicky Tataryn; HELEN RAHE, by her next friend, Jeannette Willis; and MRS. TERRY A. COBB, by her next friend, Janice Cobb, on their own behalf and on behalf of all others similarly situated, PLAINTIFFS vs. INTERIM HEALTHCARE INC. DEFENDANT	)	NO. 3-98-0042 Judge Campbell Magistrate Haynes JURY DEMAND CLASS ACTION

FIRST AMENDED AND SUPPLEMENTAL COMPLAINT - CLASS ACTION

I. INTRODUCTION

1. The plaintiffs are disabled and elderly Medicare beneficiaries. The plaintiffs have depended on the defendant corporation to provide them with Medicare-reimbursed home health services. In anticipation of changes in Medicare payment policies, which took effect January 1, 1998, the defendant company undertook a review of its patient caseload to identify those whose disabilities and care needs are likely to make them less lucrative under the new rate structure. The plaintiffs, along with many others, have been identified as economically undesirable patients to be “dumped” from the company’s home

health caseload. The defendant has abandoned, or is in the process of abandoning, some patients, thereby gravely endangering their health and causing them anxiety and injury. In the case of other frail patients, the defendant corporation has intentionally withheld from the plaintiffs and their fellow patients information about the company's intentions and the patients' rights.

2. These actions violate the plaintiffs' rights under Tennessee contract law, Section 504 of the Rehabilitation Act of 1973, the Tennessee Consumer Protection Act and the common law of tort. The plaintiffs bring this action on their own behalf, and on behalf of a plaintiff class of present and future Tennessee patients who are in similar circumstances, seeking injunctive relief to prevent the defendant from disrupting their care, and requesting an appropriate award of damages.

II. PARTIES

A. Plaintiffs

3. Plaintiff Carol Winkler is a 59 year old homebound resident of Nashville, Davidson County, Tennessee.

4. Plaintiff Ilene R. Bell is a 68 year old blind, homebound resident of Nashville, Davidson County, Tennessee. Due to her disabilities, she brings this action by and through Vicky Tataryn, acting as her next friend.

5. Plaintiff Ruby Mayes is an 84 year old homebound resident of Nashville, Davidson County, Tennessee. Due to her

disabilities, she brings this action by and through Vicky Tataryn, acting as her next friend.

6. Ms. Helen Rahe is an 85 year old homebound resident of Nashville, Davidson County, Tennessee. Due to her disabilities, she brings this action as plaintiff by and through her daughter, Jeannette Willis, acting as her next friend.

7. Mrs. Terry A. (Mabel O'Brien) Cobb is an 84 year old homebound resident of Nashville, Davidson County, Tennessee. Due to her disabilities, she brings this action as plaintiff by and through her daughter, Janice Cobb, acting as her next friend.

B. Defendant

8. Defendant Interim HealthCare Inc., (hereafter "Interim") is a Florida corporation headquartered in Fort Lauderdale, FL, and qualified to do business in Tennessee. Interim is a multi-national enterprise which operates a number of health care staffing services under the name Interim HealthCare®. Upon information and belief, based upon public disclosures made by the defendant, Interim HealthCare® is the second largest health care staffing company in North America, based on sales. Interim HealthCare® operates from offices in 400 locations across the United States and Canada. Some of the chain's operations are conducted directly, while others are conducted under franchise or license. According to the company's public disclosures, taxpayer-supported programs, such as Medicare and Medicaid, account for approximately $125 million, or about one third of the defendant's health care revenues, which total $360 million.

Home health care accounted for 78% of the company's health related revenues in 1996.

C. The Plaintiff Class

9. *Plaintiff Class defined.* The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23.01 and 23.02 (2) of the Federal Rules of Civil Procedure, on behalf of all those similarly situated. The plaintiff class is comprised of all individuals in Tennessee who are now, or will in the future be, Medicare home health agency patients of the defendant corporation, its licensees or franchisees.

10. The prerequisites to maintenance of the class action under Rule 23(a), F.R.C.P., are satisfied in the following respects:

a. The class is so numerous that joinder of all members is impracticable. Upon information and belief, the Nashville office which serves the plaintiffs is only one of Interim's several Tennessee offices which stretch from Memphis to Johnson City, and the Nashville office alone receives Medicare payments for more than fifty home health agency patients.

b. There are questions of law or fact common to the class. The defendant has a common set of legal duties to all class members, governed by a form contract which incorporates rights and obligations imposed by Medicare laws, regulations and conditions of participation. There are, therefore, common questions among class members regarding the legality of the defendants' policies and practices complained of herein. There are also common

questions of fact, arising from the defendant's application to class members of a common corporate policy of identifying and culling out patients with disabilities which require heavy care.

c. The claims of the named plaintiffs are typical of the claims of Interim's other Tennessee patients, all of whom are subject to the defendant's policies complained of herein.

d. The named plaintiffs will fairly and adequately protect the interest of the class. Each has a direct, personal interest in the outcome that ensures their vigorous prosecution of the claims which they hold in common with their fellow members of the plaintiff class. The class representatives are represented by counsel who are experienced in class action litigation involving health law issues.

11. The prerequisite to maintenance of a class action under Rule 23(b)(2), F.R.C.P., is satisfied because Interim has acted on grounds generally applicable to the class by pursuing a broad policy of screening patients and withdrawing essential health care when it appears that they are no longer sufficiently lucrative to treat, thereby making declaratory relief appropriate with respect to the class as a whole.

12. Alternatively, maintenance of a class action is appropriate under Rule 23(b)(3), F.R.C.P., because questions of law or fact common to the plaintiff class members predominate over any questions affecting only individual members, and a class action

is superior to other available methods for the fair and efficient adjudication of the controversy.

III. FACTUAL ALLEGATIONS

A. Description of the Medicare Home Health Program

13. Title XVIII of the Social Security Act, sometimes referred to as the Medicare Act, provides medical insurance benefits, known as Medicare, to certain disabled or elderly individuals who qualify for Social Security benefits. 42 U.S.C. §1395 *et seq*. Medicare is administered by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services, under the direction of the Secretary of Health and Human Services.

14. One of Medicare's two principal components is known as Part A. Part A covers inpatient hospital benefits and certain other services, including home health care. Part A is financed by payroll tax contributions to a federally administered trust fund. Individuals eligible for Medicare automatically receive Part A coverage.

15. Part B covers physician services and certain other outpatient services. Under the Balanced Budget Act of 1997, Part B will eventually fund part of the Medicare home health benefit. Part B is financed by a combination of congressional appropriations and monthly premiums paid by beneficiaries. Part B coverage is optional. In order to receive such benefits, Medicare-eligible individuals must agree to pay the monthly premium (or, more commonly, have it deducted from their monthly Social Security pension).

16. Both Part A and Part B coverage involve the imposition on beneficiaries of financial liability for deductibles and/or copayments (in addition to the premium liability associated with Part B). Most beneficiaries purchase private insurance to cover some or all of these additional costs, and, in some instances, to provide additional benefits not covered by Medicare. Such private insurance is regulated by both the state and federal governments and is known as "Medicare Supplement" or "Medigap" insurance.

17. Section 1832 of the Act, 42 U.S.C. §1395k(a)(2)(A), authorizes Medicare payments to agencies that provide home health services, which are defined by 1861(m) of the Act, 42 U.S.C. §1395x(m), to mean medical or nursing services and items delivered to an individual "under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are ... provided on a visiting basis in a place of residence used as such individual's home..." Section 1861(o), 42 U.S.C. §1395x(o), defines a home health agency as an entity which meets Medicare conditions of participation for the provision of home health services.

18. Home health agencies are not required to participate in Medicare. However, if they elect to do so, they agree as a condition of payment to comply with federal conditions of participation and all applicable federal and state laws, including laws prohibiting discrimination on the basis of disability. Those conditions include: accepting and treating

patients based on their medical need; informing patients of their rights and respecting those rights; and involving patients in the planning of their care and treatment.

19. Home health agencies generally find that it is financially advantageous to seek and accept Medicare business. Apart from the revenues which Medicare provides, certification that an agency complies with Medicare conditions of participation, serves as widely recognized indicator of quality and standing in local communities and is important in obtaining other business.

20. In August, 1997, the President signed into law the Balanced Budget Act of 1997, P.L. 105-33, which, among other things, substantially amended Title XVIII of the Social Security Act. The new law included changes in the way Medicare will reimburse home health agencies for providing home health services to the program's beneficiaries. The changes establish a so-called "prospective payment system"(PPS). Under PPS providers will ultimately receive predetermined payment amounts limited by episode of illness, as well as the opportunity for providers to share in savings to the extent they keep their costs below the prescribed payment amount. The new system will go into effect in October, 1999.

21. In the meantime, Medicare is instituting a so-called "interim payment system" (IPS), applicable to each home health agency upon the beginning of its first fiscal year after October 1, 1997. The I.P.S. continues to pay on a fee-for-service basis, but caps the total amount that Medicare will pay an agency for any one patient. The cap is based on an agency's historical

Medicare experience, without regard to the patient’s acuity. In the case of the defendant, the new I.P.S. became effective on January 1, 1998.

B. The Defendant’s Response to the Amended Law

22. Interim had anticipated the changes in reimbursement. In the annual report of the defendant’s parent company, filed with the federal Securities and Exchange Commission six months prior to enactment of the Balanced Budget Act, Interim described the then-pending congressional proposals to establish some form of prospective payment system. The defendant then asserted that,

> While there can be no assurance that any such proposals will be implemented nor any assurance as to the final form of such legislation, Interim does not anticipate any adverse impact from such changes *because of its ability to manage its Medicare caseload* and its ability to keep its current Medicare service costs well below existing cost caps.[emphasis supplied]

23. Beginning in mid-November, 1997, the local management of the defendant’s Nashville office announced to members of the nursing staff that they were initiating weekly meetings to deal with upcoming changes in Medicare reimbursement. In mid-December, the Nashville branch manager and the Director of Nursing were called away to a meeting with corporate officials in Florida. Around this same time, the defendant’s corporate office sent a person to Nashville to review the Medicare patient caseload and help local management deal with patients who, due to their greater medical need, might no longer be lucrative under the new reimbursement system. Upon information and belief,

the company utilized special software to enable it to identify such patients.

24. At a meeting of the Nashville nursing staff on Friday, December 12, 1997, local management distributed a list of about 40 patients then being served by the Nashville office. These were patients whose services were to be cut, or whose cases were to be closed, before the new reimbursement rules began to take effect. A few will be ineligible for Medicare home health benefits under new federal rules which deny coverage when the only home health service required is venipuncture (i.e., the drawing of blood). However, others on the list, including the plaintiffs, remained eligible and in need of the home health services which they had been receiving. Indeed, it is precisely *because* of their serious medical needs, and the cost of meeting those needs, that these patients were targeted by the defendant for the reduction or termination of care.

25. In sum, the defendant is responding to the new federal law, through a corporate policy of "manag[ing] its Medicare caseload", as it has assured its investors it can do, in a manner which will allow it to continue to maximize profits derived from Medicare patients.

26. According to public disclosures, the company promotes an entrepreneurial environment by making "branch, area and regional managers responsible for their own business mix". The company also has a policy that, "All Interim managers are compensated based on profits generated within their scope of responsibility." At the mid-December meeting in Florida, local

managers were warned that underperforming branches would not be tolerated, and that they must do whatever it takes to meet corporate financial expectations. These policies, combined with central corporate direction and technical support in identifying patients who are the sickest and costliest to treat, foster an environment in which managers are especially aggressive in eliminating such patients from their business mix.

C. Defendant's Violations of the Plaintiffs' rights

Carol Winkler

27. Carol Winkler is a 59 year old former legal secretary/paralegal. In 1988, Ms. Winkler was diagnosed with Multiple Sclerosis (M.S.), a degenerative disease that involves a breakdown in the immune system. Ms. Winkler's condition is especially precarious, because M.S. makes her vulnerable to infection, and she is allergic to many antibiotics. In 1988, she was found by the federal Civil Service system to be disabled, and her condition has worsened since then. Her left side is now paralyzed. She cannot walk or turn herself in bed. Ms. Winkler requires extensive medical care, including more than $1,000 per month in medications, to maintain her present limited level of functioning, to slow the decline in her medical condition, to guard against catastrophic infection, and to avoid placement in a nursing home.

28. Ms. Winkler is homebound and has received Medicare home health services from Interim HealthCare® for at least two years. Interim provides the services of a home health aide, who helps with bathing, feeding, toileting, brushing teeth, skin care,

range of motion exercises and massage, and personal hygiene. A registered nurse from the defendant agency also administers weekly injections of Avonex, then monitors Ms. Winkler for potentially dangerous reactions to the injection.

29. At the December 12, 1997, meeting described above, Ms. Winkler’s home health nurse, Vicky Tataryn, saw Ms. Winkler’s name on the defendant’s “hit list” of patients whom the company had identified as economically undesirable. The list indicated that she was to be discharged from the agency’s Medicare home health caseload by January 1, 1998. Neither her condition nor her need for home health services had changed, and the company’s intended reduction in her services was purely motivated by economic considerations. Ms. Winkler was not informed of this change, nor afforded any opportunity to participate in her plan of care, or appeal the company’s actions.

30. Upon information and belief, based on statements made by Interim employees to Ms. Winkler, most of the severely disabled Medicare home health patients served by Interim are too mentally or physically debilitated to assert themselves in the face of the company’s efforts to cull out and abandon them. Because she is mentally alert, well educated and assertive, Interim has proceeded in an indirect fashion to try to rid itself of responsibility for her care. In mid-December, Interim reduced the number of home health visits she receives from four to three per week, even though the need for four visits has not decreased. After years of reliable, predictable care, the defendant has refused to inform Ms. Winkler as to when to expect

to receive home health visits. 31. Because of her extreme medical fragility and the importance of receiving care according to a precise schedule, such uncertainty is potentially dangerous and, therefore, very frightening to the plaintiff, as Interim is well aware. By inflicting mental anguish on the plaintiff and degrading the quality of the care she received, the defendant successfully induced Ms. Winkler to switch to another home health agency in February, 1998, due to her disabilities and her consequent need for heavy care.

Ilene R. Bell

32. Ilene R. Bell is a 68 year old retired janitorial worker. Like approximately 90% of all Medicare beneficiaries, plaintiff Ilene Bell has elected to purchase Part B coverage, and her premium for such coverage is deducted each month from her Social Security retirement pension. She also buys private Medicare Supplement insurance to help cover the deductibles and co-payments imposed by Medicare.

33. Ms. Bell suffers from severe, unstable diabetes and is legally blind as a result of the diabetes. She must receive insulin shots twice daily in order to survive. She is unable to self-administer the insulin, or to monitor her blood glucose levels. Ms. Bell lives alone in a housing project in Nashville and has no close relatives capable of caring for her. Disruption of her care, even for a short period, would seriously endanger her health and could even prove fatal.

34. For more than a year, she has received home health services from the defendant corporation, under a plan of care

prescribed by her physician. She has authorized the defendant to seek reimbursement under her Medicare coverage. The defendant has regularly billed Medicare and received payment for her care. In so doing, the corporation represented to the federal government and Medicare's fiscal intermediary that Interim is in compliance with all conditions of participation, including federal and state laws which protect patients and prohibit discrimination. The defendant also represented for more than a year that all of the services it provides to her are medically necessary.

35. At the December 12, 1997, meeting described above, Ms. Bell's home health nurse, Vicky Tataryn, saw Ms. Bell's name on the defendant's "hit list" of economic undesirables whose services should be reduced by January 1. The defendant began by sending a social worker to Ms. Bell's home on December 15. The social worker tried to document that Ms. Bell is not "homebound", a prerequisite for Medicare coverage of home health care. When Ms. Bell's nurse, Ms. Tataryn, learned that the company was going to falsely report to Medicare that Ms. Bell was no longer homebound, the nurse protested. The effect of such a report by the agency would have been to not only terminate the care which she receives from Interim, but to make her ineligible to receive such care from any other provider as well. The consequent disruption of her care could well prove fatal to Ms. Bell. In the face of her nurse's protests, the defendant decided not to report that Ms. Bell was no longer eligible for care, but

to use a different strategy for getting her off of the company’s caseload.

36. On Thursday, December 18, 1997, Ms. Bell’s nurse learned that Interim was going to close Ms. Bell’s case on Monday, December 22, by transferring her care to another home health agency. Interim provided Ms. Bell with no written notice of its intent to reduce or terminate her care. On December 19, an entry was made in her medical chart indicating that she had been informed orally in person on that date that Interim was stopping its services on Monday, December 22. Ms. Bell has no recollection of such a conversation, which would have been extremely important to her had it occurred. She is emotionally attached to the Interim personnel who care for her, she trusts them to regularly enter the privacy of her home. She was not afforded an opportunity to participate in the planning of these changes in her care, nor file a grievance protesting the defendant’s actions.

37. When personnel from a new home health agency appeared at Ms. Bell’s apartment on Tuesday morning, December 23, she was emotionally traumatized. Ms. Tataryn, who resigned from Interim the same morning because of her ethical objections to the company’s policy toward its most severely disabled patients, realized how upsetting the change would be to Ms. Bell. Ms. Tataryn went to Ms. Bell’s house that morning to see her former patient. She discovered that Ms. Bell had shut herself off in her bedroom and was refusing to allow the new home health agency staff to give her an insulin shot. But for the Ms. Tataryn’s

intervention, Ms. Bell would not have received the insulin which she so desperately needs. Unfortunately, there was little that Ms. Tataryn could do to relieve the emotional trauma which Ms. Bell had experienced and continues to experience.

Ruby Mayes

38. Plaintiff Ruby Mayes is an 84 year old retired food service worker. She is a hypertensive, diabetic patient who requires daily insulin shots, but is too mentally confused to be able to self-administer those injections, or to monitor her own condition.She has no family members capable of providing the care which she needs. She has been a patient of Interim HealthCare® since 1996. Interim provides her daily nursing visits to administer the insulin injections, as well as home health aide visits three times per week. The home health aide helps her with personal hygiene tasks which she cannot perform for herself. If her home health services (especially the daily nursing visits) are interrupted, even briefly, the consequences would be grave, and potentially life-threatening.

39. At the December 12, 1997, meeting described above, Ms. Mayes' home health nurse, Vicky Tataryn, saw Ms. Mayes' name on the defendant's "hit list" of patients whom the company had identified as economically undesirable. The list indicated that her home health aide services were to be eliminated by January 1, 1998. Neither her condition nor her need for home health services had changed, and the company's intended reduction in her services were purely motivated by economic considerations. After the mid-December visit to Interim's Nashville office by

the representative from corporate headquarters, the plan for Ms. Mayes was altered. Her home health nurse was informed on December 18 that Interim would discontinue her care altogether on Monday, December 22, although there was no agreement by another home health agency to pick up her care, and no approval of the change by her physician.

40. Ms. Mayes' nurse objected that the company's plan was unfair and potentially harmful to her patient. Ms. Tataryn asked Interim's Nashville branch manager if Interim had a corporate compliance program, recommended by the federal government to reduce fraud and abuse in Medicare home health agencies. Such programs enable employees to raise legal or ethical concerns with a corporate official charged with ensuring compliance with Medicare laws and regulations. Ms. Tataryn intended to go through such a process to protest the company's plan to dump Ms. Mayes, but was told that Interim has no such program.

41. Due to a delay in obtaining a doctor's order to discharge Ms. Mayes, she had not yet been dumped on December 30, 1998, when this case was filed. The filing of the case produced a temporary reprieve. However, on January 30, 1998, Interim renewed its efforts to rid itself of Ms. Mayes, informing her and her physician that she was no longer "homebound", and was therefore ineligible for Medicare home health services. This was not true, as Interim was aware, based on the documented observations of its own staff. Interim was also aware that, if it succeeded in terminating Ms. Mayes' home health care, she would be incapable of caring for herself, and would be in grave

danger as a result. The defendant nonetheless aggressively pursued its efforts to end her Medicare home health services, and was restrained from doing so only by orders of this court. Ms. Mayes was aware of the defendant's efforts to end her care, and experienced fear and anxiety as a result.

Helen Rahe

42. Helen Rahe has been under the care of Interim since April, 1996, when she started receiving home health services after suffering a serious hip fracture. Her care, consisting of both skilled nursing services and home health aide visits, continued without interruption until January 30, 1998, when Interim gave notice that it was discontinuing her care because she was no longer homebound.

43. In fact, Interim's effort to cut off Ms. Rahe's care had been in the works since at least mid-December, 1997, when her name appeared on the "hit list" of patients to be terminated due to changes in the Medicare payment system. On December 17, 1997, an Interim employee noted in her medical chart, in a space reserved for recording the patient's medical problem, "Problem: Explanation of upcoming prospective pay under Medicare necessitating decrease in HHA Services." However, none of this was communicated to Ms. Rahe. The filing of this action forced the defendant to temporarily delay its termination of Ms. Rahe's care. But on January 30, 1998, Interim gave notice through its attorney that Ms. Rahe would be terminated, because she was allegedly no longer homebound.

44. After its effort to terminate Ms. Rahe’s care met legal resistance, Interim attempted to justify its action by asserting that it had found her to be “not homebound” due to the fact that she was in a medical facility. However, the plan to deny her Medicare home health coverage had begun well before her temporary hospitalization. Interim’s true motives and intent were confirmed when it refused to concede her homebound status, or to agree to treat her on a non-discriminatory basis, even after she was discharged back to her apartment following cancer surgery in February, 1998. Only the intervention of this court and the issuance of a preliminary injunction was the defendant from carrying through its plan to cut off Ms. Rahe’s care.

45. Interim did not inform Ms. Rahe its real motives or intentions, nor of her own Medicare eligibility status. Neither was she afforded an opportunity to participate in the formulation of her own plan of care, as promised by the defendant in its contract with Ms. Rahe. Injunctive relief did not come in time to protect Ms. Rahe from great emotional distress and fear caused by Interim’s announcement to her that it was discontinuing her home health services.

Mrs. Terry A. Cobb

46. Mrs. Terry A. (Mabel O’Brien) Cobb is 84 years old and suffers from hypertension and pathological osteoporosis, a bone-wasting disorder so severe that some of her bones are transparent on x-rays. She has suffered six separate spinal fractures, as well as complete degeneration of the cartilage in her breastbone and at least one vertebra. She started receiving

Medicare home health services from Interim HealthCare® July 24, 1994. The services consisted of injections of Calcimar every other day, to slow the degeneration of the bone and to partially alleviate the severe pain which accompanies her osteoporosis. Mrs. Cobb has been incapable of self-administering the injections, due to a tremor and lack of dexterity in her hands. Interim also provided home health aide services four days a week, to assist Ms. Cobb with activities of daily living. On several occasions throughout the period during which she has received home health care from Interim, Mrs. Cobb has also received physical therapy from the agency.

47. For more than three years, Interim regularly recertified to Medicare that, "Due to the complexity of patient's overall medical condition, skilled care remains indicated indefinitely to promote medical recovery and safety as long as patient remains in current home environment." The Medicare plan of care submitted by Interim documented that Mrs. Cobb's rehabilitation potential was poor, even for partial recovery, and noted that "patient will probably not be able to meet medical needs independently". She was deemed homebound due to "severe pains on transfers and ambulation, experiences pathological fractures and requires one man assists to leave home for medical appointments". With the claims which it submitted to Medicare, Interim regularly reported that "Patient is sensitive to changes in environment, which tend to increase blood pressure and exacerbate pain." Interim also ranked Mrs. Cobb as "high risk" requiring priority attention if there was a disaster.

48. On December 12, 1997, Mrs. Cobb’s home health nurse, Sandra Hodess, attended the staff meeting at Interim’s Nashville office, described in paragraph 28, above. She saw Mrs. Cobb’s name on the “hit list” previously described, and saw that Mrs. Cobb had been marked to have her care reduced due to changes in Medicare reimbursement policy. On December 30, 1997, Interim sent Mrs. Cobb’s physician a “revision to plan of care/treatment”, effective December 22, 1997, informing him that Interim had begun phasing out her home health aide services, due to a change “in Medicare funding”. The defendant’s actions had nothing to do with Mrs. Cobb’s medical condition, which had not changed, but were motivated by Interim’s desire to slough off its most severely disabled patients.

49. Interim gave Mrs. Cobb no written notice of the company’s intentions, however, nor was she afforded any opportunity to participate in the planning of her own care. Interim gave her no information regarding her rights in these circumstances.

50. Ms. Hodess and Ms. Christie Collins, the Interim home health aide who visited Mrs. Cobb, both informed Mrs. Cobb that her care was being phased out in response to the Medicare payment changes. The hit list called for her care to be eliminated altogether by December 31, 1997, but Ms. Hodess protested to Interim that it would be improper to do so. In the face of Ms. Hodess’ protests, Interim agreed to continue the Calcimar injections, but only through January, 1998. Interim made no effort to provide for Mrs.Cobb’s continued care after it completed its withdrawal. Ms. Hodess, troubled by the

defendant’s abandonment of its heavy care patients, resigned from Interim.

51. The extra month which Ms. Hodess had managed to buy for Mrs. Cobb afforded her family an opportunity to find another home health agency, which took over her care on January 8, 1998. But for the resistance of Ms. Hodess, and the diligence of her family, Interim would have utterly abandoned Mrs. Cobb, leaving her without the care she so desperately requires. Throughout the several weeks during which she faced the prospect of losing needed nursing care, Mrs. Cobb experienced great stress and fear, resulting in dangerously elevated blood pressure and exacerbation of the pain from her osteoporosis.

52. The defendant’s manipulation and abuse of the plaintiffs and the agency’s other Medicare home health patients were especially aggravated because Interim knew that it was acting unlawfully, and that its actions would jeopardize the patients’ health and safety. On February 3, 1998, the Administrator of the Health Care Financing Administration issued a letter to every Medicare-participating home health agency in the United States, including Interim. The letter warned them that Medicare beneficiaries’ eligibility remained largely unaffected by the Balanced Budget Act, and that an agency would be in violation of its Medicare conditions of participation if it reduced or eliminated care to patients due to reimbursement changes, or other non-clinical considerations. In spite of this warning, Interim proceeded to aggressively pursue its corporate strategy

of dumping the sickest, most disabled of its patients, as the experiences of Ms. Mayes and Ms. Rahe attest.

53. Ms. Mayes, Ms. Rahe and other especially debilitated Medicare patients like them have been and continue to be threatened by Interim's efforts to terminate vitally necessary home health care. Such actions on the part of the defendant subject the plaintiff and others similarly situated to the risk of irreparable harm, in the form of emotional trauma, disruptions of essential medical care and resulting injury to their health, including the possibility of death. The plaintiffs have no plain, adequate and speedy remedy at law, and injunctive relief is therefore required.

IV. LEGAL CLAIMS

Violations of Medicare patients' contract rights

54. The defendant corporation has a standard contract with each member of the plaintiff class. In consideration for the patients' authorization of treatment and approval for Interim to bill Medicare for services rendered, Interim agrees to comply with Medicare conditions of participation for home health agencies. The same conditions are incorporated in a contract between the defendant and HCFA, and the plaintiffs are third party beneficiaries of those contracts. Those conditions are prescribed by federal law and regulation and include the following:

> The defendant agrees to provide necessary medical care of scope and quality sufficient to attain and maintain

the highest practicable functional capacity of each such patient. 42 U.S.C. §1395bbb(c)(i)(II).

The defendant agrees that its treatment of patients will be based on their medical, nursing and social needs, and the agency's ability to meet those needs. 42 C.F.R. § 484.18.

The defendant agrees to respect patients' rights, including informing them of the right to participate in the planning of their care and treatment, to be informed regarding any proposed changes in their plan of care and to file grievances regarding the defendant's care or failure to provide care. 42 U.S.C. §1395; 42 C.F.R. § 484.10.

The defendant agrees to comply with all state licensure standards. 42 C.F.R. § 484.100. Those rules are promulgated as Tennessee Department of Health Rules, Chapter 1200-8-8, and incorporate the Medicare standards of participation described herein.

The defendant agrees that all care will be directed by a physician, and that all agency personnel will be coordinated to support the objectives in the plan of care, which is to be based on the patients' medical, nursing and social needs.

In addition to these explicit conditions, the defendant's contracts with its patients include, by operation of Tennessee's common law of contracts, a duty of good faith and fair dealing. By the actions and policies described in the preceding paragraphs, the defendant has violated, and continues to

violate, the plaintiffs' contractual rights as enumerated herein.

Violations of Section 504 of the Rehabilitation Act of 1973

55. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, prohibits discrimination in federally funded programs, including Medicare, against people based on their handicapping conditions. The defendant's actions complained of herein constitute discrimination on the basis of handicap, in violation of the plaintiffs' rights under Section 504 and its implementing regulations.

Common Law Abandonment

56. By discontinuing, or threatening to discontinue, the medically necessary home health treatment of the plaintiff and other disabled patients, under circumstances in which the defendant knows that there is not adequate provision for their continued professional care, the defendant has breached or is attempting to breach its duty of care to the plaintiffs, and is liable to the plaintiffs for the resulting damages, under the common law tort doctrine of abandonment.

Outrageous Conduct

57. The defendant has targeted its sickest and most vulnerable patients, whom the defendant well knows are dependent upon it for essential, even life-saving treatment, for reduction or termination of care. As in the case of plaintiff Ilene Bell, the effect of the defendant's policy is to inflict mental anguish on those patients whom it affects. By this policy, which is financially motivated and implemented through deception and

stealth, the defendants have engaged in behavior toward the plaintiffs which is so outrageous, cruel and oppressive in its intent as to shock the conscience, in violation of the defendant's duty under the tort doctrines of outrageous conduct.

Breach of Duty of Care

58. The federal conditions of participation and state regulations applicable to home health agencies, cited in paragraph 39, above, establish the standard of care owed by the defendant company to its Medicare home health patients. By disregarding those standards, the defendant has breached its duty of care to the members of the plaintiff class, and is, therefore, liable in tort.

Tennessee Consumer Protection Act Claim

59. Whenever it has entered into a contract with a Medicare patient to provide home health agency services, the defendant corporation has provided the patient a written notice of the patient's rights, as required by federal regulations. 42 C.F.R. §484.10. The form provided by the defendant represents that the defendant will comply with all federal conditions of Medicare participation, including those enumerated in paragraph 39, above. By willfully and deliberately misrepresenting to the plaintiff and others similarly situated the nature and extent of their medical need, by misrepresenting their own legal obligations to meet those needs, by withholding information from their patients information which they are required by Medicare law to provide such patients, all for the purpose of cheating the plaintiffs out of the medically necessary care which they

are obligated to provide them, the defendants have committed, and continue to commit, an unfair or deceptive trade practice within the meaning of Tennessee Consumer Protection Act, T.C.A. § 47-18-101 *et. seq.*

V. REQUEST FOR RELIEF

The plaintiffs respectfully requests this court to:

1. Preliminarily and permanently enjoin the defendants from denying the plaintiffs the medically necessary care and treatment to which they are entitled under the laws cited herein.

2. Empanel a jury to try this cause.

3. Award the plaintiffs compensatory and punitive damages in tort in an amount to exceed $10,000.

4. Award the plaintiffs compensatory damages for injuries sustained in violation of the statutory, contractual and regulatory rights asserted herein, in an amount to exceed $10,000, trebled pursuant to T.C.A. §§ 47-18-109.

5. Award the plaintiffs their costs, and grant all necessary and further relief, including an award of attorney's fees pursuant to T.C.A. 47-18-109(e)(1) and 42 U.S.C. §1988, to which they are entitled.

DATED this 24th day of February, 1998.

Respectfully submitted,

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Certificate of Service

I hereby certify that a copy of this document has been forwarded this 24th day of February, 1998 to the following counsel for the defendant, in the manner specified:

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DATED this 24th day of February, 1998.

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