As seen in the Summer 2018 RPTE eReport, which is an electronic publication of the Real Property Trust and Estates Law Section (RPTE) of the American Bar Association (ABA).

Update on *Jimmo v. Sebelius*[1]

By Heidi M. Brown, Esq.

On October 16, 2012, the parties to *Jimmo v. Sebelius* filed a proposed Settlement Agreement (Agreement),[2] which was later approved by the United States District Court for Vermont on January 24, 2013.[3] This case dealt with the so called "improvement standard" and whether this standard was the proper standard for Medicare to pay for skilled nursing services or home health services. In other words, is the patient required to improve in order for Medicare to pay for these services? Or, is the patient's need for these services to maintain their health or condition sufficient for Medicare to pay for skilled nursing services or home health services? This article will discuss the case, its Settlement Agreement, and whether the parties have complied with the Settlement Agreement.

On January 18, 2011, six Medicare beneficiaries filed a lawsuit on behalf of themselves and "[a]ll 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" (the Plaintiffs).[4] Also among the Plaintiffs were seven national organizations such as National Committee to Preserve Social Security and Medicare, National Multiple Sclerosis Society, Parkinson's Action Network, Paralyzed Veterans of America, American Academy of Physical Medicine and Rehabilitation, Alzheimer's Association®, and United Cerebral Palsy.[5] The Plaintiffs sought declaratory, injunctive, and mandamus relief against the Secretary of Health and Human Services (the Secretary), who at that time was Kathleen Sebelius.[6]

According to the Plaintiffs, "the Secretary… impose[d] a covert rule of thumb that operate[d] as an additional and illegal condition of coverage and result[ed] in the termination, reduction, or denial of coverage for thousands of Medicare beneficiaries annually;" however, the Secretary denied the existence of a "covert rule of thumb."[7] Specifically, this "covert rule of thumb" was called the "Improvement Standard."[8] For example, adjudicators of Medicare claims terminated or denied coverage for benefits and cited as the reasons, the beneficiary is "not improving" or the 'beneficiary needs 'maintenance services only,'" or the beneficiary has '"plateaued, or is "chronic," or "medically stable.'"[9] Further, the Plaintiffs argued that Medicare

coverage "is available for health care and therapy services that are 'reasonable and necessary for the diagnosis or treatment of illness or injury"'[10] and that neither the Medicare statutes nor regulations list improvement as a condition of coverage.[11] According to the Plaintiffs, this Improvement Standard affects mostly beneficiaries with chronic conditions, who will need nursing services and therapies more if their health deteriorates.[12] If these beneficiaries can receive these benefits, they can "slow their disease process and … maintain their functional ability."[13] Moreover, the Plaintiffs argued that the reliance of the Improvement Standard for terminations, denials, or reductions in coverage "violates the Medicare statute and regulations, the Administrative Procedure Act's and the Medicare statute's requirements for notice-and-comment rulemaking, the Freedom of Information Act's requirement of publication, and the Due Process Clause of the Fifth Amendment.[14]

The parties settled and in the Agreement they agreed that Health and Human Services (HHS) would revise certain sections of Chapters 1, 7, 8, and 15 of the Medicare Benefit Policy Manual (MBPM) in order to clarify the standards for coverage of skilled nursing facility, home health, outpatient therapy benefits and inpatient rehabilitation when a beneficiary "has no restoration or improvement potential" but yet still needs these services.[15] This was to be referred to as the "maintenance coverage standard." If the beneficiary does not have a "clinical condition [that] demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary," then Medicare will still deny these services.[16] Similarly, if the beneficiary is in a skilled nursing facility, these services will be covered if the beneficiary needs the services that require the skills of a registered nurse, and "would be covered where such skilled nursing services are necessary to maintain the [beneficiary's] current condition or prevent or slow further deterioration."[17] If the beneficiary could perform these services himself or herself or under the supervision of unskilled caregivers, the services will not be covered.[18] Finally, the Secretary agreed to revise the MBPM to clarify that benefits for an inpatient rehabilitation facility cannot be denied because the beneficiary "could not be expected to achieve complete independence in the domain of self-care" or "could not be expected to return to his or her prior level of functioning."[19]

Another section of the Settlement Agreement required the Center for Medicare and Medicaid Services (CMS) to "engage in a nation-wide educational campaign" to communicate to Medicare Administrative Contractors, Medicare Advantage Organizations, Part A/B Qualified Independent Contractors, Part C QIC/Independent Review Entities, Quality Improvement Organizations, Recovery Audit Contractors, Administrative Law Judges, Medicare Appeals Council, Medicare providers and suppliers, subscribers to CMS listserves, and relevant 1-800 MEDICARE customer service scripts the maintenance coverage standards.[20] Also, CMS was required to host National Calls for providers, suppliers, contractors, and adjudicators. [21] Finally, CMS agreed to post Program Transmittals and MLN (Medicare Legal Network) Matters articles on the CMS website regarding the manual revisions.[22]

On March 1, 2016, the Plaintiffs filed a Motion to Enforce the Settlement Agreement, arguing that the Secretary of HHS "did not adequately disavow the Improvement Standard or disseminate the Maintenance Coverage Standard," and that the Education Campaign "was so confusing and inadequate that little had changed as a result of [the] settlement."[23] Also, the Plaintiffs asked the Court to order the Secretary of HHS to '"carry out additional education activities to address the inaccuracies and inadequacies of the original [Educational] Campaign."'[24] The Court held that

> the Secretary failed to fulfill the letter and spirit of the Settlement Agreement with respect to at least one essential component of the Educational Campaign. Plaintiffs have provided persuasive evidence that at least some of the information provided by the Secretary in the Educational Campaign was inaccurate, nonresponsive, and failed to reflect the maintenance coverage standard.[25]

After each side submitted a proposed Corrective Action Plan, the Court adopted the following Corrective Action Plan proposed by the Secretary of HHS to be completed by September 4, 2017:

> 1. CMS will disavow the application of the so-called "Improvement Standard" as improper under Medicare policy for the SNF, HH, and OPT benefits, while making clear that CMS has consistently denied the existence of such an "Improvement Standard." This disavowal would appear on the forthcoming Jimmo webpage and in the transmittal message notifying stakeholders of the webpage.
>
> 2. CMS is willing, through counsel, to notify Plaintiffs and the [c]ourt once the Technical Direction Letter and Health Plan Management System memorandum have been issued to, respectively, Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations (MAOs).
>
> 3. CMS will publish on its website cms.gov a new webpage dedicated to the Jimmo settlement. The Jimmo webpage will, in one location, provide access to public documents related to the settlement that have been previously posted on the cms.gov website. In addition, the Jimmo webpage will direct providers and suppliers with questions regarding individual claims to the appropriate MAC. CMS will include at the top of the new Jimmo webpage a message about the settlement. This message will summarize the clarifications to Medicare policy that CMS has issued as part of the settlement. Once the Jimmo webpage is published, CMS will notify stakeholders of the webpage through existing communication channels and advise stakeholders seeking information about the settlement to visit the webpage. Before the new Jimmo webpage message is finalized, CMS will provide Plaintiffs' Counsel with a two-week period in which to provide comments on an advance

version of the message. CMS will consider any comments received from Plaintiffs' Counsel.

4. CMS will post on the forthcoming Jimmo webpage one set of Frequently Asked Questions (FAQs). This document would be developed by CMS and would include multiple questions and answers regarding the policy clarification resulting from the Jimmo settlement. CMS will provide Plaintiffs' Counsel with an opportunity to suggest potential questions for inclusion in the FAQ posting, which CMS will consider but would not be bound to accept.

5. CMS will include a message regarding the Jimmo settlement when it announces the publication of the Jimmo webpage to providers, adjudicators, contractors, and other stakeholders.

6. CMS will clarify the responses in the document entitled "Summary of the questions posed and answers provided during the December 16, 2013 Jimmo vs. Sebelius National Call for contractors and adjudicators" to address the concerns identified by the [c]ourt in its August 17, 2016 Opinion and Order. CMS will disseminate the Clarified Summary to contractors and adjudicators using the same communication channels as were used for the original Summary. CMS will make clear to contractors and adjudicators that the information contained in the Clarified Summary supersedes the information contained in the original Summary. Before the Clarified Summary is finalized, CMS will provide Plaintiffs' Counsel with a two-week period in which to provide comments on an advance version of the Clarified Summary. CMS will consider any comments received from Plaintiffs' Counsel but would not be bound to accept them.

7. CMS will issue a Technical Direction Letter to MACs directing them to conduct, within a specified timeframe, additional training on the Jimmo manual clarifications. CMS would provide the MACs with materials for use in conducting this training.

8. CMS will issue a Health Plan Management System memorandum to MAOs requesting that they conduct, within a specified timeframe, additional training on the Jimmo manual clarifications. CMS would provide the MACs with materials for use in conducting this training.

9. CMS will disavow the application of the so-called "Improvement Standard" as improper under Medicare policy for the SNF, HH, and OPT benefits, while making clear that CMS has consistently denied the existence of such an "Improvement Standard." This disavowal would appear on the forthcoming Jimmo webpage and in the transmittal message notifying stakeholders of the webpage.

> 10. CMS is willing, through counsel, to notify Plaintiffs and the [c]ourt once the Technical Direction Letter and Health Plan Management System memorandum have been issued to, respectively, Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations (MAOs). [26]

The Court also added two more requirements for the Secretary of HHS to follow. Because the Plaintiffs showed that there is still confusion over the Improvement Standard, the Court adopted Plaintiff's proposed statement and ordered it to be included in CMS' website regarding the Jimmo case, in the FAQs, and written materials and oral statements that the Secretary has agreed to disseminate.[27] The proposed statement, also called the Corrective Statement, reads as follows:

> The Centers for Medicare & Medicaid Services reminds the Medicare community of the Jimmo Settlement Agreement (January 2014), which clarified that the Medicare program will pay for skilled nursing care and skilled rehabilitation services when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo Settlement adopted a "maintenance coverage standard" for both skilled nursing and therapy services:
>
> Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.
>
> Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.
>
> The Jimmo Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve. The Settlement correctly implements the Medicare program's regulations governing maintenance nursing and rehabilitation in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and maintenance nursing and rehabilitation in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide. These regulations are set forth in the [MBPM].[28]

The second additional requirement is that the errors in the Summary of the Questions Posed and Answers Provided During the December 16, 2013 *Jimmo v. Sebelius* National Call for Contractors and Adjudicators must be corrected by holding another National Call in which the "Corrective Statement is orally disseminated."[29] Similarly, the Notice for the National Call must state: '"This call will include corrective action mandated by the court overseeing the *Jimmo* settlement, clarifying the rejection of an improvement standard and explaining the maintenance coverage standard now included in the Medicare Beneficiary Policy Manual."'[30]

According to the CMS website, there is a webpage regarding the *Jimmo* Settlement.[31] The Corrective Statement is featured prominently on this webpage.[32] This webpage includes a link to FAQs.[33] The webpage also includes a link to the MBPM, as well as links to the Settlement Agreement, the Program Manual Clarifications Fact Sheet, the Medicare Learning Network (MLN) Matters Article on Manual Updates to Clarify SNH, HH, and OPT Coverage, the CR 8458 Manual Updated, the CR 8644 Manual Updates, and the MLN Connects Call materials.[34] According to the Center for Medicare Advocacy, the installation of the webpage on the *Jimmo* Settlement is the "final step in a court-ordered Corrective Action Plan."[35] Perhaps now CMS and Medicare providers will stop terminating, denying, or reducing services to beneficiaries who are not improving but rather need the services in order to maintain their condition and to prevent it from worsening.

Heidi M. Brown is an attorney with Osterhout & McKinney, PA in Fort Myers, Florida and is board certified by the Florida Bar in Elder Law.

---

[1] *Jimmo v. Sebelius*, No. 5:11-cv-17, 2011 U.S. Dist. WL 5104355 (D. Vt. Jan. 18, 2011).
[2] *Jimmo*, (settlement agreement) *at* http://www.medicareadvocacy.org/medicare-info/improvement-standard/.
[3] *Jimmo,* (D. Vt. Jan. 24, 2013) (order granting final approval of settlement agreement and directing entry of final judgment) *at* http://www.medicareadvocacy.org/medicare-info/improvement-standard/.
[4] *Jimmo*, (D. Vt. Mar. 3,2011) (amended complaint for declaratory, injunctive, and mandamus relief at 7, para. 22) *at* http://www.medicareadvocacy.org/medicare-info/improvement-standard/.
[5] *Id.* at 5-6.
[6] *Id.*
[7] *Id.* at 1, para.1.
[8] *Id.*at 2, para 2.
[9] *Id.*
[10] *Id.* at 1, para 1.
[11] *Id.* at 2, para 3.
[12] *Id.* at 2, para 4.
[13] *Id.* at 2-3, para 4.
[14] *Id.* at 3, para 5.
[15] *Jimmo*, (settlement agreement at 8, para.1). "Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program." *Id.* at page 11.
[16] *Id.* at 11.
[17] *Id.* at 13.

[18] *Id*.
[19] *Id.* at 14.
[20] *Id.*at 14 -16.
[21] *Id.* at 17.
[22] *Id.* at 19.
[23] *Jimmo*, (D. Vt. Feb. 1, 2017) (opinion and order adopting defendant's corrective action plan and mandating two additional requirements at 3) *at* http://www.medicareadvocacy.org/medicare-info/improvement-standard/.
[24] *Id.*
[25] *Id.*at 4.
[26] *Id.* at 5-7.
[27] *Id.* at 8-9.
[28] *Id.* at 9.
[29] *Id.*at 10.
[30] *Id.*
[31] See generally https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html.
[32] CENTERS FOR MEDICARE & MEDICAID SERVICES, JIMMO SETTLEMENT, available at https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html.
[33] CENTERS FOR MEDICARE & MEDICAID SERVICES, FREQUENTLY ASKED QUESTIONS, available at https://www.cms.gov/Center/Special-Topic/Jimmo-Settlement/FAQs.html.
[34] CENTERS FOR MEDICARE & MEDICAID SERVICES, JIMMO SETTLEMENT available at https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html.
[35] CENTER FOR MEDICARE ADVOCACY, JIMMO CORRECTIVE ACTION PLAN COMPLETED, available at http://www.medicareadvocacy.org/medicare-info/improvement-standard/.