AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

MEMORANDUM

TO: AHCA Members

CC: Mark Parkinson, AHCA President & CEO

FROM: Elise D. Smith, AHCA SVP Finance Policy and Legal Affairs

SUBJECT: *Jimmo v. Sebelius* Civil Action No. 5:11-CV-17-CR (D. Vt.) (Final Settlement approved 1/24/2013)

DATE: February 7, 2013

I. *Jimmo* Settlement Summary

AHCA applauds the settlement between the plaintiffs in *Jimmo v. Sebelius* (hereinafter *Jimmo*) and the Department of Health and Human Services (HHS). The settlement was approved by the court on January 24, 2013.

The *Jimmo* settlement agreement indicates that Medicare coverage is available for skilled services to maintain an individual's condition. Under the maintenance coverage standard articulated in the *Jimmo* settlement, Medicare coverage turns on whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will "improve." *Jimmo* emphatically rejects the so-called "improvement standard" for skilled services.

Pursuant to *Jimmo*, medically necessary nursing and therapy services, provided by or under the supervision of skilled personnel, are coverable by Medicare if the services are needed to maintain the individual's condition, or prevent or slow their decline. In other words, maintenance services can be skilled, performed by skilled therapist or nurse, and covered by Medicare.

Note that *Jimmo* does not alter the legal limitations on Part A and Part B such as the 100 day benefit period, the requirement for a prior 3-day hospital stay for Part A post- acute Medicare coverage, and Part B limitations such as the therapy cap, Multiple Procedure Payment Reductions (MPPR) and medical manual review.

I. Key Points

There remain issues, however, regarding the implications of the settlement and how it changes current law and practice. Specifically, the *Jimmo* settlement is not self-implementing, and instead requires the Centers of Medicare and Medicaid Services (CMS) to implement it through revised manual provisions. With the settlement now officially approved, CMS is tasked with revising its Medicare Benefits Policy Manual and numerous other guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health (HH), nursing home and outpatient settings.

CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve.

CMS agreed to finalize and issue the revised manual provisions and to carry out the educational campaign provided by the settlement agreement within one year of the approval date. That could delay finalization of the changes until January of 2014.

II. AHCA Position

We believe that CMS must implement the *Jimmo* settlement and quickly clarify issues related to the settlement. We are calling on CMS to act expeditiously and are working with numerous other stakeholders, as we urge CMS to take action. We recommend that providers exercise caution in proactively trying to use the settlement since CMS has not as yet issued instructions to the Medicare Administrative Contractors (MACs). Moreover, some MACs have indicated that they have never heard of *Jimmo*.

We understand, that, depending on the reason for a denial in coverage, it might be helpful to raise the points agreed to in *Jimmo* in appeals with respect to all levels of review for services already provided. Nevertheless, it is important to keep in mind that CMS, the Office of Inspector General (OIG), the General Accounting Office (GAO), and the Department of Justice (DOJ), have all been intensely scrutinizing skilled nursing facilities regarding alleged overutilization of Part A therapy. Congress has also limited the use and payment of Part B therapy through tools such as the $1,900 therapy cap, the $3,700 medical manual review process and the 50% reduction in the MPPR. Under these circumstances, clear and timely CMS articulation on the application of *Jimmo* for both Part A and Part B is needed.

Thus, a key AHCA action that we will take in concert with other stakeholders is to push CMS for guidance now. For further discussion of AHCA's Jimmo initiative, see below on page 7 of this memo.

III. Background

Since the 1980s, Medicare beneficiaries, patient advocacy organizations, and Medicare providers have objected to the "improvement standard" used by agencies and contractors to deny Medicare coverage of skilled services, including HH care, SNF care, physical therapy (PT), speech therapy (ST), and occupational therapy (OT).[1] The improvement standard is a term used to encompass all Medicare coverage denials issued because a patient's condition is stable, chronic, or not improving, or because the agency or contractor perceives that the skilled services only "maintain" the patient's condition.

Neither the Medicare statute nor the implementing regulations refer to or suggest an improvement standard. In fact, the regulations related to criteria for skilled services and the need for skilled services actually specify that the "restoration potential of a patient is not the determining factor in whether skilled services are needed."[2]

In spite of the language of the statute and regulations, the improvement standard became part of Medicare contractors' internal guidelines due to a simplification of confusing language contained in the *Medicare Benefit Policy Manual*.[3] In practice, internal guidelines in the form of Local Coverage Determinations dictate whether or not a Medicare contractor will approve or deny coverage. Because some Local Coverage Determinations stipulate an improvement standard in relation to the coverage of skilled services, some beneficiaries are denied coverage of these services.[4]

The Medicare beneficiaries most likely to be negatively affected by the improvement standard include individuals with chronic, progressive conditions

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[1] *See Fox v. Bowen*, 656 F. Supp. 1236 (D. Conn. 1987); Hooper v. Sullivan, 1989 WL 107497 (D. Conn. 1989). See also Gill Deford, *How the "Improvement Standard" Improperly Denies Coverage to Medicare Patients with Chronic Conditions,* 43 J. Poverty L. & Pol'y 9-10, 427 (2010).

[2] 42 C.F.R. §409.32(c) (2011). The regulation further states, "Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities."

[3] *See Medicare Benefit Policy Manual*, Chapter 7, 40.2.3(3), *available at* http://www.cms.gov/manuals/iom/itemdetail.asp?itemid=CMS012673: "Speech-language pathology would be covered where the service can only be provided by a speech-language pathologist and where it is reasonably expected that the service will materially improve the patient's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurably at a higher level of attainment than that prior to the initiation of the services." (emphasis added).

[4] *See Jimmo v. Sebelius*, No. 5:11-CV00017-CR (D. Vt. filed Jan. 18, 2011) [hereinafter *Complaint*], at 10, ¶32. "LCDs are created by individual contractor to provide guidance in those jurisdictions in which they operate. . . [and] employ language that enforces an Improvement Standard. ('There must be an expectation that the condition will improve significantly in a reasonable and generally predictable period of time. . .')." Note that the plaintiffs filed an amended complaint March 3, 2011.

such as Alzheimer's Disease, Multiple Sclerosis, and Parkinson's Disease.[5] Often, these beneficiaries require skilled services such as SNF care, PT, ST, and OT to slow the deterioration of, or to maintain, their functional capabilities.

Denials of coverage based on the improvement standard can also impact Medicare providers. Because a Medicare beneficiary cannot obtain a coverage decision prior to receiving care under Medicare Parts A and B, if coverage for skilled services is denied based on the improvement standard and the beneficiary is unable to afford the services he or she has already received, the provider will remain uncompensated for the care and services provided.

CMS did clarify the improvement standard issue somewhat in regulations issued on November 17, 2010, which took effect on January 1, 2011. CMS pointed to the non-existence of the improvement standard in home health care coverage regulations.[6]

Finally, on January 18, 2011, the Center for Medicare Advocacy and co-counsel from Vermont Legal Aid filed a class action lawsuit against HHS, aimed at ending the application of the improvement standard and providing a remedy to Medicare beneficiaries denied coverage as a result of its application.

IV. Discussion of the Implications of *Jimmo*

The *Jimmo* settlement agreement states that:

- Manual provisions will clarify that SNF, HH and outpatient therapy (OPT) coverage to perform a maintenance program does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.
- Manual provisions will clarify that SNF and HH coverage of nursing care to perform a maintenance program does not turn on the presence or absence of a beneficiary's potential for improvement from the nursing care, but rather on the beneficiary's need for skilled care.
- Manual provisions will clarify that an inpatient rehabilitation facility (IRF) claim cannot be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care; or (2) because a patient could not be expected to return to his or her prior level of functioning. [7]

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[5] Center for Medicare Advocacy, The Medicare Improvement Standard: A Barrier to Necessary Care, http://www.medicareadvocacy.org/Projects/Improvement/Improvement_09_03.26.ImprovementStandard.htm (last visited January 26, 2011).

[6] Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices, 75 Fed. Reg. 70461 (Nov. 17, 2010) (amending 42 C.F.R. §409.44).

[7] *See Jimmo v. Sebelius*, No. 5:11-CV00017-CR (Proposed Settlement Agreement pages 10-14).

CMS' task, in part, is to clarify these agreement provisions with respect to Part A SNF PPS services and Part B therapy services in nursing facilities. The *Jimmo* agreement now applies to all beneficiaries, but a brief review of the conditions of the five named plaintiffs appears to suggest that many of these denials occurred in the HH environment. (*See* Appendix A.)

One individual *Jimmo* plaintiff complained of a SNF PPS denial, but that denial was made by a managed care plan. The Part C Medicare Advantage plan, United HealthCare, stopped covering the plaintiff's stay in the SNF. According to the complaint, the plaintiff appealed the denial, which was affirmed based on the determination that, "[t]herapy services must . . . be reasonable in relation to the expected improvement in your condition."[8] Another plaintiff, Miriam Katz, was the executor of her husband's will, and her husband's SNF care was denied coverage, beginning December 1, 2010, during a reconsideration decision on expedited review by a Qualified Independent Contractor on December 3, 2010.[9]

A. Part A Therapy in SNFs – Current Practice and *Jimmo*

In Part A SNF PPS services there are two key factors that are under scrutiny: (1) the RUG category assigned to the patients as affected by the minutes of therapy; and (2) the length of stay. Both indices are under scrutiny by the government. It is not clear to us at AHCA how *Jimmo* affects these factors.

The current Medicare regulations that govern coverage of post hospital skilled care state, at 42 C.F.R. § 409.32 that, "The 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."

While both sections 409.32 and 409.33 seem to distinguish skilled nursing and therapy services from non-covered services such as maintenance therapy, personal care, and routine services, they do nevertheless make clear that "…if a patient's overall condition supports a finding that recovery and safety can be ensured only if total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are provided." 42 C.F.R. 409.33.

Despite the positive implications of the *Jimmo* settlement and current regulations and guidance language that support skilled services to deter deterioration, AHCA recommends that providers exercise caution in trying to implement the settlement without further clarification from CMS.

As you know, rehabilitation therapy appears to be under siege from the federal government regarding minutes of rehabilitation therapy, statistics regarding

[8] *Complaint* at 21-22, ¶ 78.
[9] *Complaint* at 4, ¶ 10.

percentages of patients in rehabilitation RUG categories, length of stay, and documentation that supports the need for the actual therapy provided.

These are key issues not only for "original" Medicare, but also for managed care, bundled payment innovation, and the demands of Accountable Care Organizations (ACOs.) Under these circumstances, we believe that CMS must issue further guidance immediately regarding the implications of *Jimmo.*

B. Part B Therapy in NFs – Current Practice and *Jimmo*

Consistent with Medicare policy, the amount of skilled rehabilitation services provided are dependent on the needs of the patient. The levels of patient service that allow for skilled rehabilitation are Rehabilitation Services (therapy), a Restorative Nursing Program and/or a Maintenance Program.

Restorative Nursing Programs and Maintenance Programs allow for skilled rehabilitation to design and train non-rehabilitation staff to implement the program (*see* Medicare Benefit Policy Manual Chap 15 Section 220.0 and MDS 3.0 RAI Chapter 3 Section O). In many instances, Restorative Nursing Programs and/or Maintenance Programs are established toward the end of a course of skilled rehabilitation services.

In summary, the current process is as follows:

- Rehabilitation Services: Skilled services by rehabilitation professionals to evaluate the patient establish a plan of care and treat the patient.
- Restorative Nursing Program: Skilled services by rehabilitation professionals to establish a program and train a patient and the patient's caregivers. Restorative nursing staff implement the restorative programs, under skilled nursing care.
- Maintenance Program: Skilled services by rehabilitation professionals to establish a maintenance program and train caregivers. Nursing staff implements the program and integrates it into daily patient care.

Thus, it is to be noted that there is an inconsistency between the current regulations and Medicare guidance and the language of the *Jimmo* settlement. Specifically, the *Jimmo* settlement states that the coverage of therapy to perform a "maintenance program" does not turn on the beneficiary's potential for improvement from the therapy. However, the current Medicare regulations, at 42 C.F.R. § 409.33, state that "the actual carrying out of [a] maintenance program[]" is considered personal care services, which are not skilled services.
In addition there are inconsistencies even between current manual provisions. Section 220.2.C of Chapter 15 of the *Medicare Benefit Policy Manual* states: "Rehabilitative therapy occurs when the skills of a therapist, (See definition of therapist in section 220 of this chapter) are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an

impairment or functional limitation. (See also section 220.3 of this chapter for documenting skilled therapy.) Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition."

Section 220.2.D of Chapter 15, related to "maintenance programs" states:

"During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.
The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members."

The bottom line is this: One could argue that as of today there is enough usable language in the manuals coupled with the *Jimmo* settlement agreement language to perhaps support coverage of Part B skilled maintenance therapy. But, for all the reasons discussed above, caution is still recommended until CMS speaks.

V. AHCA *Jimmo* Initiative

Time is of the essence in part because of pressure beneficiaries and advocates are placing on providers across the spectrum of SNFs, NFs, HH and OPT to "apply" *Jimmo* now.

On the one hand the settlement seems obvious, but there are sub-issues that are anything but easy. We have met now with groups in DC who all agree that we need CMS to provide clear guidance. We are working on a meeting with CMS, further meetings with stakeholders, a letter to CMS, close coordination with advocates (e.g., the National Multiple Sclerosis Society, the Parkinson's Action Network, Alzheimer's Association, etc.) and with associations representing the rehabilitation therapists (American Occupational Therapy Association (AOTA), American Physical Therapy Association (APTA), American Speech Language Association, etc.) Our attorneys at Reed Smith are in discussion with the attorneys for the advocates (e.g., the Center for Medicare Advocacy). In summary, AHCA initiative includes the following:

- Creation of a *Jimmo* Therapy Workgroup that includes the therapists that we have worked with for years on matters such as Short Term Alternatives to Therapy Services -- Alternative Payment Model (STATS) and Developing Outpatient Therapy Payment Alternatives (DOTPA);
- A memo to AHCA members;
- A letter to CMS;
- A meeting with CMS;
- Partnering with the National Association for the Support of Long Term Care (NASL);
- Outreach to the Center to Medicare Advocacy, additional advocates, and Ombudsman office of the Administration on Aging;
- Consultation with Gill Deford (CMA Counsel who brought the case); and
- Development of a stakeholder coalition.

VI. Conclusion

Jimmo provides a most welcome statement on the demise of the "improvement standard." AHCA will provide up-to-date information as we acquire it. This memo is not meant to restrain providers from any action they wish to take on medically necessary therapy services. It is meant to alert our members that CMS has the responsibility to interpret and implement *Jimmo* and must do so expeditiously. This is our goal.

Appendix A -- Named Plaintiffs

A. Individual Plaintiffs

1. Glenda Jimmo

During the periods at issue, plaintiff Glenda Jimmo was a seventy-one-year-old resident of Vermont who was legally blind, had a below-the-knee amputation, and suffered from a number of other serious, chronic conditions. At all relevant times she was eligible for Medicare Parts A and B. As a result of her substantial medical conditions, her physician ordered intermittent HH services. Jimmo's physician certified the need for these HH services, but Jimmo's Medicare contractor denied coverage of the prescribed home health services, stating that "[h]er condition was stable with no acute changes."[10] Both an administrative law judge ("ALJ") and the MAC affirmed the Medicare contractor's denial. According to the complaint, the ALJ stated that "[o]bservation and assessment of the beneficiary was not necessary as the Beneficiary was stable."[11]

[10] *Complaint* at 15, ¶ 47.
[11] *Complaint at 15-16, ¶ 49.*

2. Plaintiff KR

During the periods at issue, plaintiff KR was a severely disabled forty-eight-year-old resident of Vermont. She suffers from congenital quadriplegia, epilepsy, and has significant cognitive impairments, including mental retardation. Her physician ordered skilled PT for her starting on September 26, 2008, in order to evaluate her functional ability, perform therapeutic exercise, and develop a home exercise program. Her claim for Medicare coverage of PT was denied initially and upon review by the Qualified Independent Contractor ("QIC"). The QIC's decision was upheld by an ALJ. According to the complaint, when reviewing the initial denial, the QIC stated, "the services failed to meet Medicare criteria for coverage because therapy services may [only] be covered when there is a reasonable expectation that the beneficiary will show measurable improvement in performing normal daily activities."[12]

3. Plaintiff Miriam Katz

Miriam Katz is the widow of David Katz and the executor of her deceased husband's will. Mr. Katz had been in a SNF in Connecticut from November 19, 2010, through November 30, 2010. Plaintiff was notified on November 22, 2010, that her husband's skilled nursing care would no longer be covered, effective November 30, 2010. She requested an expedited review of the coverage denial and received a reconsideration decision from the QIC affirming the denial of coverage.

4. Plaintiff Edith Masterman

Plaintiff Edith Masterman is a seventy-nine-year-old resident of Maine who is a paraplegic with diabetes. Over the last ten years, she has developed a problem with pressure sores, and her wound care doctor ordered HH care to mitigate and alleviate the pressure sores. After a stay in a SNF that lasted until January 2010, her doctor once again ordered HH care for her pressure sores but the home care and hospice agency refused to accept her back as a patient, stating that "Medicare will not pay for a chronic problem."[13]

5. Plaintiff Mary Patricia Boitano

During the time at issue, plaintiff Mary Patricia Boitano was an eighty-three-year-old resident of Rhode Island. She was hospitalized in October 2010 for renal failure, among other issues, and was transferred to a SNF after a week-long stay in the hospital. On November 19, 2010, plaintiff's husband received notice that her Part C plan, United HealthCare, would stop covering her stay in the SNF on November 22, 2010. According to the complaint, the plaintiff appealed the denial, which was affirmed based on the determination that, "[t]herapy services

[12] *Complaint* at 17-18, ¶ 57.
[13] *Complaint* at 20, ¶ 68.

must . . . be reasonable in relation to the expected improvement in your condition."[14]

B. Organizations as Plaintiffs

The organizations named as plaintiffs in the lawsuit are: the National Committee to Preserve Social Security and Medicare, the National Multiple Sclerosis Society, Parkinson's Action Network, Paralyzed Veterans of America, and the American Academy of Physical Medicine and Rehabilitation. The National Committee to Preserve Social Security and Medicare is a nonpartisan, nonprofit organization with 3.2 million members and supporters throughout the country. The National Multiple Sclerosis Society, Parkinson's Action Network, and Paralyzed Veterans of America are patient advocacy groups that wish to ensure that Medicare provides services and benefits to beneficiaries with chronic illnesses and disabilities. Finally, the American Academy of Physical Medicine and Rehabilitation is a medical society for the specialties of physical medicine and rehabilitation. The American Academy of Physical Medicine has more than 7,500 members across the country and represents more than seventy-five percent of Board certified physiatrists in the United States.

C. The Class Defined

The complaint defines the class 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 SNF, or in a HH setting, denied, terminated, or reduced due to the application of the Improvement Standard, on or after January 1, 2006."[15] The complaint estimates the class to include tens of thousands of members.

[14] *Complaint* at 21-22, ¶ 78.
[15] *Complaint* at 6, ¶ 19.