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Jimmo Settlement Invalidates Improvement Mandate for Medicare Coverage

BY JUDITH STEIN

Mrs. "P" was 68 years old and living with Amyotrophic Lateral Sclerosis (ALS, commonly known as Lou Gehrig's disease) when she contacted the Center for Medicare Advocacy. She needed a wheelchair, was unable to stand on her own, needed assistance to move from bed to wheelchair, and had lost the use of her arms and hands.

Mrs. P had been receiving home health care services, including nursing twice per month, occupational therapy twice per month, and daily home health aide visits.

Despite her certain need for this care, Mrs. P's private Medicare Advantage plan and home health agency informed her that Medicare would no longer cover her home care because she was chronic and "stable in her disease state," and would not improve. She was informed that she therefore did not need skilled care—a prerequisite for Medicare home health coverage.

Mrs. P's situation was so dire that, when the administrative process failed her, the Center for Medicare Advocacy filed a lawsuit on her behalf in federal district court. The court issued a restraining order requiring Medicare to grant coverage and the home health agency to provide the care ordered by Mrs. P's physician.

While the Center was able to successfully intervene and help Mrs. P, her situation is far from unique. The "Improvement Standard" that denied Mrs. P much needed services also harms thousands of other beneficiaries nationwide.

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The Improvement Standard

For decades, Medicare beneficiaries like Mrs. P.—particularly those with long-term or debilitating conditions and those who need rehabilitation services—have been denied necessary care based on an Improvement Standard.

The Improvement Standard is a longstanding policy whereby the Centers for Medicare & Medicaid Services and the insurance companies who process Medicare claims decide that coverage is not available for beneficiaries whose condition is not improving, those who have "plateaued" or those in need of "maintenance services only."

This standard, included in the CMS policies used to interpret and administer Medicare law, often conflict with the actual Medicare statute and regulations.

As a result, "maintenance only" services are regularly denied Medicare for beneficiaries who are deemed to be "stable," "chronic," or "not improving." This illegal standard has particularly devastating effects on patients with chronic conditions such as Multiple Sclerosis, Alzheimer's disease, ALS, Parkinson's disease and paralysis, among others—patients who may not "improve" but who need continued care to maintain their status and quality of life or slow deterioration.

When Medicare denies payment for these services, these most vulnerable patients may find themselves spending all their savings or foregoing necessary care. They may lose the home health care that kept them independent in their home and community and be forced into a nursing facility. The impact on beneficiaries and their family and friends can be devastating.

Medicare Law and the Improvement Standard

Although the use of this illegal rule of thumb to deny coverage conflicts with the Medicare Act, it has none-

theless become deeply ingrained in the system, in all care settings. It also is ardently followed by those who make coverage determinations throughout the Medicare decision-making continuum, from providers who ''know'' that their services will be denied by Medicare, to the contractors who issue initial and mid-level appeal decisions, and even to many Administrative Law Judges who give weight to CMS policy.

Importantly, the Medicare Act and federal regulations *support* coverage for maintenance health care and therapy. For example, federal regulations state:

> ''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. . .''[1]

In addition, the regulations support coverage if the individuals' condition will improve ''OR the skills of a therapist [are] necessary to perform a safe and effective maintenance program.''[2] (Emphasis added.) Indeed, the Medicare Act itself only refers to the need to improve with regard to services for a ''malformed body member.''[3] So, unless care is specifically for the improvement of a ''malformed body member,'' improvement is *not* necessary for Medicare coverage.

Jimmo v. Sebelius

Having heard of too many people like Mrs. P., who were denied their rightful coverage, attorneys from the Center for Medicare Advocacy and Vermont Legal Aid undertook litigation to eliminate the Improvement Standard.

The lawsuit, *Jimmo v. Sebelius*, No. 11-cv-17 (D. Vt.), filed Jan. 18, 2011, (22 MCR 81, 1/21/11) was brought on behalf of a nationwide class of Medicare beneficiaries by six individual beneficiaries and six national organizations representing people with chronic conditions, to challenge the use of the illegal Improvement Standard.

After two years of ongoing litigation, a Settlement Agreement among the Center, Vermont Legal Aid, and the Centers for Medicare & Medicaid Services was reached. The proposed settlement was filed in federal district court on Oct. 16, 2012. On Nov. 20, 2012, Chief Judge Christina Reiss of the District of Vermont signed an order preliminarily approving the Settlement Agreement (23 MCR 1236, 10/26/12).

By December 10, 2012, notice of the settlement was posted on the websites of numerous organizations, including the six national organizations that served as plaintiffs in the case, to alert advocates and beneficiaries to the terms of the settlement. There was also a period in which class members were able to file written objections.

With only one written comment received, and no class members appearing at the fairness hearing to question the settlement, the judge granted the motion for final approval after the Fairness Hearing on Jan. 24 (24 MCR 135, 2/1/13).

[1] 42 CFR § 409.32(c)
[2] 42 CFR § 409.44(c)(2)(iii) (emphasis added)
[3] 42 USC § 1395y(a)(1)(A).

The *Jimmo* Settlement

The settlement is the culmination of years of hard work leading up to and litigating the *Jimmo* case. Key provisions of the Settlement Agreement include the following:

- A nationwide class was certified consisting of all Medicare beneficiaries who received an adverse administrative decision based on the Improvement Standard that became final and non-appealable after Jan. 18, 2011. This means that the case applies to Medicare beneficiaries all over the country. Many class members will be entitled to a re-review of their claims if they were denied on the basis of an Improvement Standard.
- CMS, with input from plaintiffs' counsel, must revise relevant portions of the *Medicare Benefit Policy Manual* and other guidelines, to eliminate the requirement that a beneficiary show a potential for improvement in order to qualify for coverage. CMS also has the option of issuing a Ruling on the corrected policy.
- CMS will engage in a nationwide Educational Campaign, using written materials, interactive forums, and national calls, to communicate the corrected maintenance coverage standards to beneficiaries, providers, contractors, and adjudicators.
- CMS will do random samplings of Medicare Qualified Independent Contractor (QIC) decisions to determine if the corrected policy is being applied appropriately, review up to 100 claims brought to them by plaintiffs' counsel, and meet with plaintiffs' counsel five times on a biannual basis.
- The Court will maintain jurisdiction for up to two or three years after the end of the Educational Campaign (the time frame depending on whether CMS issues a *CMS Ruling*), during which time plaintiffs may seek enforcement of any Settlement provisions with which the Secretary is not complying.

The Impact of End of the Improvement Standard

Lead plaintiff in the Improvement Standard case, Glenda Jimmo of Bristol, Vt., is blind and has had her right leg amputated due to complications from diabetes. She requires a wheelchair, and receives multiple weekly home health services for her complex condition. However, Medicare denied coverage for those services on the grounds that she was unlikely to improve.

Ms. Jimmo and Mrs. P are just two of the many people impacted by the Improvement Standard. Many other people will be helped by the settlement, including the following:

- Mrs. J's husband is one of the few remaining World War II veterans who served in both the Atlantic and Pacific theaters. He joined the U.S. Navy right after Pearl Harbor and even served in the Battle of Iwo Jima. He has suffered from Parkinson's disease for several years and recently fell in his home. After he was released from the hospital, he was transferred to a skilled nursing facility. After some time, his Medicare coverage was terminated because he was not ''improving.'' Because of the *Jimmo* settlement, Mr. J should be able to obtain Medicare coverage for his skilled maintenance physical therapy.
- Ms. V is relieved, as her mother has repeatedly been denied the ability to continue the physical therapy she needs in order to prevent further deterioration of her condition. Once, after her services stopped because they weren't covered, it actually endangered

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her life, resulting in extremely expensive 24/7 care. If she had been able to continue her maintenance physical therapy services, this would not have happened.

- Mr. T, a practicing physical therapist, actually left the field and began practicing law because of this very issue. He was being forced to discharge clients much sooner than they should have been, they would decline without skilled care, but it wouldn't be covered since they were not ''making progress.'' Mr. T can take comfort in the fact that beneficiaries will now continue to get the care their conditions require.

Settlement Agreement Applies Immediately

The Settlement Agreement standards for Medicare coverage of skilled maintenance services apply *now*—while CMS works on policy revisions and its education campaign. Nonetheless, the Center for Medicare Advocacy is hearing from beneficiaries who are still being denied Medicare coverage based on an Improvement Standard.

The settlement is the law of the land—agreed to by the federal government and approved by a federal judge. The Center encourages people to appeal should they be denied coverage for skilled nursing or therapy because they are not improving.

To help, the Center for Medicare Advocacy has materials available on its website, http://www.medicareadvocacy.org. This information can help individuals understand proper coverage rules and learn how to contest Medicare denials for outpatient, home health, or skilled nursing facility care.

This time next year, Medicare policies will clearly state that a beneficiary's access to coverage does not depend on the potential for improvement, but rather on the need for skilled care. The *Jimmo* settlement offers hope that Medicare beneficiaries like Mrs. P will not have to forgo necessary care or deal with the stress of coverage denials based on an Improvement Standard.