

Implementing *Jimmo v. Sebelius*: An Overview

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BACKGROUND

In 2013, a federal district court approved a settlement agreement in [*Jimmo v. Sebelius*, No. 5:11-CV-17 \(D. VT\)](#). The *Jimmo* Settlement confirmed that Medicare coverage should be determined based on a beneficiary’s need for skilled care (nursing or therapy), **not** on the individual’s potential for improvement. **The *Jimmo* Settlement and court decisions pertain to all Medicare beneficiaries throughout the country and apply regardless of whether an individual is in traditional Medicare or a Medicare Advantage plan.**

The *Jimmo* case was brought as a national class action by the Center for Medicare Advocacy (the Center) and Vermont Legal Aid. The Settlement required the Centers for Medicare & Medicaid Services (CMS) to confirm that coverage of skilled nursing or therapy is available to maintain or slow decline of an individual’s condition for beneficiaries in home health, skilled nursing facility, or outpatient settings. The Settlement also clarified the rules for individuals in inpatient rehabilitation hospitals/facilities (IRH/F).

Among other things, the Settlement required CMS to conduct an “Educational Campaign” to inform Medicare providers and decision-makers about the *Jimmo* “clarification” that Medicare-covered skilled services include care that improves, maintains, or slows decline of a patient’s condition. Medicare coverage should not be denied solely because an individual has an underlying condition that won’t get better, such as MS, ALS, Parkinson’s disease, or paralysis.

Unfortunately, more than six years after the Settlement’s approval, the Center still regularly hears from Medicare beneficiaries and providers about problems with its implementation in home health, skilled nursing facility, outpatient therapy, and inpatient rehabilitation hospital settings across the country.

The ongoing lack of knowledge about the *Jimmo* Settlement among providers, contractors, and adjudicators is unacceptable but, regrettably, not surprising. In late 2018, the Center conducted a [national survey](#) of Medicare providers to assess their knowledge about the *Jimmo* Settlement and their experience with its implementation. Sadly, our survey found that 40% of respondents had not even heard about the Settlement and that 30% of respondents were not aware that Medicare coverage does not depend on a beneficiary’s potential for improvement.

In the face of enduring barriers to Medicare-covered care for people with longer-term and chronic conditions, the Center compiled this Issue Brief to provide Medicare stakeholders with an overview of the *Jimmo* Settlement, what it means in different care settings, some of the Center’s key implementation work, and links and references to helpful resource materials. The Center hopes this information will help Medicare beneficiaries, families, providers, contractors, adjudicators, and other stakeholders learn about the principles articulated in *Jimmo* and access relevant resources to ensure the Settlement is properly implemented. For more information about the *Jimmo* Settlement, please visit the Center’s [Improvement Standard and Jimmo News webpage](#).

***JIMMO* SETTLEMENT & CORRECTIVE ACTION PLAN**

Jimmo was brought on behalf of Medicare beneficiaries who had or will have Medicare coverage of nursing or therapy services denied, terminated, or reduced on the basis that they were not improving or not demonstrating a potential for improvement (known as the “Improvement Standard”).

The *Jimmo* Settlement required CMS to undertake the following to remedy the practice of erroneously denying Medicare coverage based on an Improvement Standard:

1. Revise the Medicare Benefit Policy Manual to clarify that the need for skilled care is the determinative factor for coverage of nursing and therapy services, regardless of whether skilled care is needed to improve or maintain the individual’s condition.
2. Conduct a nationwide Educational Campaign, using written materials, interactive forums, and national calls, to communicate the correct maintenance coverage standards to Medicare providers, contractors, and adjudicators.

After receiving input regarding the proposed Settlement from the Center and Vermont Legal Aid, the Secretary of the U.S. Department of Health and Human Services (HHS) published several revised chapters of the Medicare Benefit Policy Manual on December 6, 2013. The revised Manual emphasizes that coverage for skilled nursing facility, home health, or outpatient therapy cannot depend on a beneficiary’s ability to improve. Because of the *Jimmo* Settlement, Medicare policy now clearly states that coverage:

[D]oes not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care. Skilled care may be necessary to improve a patient’s condition, to maintain a patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

[CMS Transmittal 179, Pub 100-02, 1/14/2014](#); see also Medicare Benefit Policy Manual (MBPM), [Chapter 7](#) – Home Health Services, Sections 20.1.2, 40.1-40.2; MBPM, [Chapter 8](#) - Coverage of Extended Care (SNF) Services Under Hospital Insurance, Sections 30.2-

30.4; MBPM, [Chapter 15](#) – Covered Medical and Other Health Services, Sections 220, 220.2-220.3, 230.1.2.

In February 2017, the *Jimmo* court found that CMS had not properly implemented the Educational Campaign required by the Settlement and ordered the Medicare agency to carry out a [Corrective Action Plan](#) to remedy the problems. As urged by the *Jimmo* class counsel, the Court ruled that CMS failed to explain that consideration of the need for skilled care, not the potential for improvement, should govern Medicare coverage determinations. As a result, the Corrective Action Plan required the creation of a new [CMS webpage dedicated to Jimmo](#) on its cms.gov website, the publication of a “Corrective Statement” disavowing the Improvement Standard, the posting of Frequently Asked Questions, and new training for Medicare contractors who make coverage decisions.

HOME HEALTH COVERAGE IN LIGHT OF THE *JIMMO* SETTLEMENT

Medicare home health coverage can be an important resource for people with long-term and chronic conditions who need care at home. Contrary to common belief, Medicare home health coverage is not just a [short-term, acute care benefit](#). In fact, under the law, Medicare beneficiaries who meet the qualifying criteria are eligible for home health coverage so long as skilled care is reasonable and necessary. There are six threshold requirements for Medicare home health coverage:

1. The beneficiary must be homebound. This requirement means it is difficult, or contraindicated, for the individual to leave home alone, he/she does so infrequently, or for medical or certain other allowed purposes. The requirement does not mean that a beneficiary can never leave home, or that the beneficiary must be bedbound;
2. The beneficiary must require skilled nursing care on an intermittent basis, physical therapy, speech language pathology services, or, in some instance, occupational therapy;
3. A physician, or a recognized non-physician health care professional, must have a face-to-face meeting with the beneficiary prior to certifying his/her need for home health care;
4. A physician must order the care to be provided by the home health agency, and sign and certify a “Plan of Care;”
5. A document about the face-to-face meeting, signed by a physician, must be included in the home health care certification; and
6. The home health agency must be a Medicare-certified provider.

Unfortunately, home health agencies and Medicare Contractors, which make Medicare claim determinations, continue to deny Medicare home health coverage, and/or access to care, even for patients who meet these coverage criteria. Too often, beneficiaries are told Medicare will not cover skilled nursing or therapy services because they have “plateaued,” or are “chronic,” or “stable,” or lack potential for improvement. **These denials, based on an erroneous “Improvement Standard,” without an inquiry into whether skilled care may be required to maintain or prevent deterioration of a patient’s condition, violate the *Jimmo* Settlement.**

SKILLED NURSING FACILITY COVERAGE IN LIGHT OF THE *JIMMO* SETTLEMENT

Medicare skilled nursing facility (SNF) coverage is an indispensable resource for beneficiaries in need of skilled nursing and/or therapy services in an institutional setting. Medicare beneficiaries are entitled to a maximum of 100 days of SNF care during a benefit period. However, it is possible to have more than one benefit period in a calendar year. Medicare coverage of SNF care depends on the following requirements:

1. The beneficiary must have a qualifying three-day inpatient (as opposed to outpatient) hospital stay. Medicare Advantage plans and Accountable Care Organizations might not have this requirement. Generally, the admission to the SNF must occur within 30 days of leaving the hospital;
2. The SNF care must have been ordered by a physician and must relate to a condition for which the beneficiary received inpatient hospital services or that arose at the skilled nursing facility while being treated for a condition for which the beneficiary received inpatient hospital services. As a practical matter, the care must only be available on an inpatient basis; and
3. The beneficiary must require and receive skilled nursing seven days a week, skilled therapy five days a week, or a combination of both skilled nursing and therapy services seven days a week. Skilled care means that services must be provided by, or under the supervision of, a skilled professional in order to be safe and effective.

Skilled nursing facilities and Medicare Contractors continue to deny Medicare SNF coverage, and/or access to care, to patients who meet these coverage criteria. Too often, beneficiaries are told Medicare will not cover skilled therapy services because they have “plateaued,” or are “chronic,” or “stable,” or lack potential for improvement. **These denials, based on an erroneous “Improvement Standard,” without an inquiry into whether skilled care may be required to maintain or prevent deterioration of a patient’s condition, violate the *Jimmo* Settlement.**

OUTPATIENT THERAPY COVERAGE IN LIGHT OF THE *JIMMO* SETTLEMENT

Medicare coverage of outpatient therapy services is an essential resource for Medicare beneficiaries in need of short-term or long-term skilled therapy for the safe and effective treatment of their conditions. Under Medicare Part B, beneficiaries have access to physical therapy, occupational therapy, and speech language pathology services when these services are medically reasonable and necessary. However, Medicare places certain conditions on the coverage of these outpatient therapy services:

1. The therapy must be provided by or, in some instances, directly supervised by, a qualified therapist;
2. A physician, non-physician practitioner, or therapist must develop a plan of care for providing the outpatient therapy services, and that plan of care must be periodically reviewed by the physician or non-physician practitioner;
3. The beneficiary must be under the care of a physician at the time the services are provided;
4. The plan of care must include, at a minimum, the diagnoses, long-term treatment goals, and type, amount, duration and frequency of therapy services;
5. The beneficiary’s functional limitations must be consistent with the functional limitations in the beneficiary’s plan of care and must be included in the beneficiary’s long-term goals; and
6. The physician or non-physician practitioner must certify that the preceding conditions have been met by certifying the plan of care. (MBPM, Chapter 15, Section 220.1.1-2).

Practice Tip: Certification requirements are met when the individual’s physician certifies the plan of care. If a signed order includes a plan of care, no further certification is required. Medicare payment depends on certification of the plan of care rather than an order, but the use of an order is recommended to show a physician is involved in the care and available to certify the plan.

Outpatient therapy entities and Medicare Contractors continue to deny Medicare outpatient therapy coverage, and/or access to care, even for patients who meet these coverage criteria. Too often,

beneficiaries are told Medicare will not cover skilled therapy services because they have “plateaued,” or are “chronic,” or “stable,” or lack potential for improvement. **These denials, based on an erroneous “Improvement Standard,” without an inquiry into whether skilled care may be required to maintain or prevent deterioration of a patient’s condition, violate the *Jimmo* Settlement.**

INPATIENT REHABILITATION HOSPITAL/FACILITY COVERAGE IN LIGHT OF THE *JIMMO* SETTLEMENT

Because of the *Jimmo* Settlement, the Medicare Benefit Policy Manual now clearly states that coverage of a Medicare-certified IRH/F does not depend on a beneficiary’s ability to achieve complete independence in self-care or the prior level of functioning. Rather, a stay is considered medically necessary when the beneficiary’s medical record, admission order, pre- and post-admission screenings, and plan of care demonstrate that the following coverage criteria were met at the time of admission:

1. The individual requires a relatively intense, multidisciplinary rehabilitation program (physical therapy, occupational therapy, speech-language pathology, and/or prosthetics/orthotics). The care includes physical or occupational therapy. A coordinated, multi-disciplinary team that meets at least bi-weekly provides the care.
2. The individual requires at least three hours of therapy per day five days a week or, in certain cases, at least 15 hours of therapy within a consecutive seven-day period. However, Medicare cannot deny claims solely because the threshold therapy time was not satisfied. There must be a clinical review “based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time.” [CMS Transmittal 771, 100-08, 2/23/2018](#); and
3. The individual can actively participate in, and benefit from, the IRH/F care. There is a reasonable expectation that the individual will make measurable improvement that will be of practical value to improve his/her functional capacity or adaptation to impairments within a prescribed period of time. Medicare does not require that the individual achieve complete independence in self-care or return to his or her prior level of functioning; and
4. The individual requires the supervision of a rehabilitation physician, i.e., “a licensed physician with specialized training and experience in inpatient rehabilitation.” The individual and the physician must have at least three face-to-face visits per week during the beneficiary’s IRH/F stay.

Inpatient rehabilitation hospitals/facilities and Medicare Contractors continue to deny Medicare IRH/F coverage, and/or access to care, even for patients who meet these coverage criteria. Too often, beneficiaries are told Medicare will not cover skilled therapy services because they have “plateaued.” **These denials, based on an erroneous “Improvement Standard,” without an inquiry into the specific standards for skilled care in an IRH/F – whether the nursing and/or therapy is necessary for the patient to adjust to a new level of disability or to obtain a level of function that is of practical value to the individual – violate the *Jimmo* Settlement.**

***JIMMO* IMPLEMENTATION COUNCIL**

Facing ongoing implementation barriers, the Center convened the [Jimmo Implementation Council](#) on June 23, 2015. The Council brought together community experts, including advocates, providers, nurses, therapists, policymakers, and other stakeholders. Led by Center attorneys and physical therapist Cindy Krafft, the Council discussed implementation in the various care-settings, identified specific barriers to implementation, and considered effective methods to implement the Settlement.

The *Jimmo* Council identified the following barriers to implementation:

1. Limited education and outreach on the part of CMS;
2. Widespread myths that improvement is necessary for Medicare coverage and payment;
3. Limited number of studies and guidelines to demonstrate benefits of maintenance therapy;
4. Difficulty adequately documenting and billing maintenance nursing and therapy;
5. Concerns about auditing of documentation; and
6. Provider reluctance in pursuing exceptions to therapy caps.

The *Jimmo* Council identified the following recommendations for implementation:

1. Development of more in-depth literature and research studies to produce evidence-based materials about maintenance care;
2. Additional CMS education and outreach;
3. Educational outreach through courses, webinars, toolkits, continuing educational opportunities, and nursing/therapy school curricula;
4. A briefing on Capitol Hill about *Jimmo*;
5. Development of consumer materials discussing maintenance therapy and *Jimmo*;
6. Engaging in legislative advocacy;
7. Engaging in administrative advocacy;
8. Advocating for CMS to create a National Coverage Determination for *Jimmo*, which would serve to eliminate existing inconsistencies in Local Coverage Determinations and communicate the importance of the Settlement; and
9. Ensuring that electronic medical record programs include easily accessible choices to record skilled maintenance nursing and therapies and that appropriate billing codes exist for these services.

EFFORTS TO IMPROVE IMPLEMENTATION

The Center has taken steps to address the barriers and recommendations identified by the *Jimmo* Implementation Council. In addition to taking CMS back to court in 2017, which resulted in the above-mentioned Corrective Action Plan, the Center has developed self-help materials that are free and publicly available on our website www.MedicareAdvocacy.org. These educational materials include **Checklist Toolkits** (reviewing coverage criteria for the different care settings and guidance on appeals), **Comprehensive Toolkits** (containing relevant resources from both the Center and CMS), **Fact Sheets**, **CMA Alerts**, and **webinars**. The Center has also worked with Medicare stakeholders, including Congress and CMS, to remove identified barriers. For instance, the Center was part of a coalition of advocates that worked to eliminate the arbitrary [outpatient therapy caps](#).

NEXT STEPS

The Center for Medicare Advocacy is committed to implementing *Jimmo*. In the coming year we will focus on education for Medicare providers, contractors, adjudicators, and policymakers. The Center plans to host interactive webinars with and for providers – including members of our *Jimmo Council* – to consider challenges and best practices when providing care in accordance with the *Jimmo* Settlement. The webinars will consider Medicare coverage, effective documentation, and billing – offering providers

a platform to explain and discuss their experiences providing skilled maintenance nursing and/or therapy in various settings. We will also consider next steps together as we plan further actions to implement *Jimmo*. The Center will continue to confer with CMS and policymakers to help ensure the *Jimmo* Settlement opens doors to care as intended by the Court. We also hope to meet with the HHS Office of Inspector General about improper provider audits.

As always, we are eager to hear from beneficiaries, families, and providers who have been able to obtain care, or provide care, to maintain or slow decline of a chronic and/or debilitating condition. Please write us about your experience at Improvement@MedicareAdvocacy.org.

IMPORTANT RESOURCES FROM THE CENTER FOR MEDICARE ADVOCACY

Checklist Toolkits:

- [Medicare Skilled Nursing Facility Coverage and Appeals In Light of *Jimmo v. Sebelius*](#)
- [Medicare Home Health Coverage and Appeals In Light of *Jimmo v. Sebelius*](#)
- [Medicare Outpatient Therapy Coverage and Appeals In Light of *Jimmo v. Sebelius*](#)

Comprehensive Toolkits:

- [Medicare Skilled Nursing Facility Coverage And *Jimmo v. Sebelius*](#)
- [Medicare Home Health Coverage And *Jimmo v. Sebelius*](#)
- [Medicare Outpatient Therapy Coverage And *Jimmo v. Sebelius*](#)

Fact Sheets:

- [Medicare Inpatient Rehabilitation Hospital/Facility Coverage In Light of *Jimmo v. Sebelius*](#)
- [Medicare Coverage In Light of *Jimmo v. Sebelius* For Providers, Contractors, and Adjudicators](#)

FAQs:

- [Frequently Asked Questions \(FAQ\) Regarding the *Jimmo v. Sebelius* “Improvement Standard” Settlement](#)

CMA Alerts:

- [Congress Repeals Medicare Outpatient Therapy Caps, Strengthening the *Jimmo* Settlement Agreement](#)
- [*Jimmo* Implementation: Beneficiary Successfully Appeals Denial of Maintenance Therapy](#)
- [*Jimmo* Implementation Update: Where is CMS?](#)

Webinars:

- [*Jimmo v. Sebelius* Update – Medicare Coverage for Maintenance Care, CMS Corrective Action Plan and Implementation](#)
- [Key Medicare Issues Facing People with Serious Illnesses](#)