THE JIMMO V. SEBELIUS SETTLEMENT AGREEMENT
AN ISSUE BRIEF FOR MEDICARE PROVIDERS
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What is the Jimmo Settlement Agreement?
Jimmo v. Sebelius, No. 5:11-CV17 (D. Vt., 1/24/2013), was a nationwide class-action lawsuit brought against the Centers for Medicare & Medicaid Services (CMS) on behalf of individuals with chronic conditions who had been denied Medicare coverage on the basis that they were not improving or did not demonstrate a potential for improvement. In 2013, a U.S. District Court approved the settlement agreement, which required CMS to confirm that Medicare coverage is determined by a beneficiary’s need for skilled care, not on a beneficiary’s potential for improvement. Plaintiffs were represented by the Center for Medicare Advocacy and Vermont Legal Aid.

The Jimmo Settlement applies to all Medicare beneficiaries throughout the country, regardless of whether an individual is in traditional Medicare or has a Medicare Advantage plan.

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.
Does Jimmo Apply to My Practice?
The *Jimmo* settlement applies in the following health care settings:

1. Home health;
2. Skilled nursing facilities;
3. Outpatient therapy; and
4. Inpatient rehabilitation hospitals/facilities

**Note:** While improvement is a coverage criterion for inpatient rehabilitation hospitals/facilities, the *Jimmo* Settlement means that coverage in this setting does not depend on the individual’s ability to achieve complete independence in self-care or a prior level of functioning. For more information, please see our Fact Sheet.

What Does Jimmo Mean for My Patients?
The *Jimmo* Settlement means that Medicare beneficiaries should not be denied maintenance nursing or therapy when skilled personnel must provide or supervise the care for it to be safe and effective. Medicare-covered skilled services include care that improves, maintains, or slows the decline of a patient’s condition. Thus, Medicare coverage should not be denied solely because an individual has an underlying condition that will not get better (such as MS, ALS, Parkinson’s disease, or paralysis).

Are Providers Implementing Jimmo?
Yes! However, the Center still hears from beneficiaries and their families about coverage denials for skilled care based on some variation of an “Improvement Standard.” Such unlawful denials may be the result of a misunderstanding among providers. According to the Center’s 2018 national survey of providers, 40% of respondents had not heard about the *Jimmo* Settlement and 30% of respondents were not aware that Medicare coverage does not depend on a beneficiary’s potential for improvement.

How Do PDPM and PDGM Affect Jimmo?
While both the Patient Driven Payment Model (PDPM) and the Patient-Driven Groupings Model (PDGM) create a new set of financial incentives for skilled nursing facilities and home health agencies, respectively, these payment models do not change Medicare coverage and eligibility criteria. In FAQs, CMS specifically states that “PDPM does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients.” Likewise, in the PGPM Final Rule, CMS states that it expects “the provision of services to be made to best meet the patient’s care needs and in accordance with the home health [Conditions of Participation] CoPs at §484.60 which sets forth the requirements for the content of the individualized home health plan of care . . . .” Thus, patient care needs must still be based on clinical standards and judgment related to individual care needs.
What Can I Do to Help My Patients?

Medicare providers must be patient advocates. Providers must ensure that patients receive maintenance nursing or therapy services when skilled care is needed for safe and effective treatment. Careful and thorough documentation of the patient’s medical need for maintenance services can help providers assure coverage and payment. The Center encourages providers to use the materials below to help them implement the correct standards under the Jimmo Settlement.

CMS Resources

- CMS’s Jimmo Homepage
- CMS’s Frequently Asked Questions
- CMS’s MLN Matters Fact Sheet

Relevant Medicare Benefit Policy Manual Citations

- Inpatient Rehabilitation Hospital/Facility Services (Ch. 1, Section. 110.3)
- Home Health Services (Ch. 7, Sections 20.1.2, 40.1-40.2)
- Skilled Nursing Facility Services (Ch. 8, Sections 30.2-30.4)
- Outpatient Therapy Services (Ch. 15, Sections 220, 220.2-220.3, 230.1.2)

Practice Tips

- Orders Needed for Maintenance Skilled Care
- Medicare Maintenance Therapy Documentation (Good Shepherd Rehabilitation – .pdf)

CMA Webinars

- Jimmo Implementation Council (November 2019) – A panel of experienced providers discuss the documentation and provision of successful maintenance therapy.
- Jimmo Implementation Council (March 2020) – Join us as our guest speakers share their expertise on providing maintenance nursing. Register Now!

CMA Alerts

- Congress Repeals Medicare Outpatient Therapy Caps, Strengthening the Jimmo Settlement Agreement
- Home Health Practice Guide
- Medicare Skilled Therapy under PDPM
- Expedited/Fast-Track Medicare Appeals in Skilled Nursing Facilities in Light of the Jimmo v. Sebelius Settlement Agreement

Stay Engaged!

Please consider joining the Jimmo Implementation Council. Established in 2015, the Jimmo Council is a multi-disciplinary community committed to implementing the Jimmo Settlement. For more information about the Jimmo Council and to sign-up, please visit: https://www.medicareadvocacy.org/jimmo-implementation-council/.