INCORRECT IMPLEMENTATION OF THE *JIMMO V. SEBELIUS* SETTLEMENT IN A SKILLED NURSING FACILITY: A CASE STUDY

I. Background - *The Jimmo* Settlement

In 2013, a U.S. District Court approved the settlement agreement in *Jimmo v. Sebelius*,[1] requiring the Centers for Medicare & Medicaid Services (CMS) to confirm that Medicare coverage of home health, skilled nursing facility (SNF), and outpatient therapy services is determined by a beneficiary's need for skilled nursing and/or therapy, not on a beneficiary's potential for improvement. [2] The *Jimmo* Settlement clearly directs that Medicare covers skilled services not only to improve a resident's condition, but **equally to maintain or slow the decline** of a patient's condition. Sadly, seven years later, beneficiaries and their families are still being denied skilled care on the basis of an erroneous "Improvement Standard."

II. Case Study

In early 2020, the son of a Medicare beneficiary in traditional Medicare wrote the Center for Medicare Advocacy (the Center) to describe his experience with the poor implementation of the *Jimmo* Settlement. He stated that his father's Medicare coverage in a SNF was terminated because he had "plateaued" and was purportedly no longer making progress in skilled therapy.

During the expedited appeals process, Medicare contractors "stressed . . . in advance over the phone that they would only consider medical records as evidence and they would absolutely refuse to consider any violations of *Jimmo* law when they ruled on our appeal." A 1-800-MEDICARE representative told him that "[t]he *Jimmo* regulations were from 2014, and they are outdated now and don't apply anymore." After pointing to CMS's *Jimmo*-dedicated webpage,[3] the Medicare representative escalated the case to the Advanced Resolution Center (ARC). Unfortunately, the ARC also refused to discuss the SNF's violation of the *Jimmo* Settlement.

Because the SNF terminated Medicare coverage, the beneficiary was responsible for the cost of any skilled care he received after the termination date (which amounted to over $10,000). The beneficiary's father asked the SNF twice to submit a "demand bill" to Medicare for the cost of those services, thereby setting up his father's right to file a standard appeal. Two months later, the SNF had yet to fulfill his request. During his conversation with the ARC, he was told there was no "such a thing as a Standard Medicare Appeal or a Demand Bill."

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[1] No. 5:11-CV17 (D. Vt., 1/24/2013).
[2] The *Jimmo* Settlement also applies in inpatient rehabilitation hospital/facilities. While improvement is a coverage criterion for inpatient rehabilitation hospitals/facilities, the 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 visit: https://www.medicareadvocacy.org/wp-content/uploads/2019/04/IRF-JIMMO-Factsheet.pdf.
[3] https://www.cms.gov/Center/Special-Topic/Jimmo-Center.

III. Discussion

A. Response to the *Jimmo* Problems

1. Contrary to what the Medicare representative told the beneficiary's son, the *Jimmo* Settlement absolutely still represents official Medicare policy. There is no end to the Settlement's conclusions. As noted on CMS's *Jimmo* webpage, "[t]he *Jimmo* Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy . . . and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide."[4]

2. The Settlement applies to all Medicare beneficiaries nationwide, regardless of whether the individual is in real/traditional Medicare or a private Medicare Advantage plan.[5] Thus, any SNF that has been certified to participate in the Medicare program may not end Medicare-covered skilled services solely on the basis that a beneficiary lacks the potential to improve.

3. Medicare contractors cannot simply refuse to follow the law or accept relevant evidence. Federal regulations state that beneficiaries can submit evidence to be considered by the Medicare contractors overseeing expedited appeals in making their decision.[6] Additionally, the Medicare provider has the burden of proof to demonstrate that "termination of coverage is the correct decision, either on the basis of medical necessity, **or** based on other Medicare coverage policies."[7]

> **Note:** For additional information about expedited/fast-track Medicare appeals in SNFs, please visit: https://www.medicareadvocacy.org/expedited-fast-track-medicare-appeals-in-skilled-nursing-facilities-in-light-of-the-jimmo-v-sebelius-settlement-agreement/#_ftn23.

B. Response to the Demand Billing Problem

1. Contrary to what the Advance Resolution Center (ARC) told the beneficiary's son, demand bills and standards appeals are real, important components of Medicare beneficiary appeal

[4] Important Message About the Jimmo Settlement, CMS, https://www.cms.gov/Center/Special-Topic/Jimmo-Center (last visited 1/24/2020).
[5] *See* Frequently Asked Questions (FAQs) Regarding Jimmo Settlement Agreement, CMS, https://www.cms.gov/Center/Special-Topic/Jimmo-Settlement/FAQs (referencing question 15) (last visited 1/24/2020).
[6] 42 C.F.R. §§ 405.1202(b)(3), 405.1202(d)(2), 405.1204(b)(3), 405.1204 (c)(2). Please note that this refers to expedited appeals before Quality Improvement Organizations (QIOs) and Quality Independent Contractors (QICs). Individuals with Medicare Advantage plans may have different appeal rights.
[7] *Id.* at § 405.1202(d) (emphasis added).

rights. The Medicare Claims Processing Manual (MCPM) states that "[d]emand bills are both a principle and a mechanism of Medicare."[8] The MCPM further notes:

> *The principle goes back to the founding of the Program, reflected in the protection of the rights of the Program's beneficiaries being among the first sections of Title XVIII. The principle assures that beneficiaries have the right to demand that Medicare be billed for the services provided to them, whether or not that billing provides Medicare payment. By assuring claims are sent to and processed by Medicare, permitting official payment decisions to be made, beneficiaries retain the right to appeal payment decisions made on those claims, when they believe need to use that right exists*.[9]

2. **SNFs cannot refuse to submit demand bills to Medicare.** Medicare beneficiaries have the right to demand that SNFs submit claims to Medicare for services they have received. The refusal to bill Medicare for those services impedes a beneficiary's ability to exercise his or her right to a standard appeal.

IV. Conclusion

CMS is failing to ensure that the *Jimmo* Settlement Agreement is being properly implemented in the applicable health care settings. Moreover, the poor education of Medicare representatives and contractors about the Settlement is continuing to harm Medicare beneficiaries in need of maintenance nursing and/or therapy services, and is shifting the cost of Medicare-covered care onto beneficiaries and families. CMS must conduct a meaningful education campaign to ensure that Medicare providers, contractors, and adjudicators are correctly implementing the *Jimmo* Settlement (as well as other Medicare laws, regulations, and policies).

Latest Resource from the Center

The Center recently published, "The *Jimmo v. Sebelius* Settlement Agreement: An Issue Brief for Medicare Providers." This Issue Brief was developed to educate Medicare providers about the *Jimmo* Settlement and to help them implement the correct standards. Medicare beneficiaries and their families are encouraged to share this Issue Brief with providers.

[8] Medicare Claims Processing Manual (MCPM), General Billing Requirements, Chapter 1, § 60.3.1 (rev. 4415, 01-06-2020), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01pdf.pdf.
[9] *Id.*