MEMORANDUM

To: CCD Health Task Force

From: Peter W. Thomas, J.D.

Date: October 26, 2012

Subject: **Jimmo v. Sebelius – Settlement Agreement Has Major Implications on Medicare Beneficiaries with Disabilities and Chronic Conditions**

The U.S. Secretary of Health and Human Services and the Center for Medicare Advocacy announced yesterday a proposed settlement of a nationwide class-action lawsuit that is expected to significantly expand coverage of therapy and skilled nursing services for Medicare beneficiaries with chronic conditions or disabilities. It also would make more limited changes to coverage of inpatient rehabilitation hospital/unit ("IRH/U" or "IRF") care. The settlement must first be approved by the court, a process which could take several weeks.

The case, Jimmo v. Sebelius, was brought by the Center for Medicare Advocacy on behalf of a class of Medicare beneficiaries. Other plaintiffs in the case included the National Multiple Sclerosis Society, the Paralyzed Veterans of American, the Parkinson's Action Network, and the National Committee to Preserve Social Security and Medicare. (The American Academy of Physical Medicine and Rehabilitation had been an original plaintiff but was dismissed by the court based on lack of legal standing to sue.)

The case, filed in January of 2011 in federal district court in Vermont, challenged Medicare's use of an "improvement standard" in determining medical necessity for skilled nursing services and outpatient therapy on the grounds that it violated Medicare law and deprived Medicare beneficiaries of needed care. That standard effectively denied coverage for skilled nursing facility ("SNF") care, home health ("HH") care, and outpatient therapy ("OPT") services on the basis that an individual was not improving, without regard to the reasonableness and necessity of the care.

The improvement standard does not appear in Medicare statute or regulations but instead is a de facto "rule of thumb" that has been used by Medicare contractors for years to deny or discontinue care. The weight of this rule fell most heavily on Medicare beneficiaries with disabilities and those with chronic conditions such as stroke, Alzheimer's disease, multiple sclerosis, traumatic brain injury, and Parkinson's disease. Many of these patients are unable to obtain the skilled services they need to manage their chronic condition, maintain their existing function, and prevent or limit deterioration of function as a result of application of this standard.

Terms of the Proposed Settlement

Under the terms of the proposed settlement, Medicare would be required to rewrite its manual provisions to state that coverage standards for SNF, HH, and OPT coverage of therapy does not turn on the individual's potential for improvement, but rather on their need for skilled

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care. More specifically, CMS would agree to revise its Medicare Benefits Policy Manual ("MBPM") to clarify that:

- SNF, HH and OPT coverage standards provide for maintenance coverage of skilled therapy services when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or to prevent or slow further deterioration. The design of the a maintenance program by a qualified therapist, the instruction of the beneficiary regarding the maintenance program, and necessary periodic reevaluations by a qualified therapist are all covered services, assuming that specialized knowledge and judgment of a qualified therapist are required.

- The SNF and HH benefits provide for coverage of skilled nursing services when an individualized assessment of the patient's clinical condition demonstrates that the skills of a registered nurse or a licensed practical nurse are necessary to maintain the patient's current condition or prevent or slow further deterioration.

Thus, if the settlement is approved, Medicare will no longer be able to deny skilled services based on failure to improve, lack of restorative potential, the patient's progress having "plateaued," and other similar "rules of thumb" that have been used in the past and are routinely used today. The new rules would apply to fee-for-service Medicare as well as Medicare Advantage plans and would apply to all Medicare beneficiaries including those eligible for Medicare based on disability and end-stage renal disease ("ESRD").

However, the settlement does contain some limiting provisions to prevent an unlimited Medicare benefit of these services. The settlement provides that Medicare is not required to cover skilled therapy where the maintenance program could be safely and effectively accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers. Rather, the patient must have "special medical complications" or the needed therapy procedures must be "of such complexity" that the skills of a qualified therapist are required. Similar standards would apply to skilled nursing services. The settlement would not change existing Medicare eligibility requirements for coverage such as the "homebound" standard for HH care. Nor would it impact the existing caps on outpatient therapy services.

Impact on Inpatient Rehabilitation Hospitals and Units

With respect to IRH/Us, the MBPM would be revised to clarify that an IRF claim could never be denied:

- Because a patient could not be expected to achieve complete independence in the domain of self-care; or

- Because a patient could not be expected to return to his or her prior level of functioning (prior to the illness or injury that caused the hospital stay).

The settlement's more expansive policy for SNFs, HHs and OPT services would not apply to IRH/Us. This is because IRH/Us are required by regulation to demonstrate that a patient, upon admission, has an expectation of improvement. The regulations do not require that the patient actually improve their functional status during the course of the IRH/U stay in order for the care to be covered, but the need for an intensive inpatient rehabilitation hospital program must be present throughout the course of the stay. Still, the terms of the settlement that relate to IRH/U care should help prevent at least some denials of access in the future and the settlement may engender additional challenges to the current regulatory standard in the inpatient rehabilitation hospital setting.

Redrafting the Medicare Benefits Policy Manual

The settlement makes clear that nothing in the agreement alters existing Medicare eligibility requirements for receiving Medicare coverage of services provided by SNFs, HH agencies, OPT, or IRH/Us. However, CMS is required to revise and eliminate any provisions in the MBPM that conflict with the standards set forth in the settlement. Plaintiff's counsel will have two separate opportunities to review the MBPM changes and offer recommendations through one set of consolidated comments. CMS will be required to consider these comments in good faith but retains final authority as to the ultimate content of the manual provisions.

Educational Campaign and Accountability

If the court approves the settlement and it becomes final, CMS would be required to engage in a nationwide educational campaign to communicate the new standards to contractors—such as Recovery Audit Contractors ("RACs") and Medicare Administrative Contractors ("MACs")—providers and suppliers, as well as those involved in claims adjudications such as Qualified Independent Contractors ("QICs"), Administrative Law Judges ("ALJs"), and the Medicare Appeals Council, the highest level of administrative review for Medicare claims. Plaintiffs to the suit would have two separate opportunities to review and make written recommendations on any proposed educational materials prior to use, which CMS would be required to consider in good faith.

CMS would also commit to a random sampling of QIC decisions to determine whether there are problems in the application of the new standards. If errors are identified, CMS would be required to address the issues with the contractor.

CMS would also agree to hold bi-annual meetings with plaintiffs' counsel to review the results of claims sampling. Plaintiffs would also be entitled to present to CMS individual claims determinations they believe were not decided in accordance with the new coverage standards. These bi-annual meetings would proceed for two-and-a-half years for a total of five meetings. The government has also agreed to pay plaintiffs' attorneys fees of $300,000.

The Court would maintain jurisdiction over the case for up to three years after the end of the educational campaign to ensure the terms of the settlement are being followed.

Preliminary Implications

After decades of CMS enforcement of a *de facto* improvement standard that never existed in statute, the Center for Medicare Advocacy finally challenged this standard on behalf of Medicare patients and providers with stunning results. Advocates for Medicare beneficiaries have been arguing for years that therapy and related services are just as important to maintain or prevent deterioration of function as they are to improve function. The Jimmo v. Sebelius settlement finally makes this clear. The implications of this settlement, if approved by the court, are highly significant for people with disabilities and chronic conditions, as well as the providers who serve them. In fact, the implications are so significant that, given the current fiscal environment, the prospect of Congress intervening should not be underestimated or dismissed.

If the settlement is approved and the MBPM revised appropriately, not only will Medicare beneficiaries with disabilities and chronic conditions benefit, but this new standard will set a high bar for private insurers. Because the settlement would apply to Medicare Advantage plans, private plans that serve Medicare beneficiaries will have to follow the new rules. This creates tremendous opportunities for advocates to press for widespread adoption of this new standard. In addition, as the essential health benefits packages are being developed at the state level, and overseen by HHS, this settlement may influence the contents of the rehabilitative and habilitative services and devices benefit packages in the private market. Finally, especially with respect to individuals who are dually eligible for Medicare and Medicaid, this settlement will likely have a ripple effect across Medicaid benefits as well.

For more information, please contact us at your convenience.