

## **The Myth of the Medicare Improvement Standard**

### **INTRODUCTION**

For many years Medicare recipients who have need for professional medical services or therapy have been denied Medicare coverage when their providers found that their conditions have ceased to improve, even though these recipients still require professional services to maintain their current condition or to slow or delay their decline. The Medicare rules themselves never prevented Medicare recipients from receiving coverage for necessary nursing or therapy services when they ceased to improve, but the need for an “improvement standard” became an ingrained myth among the morass of companies who are responsible for reviewing Medicare claims.

This article will discuss the background and many past litigations for the attempt to do away with the improvement myth, and will further discuss the noble efforts of many beneficiaries and their attorneys to remedy the myth of the improvement standard in the many settlements of *Jimmo v. Sebelius*.<sup>1</sup>

### **BACKGROUND FOR THE “IMPROVEMENT STANDARD”**

Medicare is a national health insurance program that was created for Social Security recipients who are ages 65 and over, and in 1972 Medicare was expanded to cover younger people who have long term disabilities.<sup>2</sup> Medicare recipients are covered under either “original” Medicare or “Medicare Advantage” plans, which are plans that have benefits either equal to or better than original Medicare plans.<sup>3</sup>

For many years Medicare coverage for Home Health Services (HH), for Skilled Nursing Facilities (SNF) and for Outpatient therapy services (OPT) has provided that Medicare beneficiaries whose conditions are not expected to improve but who still require skilled nursing, physical therapy, occupational therapy, and speech-language pathology services (Services) to maintain their current capabilities or to prevent further deterioration are entitled to have these Services covered under Medicare.<sup>4</sup>

In 1987, this was discussed in an injunction for Connecticut SNF residents that prohibited providers and intermediaries from using “rules of thumb” to deny SNF coverage to patients who required skilled maintenance therapy.<sup>5</sup> The Court found that these “rules of thumb” had been improperly “applied across the board without regard to the medical condition or the therapeutic requirements of the individual patient.”<sup>6</sup>

Another case that considered whether a patient was entitled to Medicare-covered nursing services was considered in 1994.<sup>7</sup> In this case, a visiting nurse association was notified that Ms. McDonald did not require skilled nursing services because her condition was stable<sup>8</sup> even though her doctor found that her condition was fragile and that skilled care was required to “monitor and interpret any signs of change in her condition.”<sup>9</sup> The Court noted that Ms. McDonald needed skilled care to avoid the risk of deterioration and stated that: “The fact that skilled care has stabilized a claimant’s health does not render that level of care unnecessary.”<sup>10</sup> The Court found that the denial of her Medicare coverage had been improper.<sup>11</sup>

A paper published in 2003 points out that some of the confusion as to whether a treatment goal used solely to maintain a patient's condition and prevent further deterioration is permitted under Medicare lies with Local Medical Review Policies developed by Medicare carriers and intermediaries (LMRP).<sup>12 13</sup> Most of the "rules" developed by the LMRP, "are not found in the Medicare statute and regulations, but are set out in program manuals or in sporadic publications of local contractors."<sup>14</sup> Thus, "even when the Medicare statute and regulations include a framework to evaluate needs of those with chronic conditions, LMRPs often contain standards that are inconsistent with the Medicare statute and regulations."<sup>15</sup> The paper points out that "medical necessity determinations in individual claims . . . should be revised to recognize that the overwhelming majority of beneficiaries have at least one chronic condition . . . [and] [t]he determination in each case must be made in the context of each individual's unique situation."<sup>16</sup>

Further, in July of 2004, The Center for Medical Advocacy (CMA) published a note that reported that its attorneys had negotiated with the Centers for Medicare & Medicaid Services (CMS) (which operates under the Department of Health and Human Services (DHHS)) and the government contractor, Maximus Center of Health Dispute Resolution (Maximus) over the improvement standard that Maximus had been using to decide on the need for skilled therapy in a SNF.<sup>17</sup> The CMA said that the Improvement Standard used by Maximus had required a patient's doctor to say that the patient must get better every day in therapy and that the doctor should tell Medicare how long it will take for the patient to get better.<sup>18</sup> CMA pointed out that this Improvement Standard was very difficult to satisfy and did not comply with the relevant federal requirements. "In particular it violated 42.C.F.R. 409.32(c), which states: 'The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery . . . is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.'"<sup>19</sup> CMA was able to facilitate CMS and Maximus not to require an improvement standard as a prerequisite for Medicare reimbursement.<sup>20</sup>

One may have assumed that the improvement standard issue had been resolved, but many HH and SNFs continued to require this improvement standard. In early 2010 Clearinghouse Review wrote about how 68-year-old Eileen Prendergast, a patient with Amyotrophic Lateral Sclerosis, was told by her home health agency that Medicare would no longer cover her much needed home health care because she was 'stable in her disease state' and would not improve.<sup>21</sup> The article stated that "the agency was following a Medicare tradition that has become virtually an urban myth among . . . [those] . . . responsible for making Medicare decisions. The myth is that coverage of skilled care requires a beneficiary to be improving."<sup>22</sup>

By 2011, The CMA,<sup>23</sup> published an excellent summary of Medicare Coverage for home health care and discussed the "Medicare Improvement Myth," stating, "[t]here is a long-standing myth that Medicare coverage is not available for beneficiaries who have an underlying condition from which they will not improve. This is not true."<sup>24</sup> The article discussed that Medicare coverage would be available for home health care when the beneficiary has no hope of improving but will need benefits to "maintain the person's condition or to arrest or retard further deterioration."<sup>25</sup> Further, the article states that, "[i]t is not necessary for the individual's underlying condition to improve to qualify for Medicare coverage!"<sup>26</sup>

### **JIMMO v. SEBELIUS**

#### **A. *Jimmo* Complaint Filed:**

On January 18, 2011, attorneys from the CMA,<sup>27</sup> filed a Class Action Complaint for Declaratory,

Injunctive, and Mandamus Relief, with the United States District Court for the District of Vermont against the CMS, *Jimmo v. Sebelius*.<sup>28</sup> The question of fact that was common to all class members was “that all class members have had their Medicare coverage reduced, denied, or terminated on the ground that their conditions were not improving.”<sup>29</sup> “The shorthand term for this rule of thumb masquerading as a condition of coverage is the Improvement Standard.”<sup>30</sup> The common question of law common to all class members was whether the Medicare statute was violated by imposing this “covert condition of eligibility.”<sup>31</sup> The Complaint defined the class action to include “All beneficiaries of Medicare Parts A, B, or C who have had or will have coverage for health care or therapy services, as an outpatient, in a hospital, in a SNF, or in a HH setting, denied, terminated, or reduced due to the application of the Improvement Standard, on or after January 1, 2006.”<sup>32</sup> The Complaint was filed as a Class Action lawsuit.<sup>33</sup>

#### **B. The Stories Behind the *Jimmo* Complaint:**

The named plaintiff in the Complaint was Glenda Jimmo, who was, during the periods at issue, a 71-year old resident of Vermont who was legally blind and had a below-the-knee amputation.<sup>34</sup> She also suffered from a number of very serious disorders,<sup>35</sup> from which her physician stated she was homebound and ordered skilled nursing and home health aide nursing services to be provided to her at her home.<sup>36</sup> Ms. Jimmo’s Medicare contractor denied payment for these services, stating that “[h]er condition was stable with no acute changes.”<sup>37</sup> Her claim was then considered and turned down through many of the parts of the Medicare appeals process, first by the Quality Improvement Organization (QIC), next by an administrative law judge (ALJ), and then by the Medicare Appeals Council (MAC).<sup>38</sup>

Plaintiff KR, during the periods at issue was a 48-year old severely disabled resident of Vermont, who suffered from congenital quadriplegia, patellofemoral syndrome, depression and significant cognitive impairments and required the use of a wheelchair or walker and the assistance of at least one person to go out.<sup>39</sup> Skilled physical therapy was ordered for her by her physician to evaluate her functional ability, perform therapeutic exercises, teach her transfer technique and gait training and develop a home exercise program.<sup>40</sup> Her claim for Medicare coverage was denied and this denial was affirmed by the QIC, which stated that the services would not be covered because there was not “a reasonable expectation that the beneficiary will show measurable improvement in performing normal daily activities.”<sup>41</sup> The ALJ then followed by relying on the Improvement Standard with a denial of Medicare coverage because there was no expectation that KR would show “material improvement.”<sup>42</sup>

Plaintiff Miriam Katz was the widow of David Katz and executor in her deceased husband’s will.<sup>43</sup> David Katz, a 90 year-old resident of Connecticut, had been in a SNF where Medicare covered his stay for 11 days when he received a notice that his stay would no longer be covered by Medicare because the care he was receiving was custodial and could be performed by unskilled aides.<sup>44</sup> This reason for denial was relied upon by the QIC in denying the coverage.<sup>45</sup>

Plaintiff Edith Masterman was a 79 year-old resident of Maine, who was a diabetic, had needed a wheelchair since she had become a paraplegic as a teenager and had, over the past 10 years developed a problem with pressure sores for which her doctor ordered HH wound care.<sup>46</sup> Medicare covered the cost of her HH wound care until after she required a stay in a hospital followed by a

SNF, when her HH agency told her that Medicare would not cover the wound care ordered by her doctor because the wound care was chronic and was not expected to heal.<sup>47</sup>

Plaintiff Mary Patricia Boitano was an 83 year-old resident of Rhode Island who was hospitalized for several serious issues after which she was transferred to a SNF.<sup>48</sup> After she was in the SNF for about three weeks she was notified that her Medicare coverage would stop because "[t]herapy services must . . . be reasonable in relation to the expected improvement in your condition."<sup>49</sup>

In addition to the above individual Plaintiffs several organizational Plaintiffs, listed in Endnote 1, joined the lawsuit. These organizations represented several million members across the United States.<sup>50</sup>

### C. The Law Behind the *Jimmo* Complaint:

- a. *The Regulatory Requirements* – The Complaint states that the Medicare statute does not claim that improvement is a condition of coverage.<sup>51</sup> The Complaint goes through the SNF, HH, OPT and all Service regulations to state that **all of these relevant regulations do not require any Improvement Standard.**<sup>52</sup> Citing the Medicare Benefit Policy Manual (Manual) the Complaint "states that the determination of whether a skilled service is reasonable and necessary cannot be based on 'rules of thumb' but instead requires assessment of the particular individual's need for care,"<sup>53</sup> and adds that the Manual states that "skilled care may . . . continue to be necessary for patients whose condition is stable."<sup>54</sup>

The Complaint states that "lower level decision-makers, however, rarely follow these regulatory and Manual prohibitions against the Improvement Standard."<sup>55</sup> These decision-makers often rely on Medicare contractor instructions and Local Coverage Determinations (LCDs), which often use language that forces an Improvement Standard.<sup>56</sup>

- b. *The Administrative Review Process* - The Complaint guides the Court through the rather complex administrative review process for Medicare, first for original Medicare (Parts A and B) and next for Medicare Part C (the Medicare Advantage program).<sup>57</sup> These reviews, for Medicare Parts A and B, start with a Medicare Summary Notice (MSN) of non-coverage from the contractor followed by a review of the initial determination, reconsideration by a QIC and an expedited determination by the Quality Improvement Organization (QIO), where a beneficiary who is denied may go back to the QIC for reconsideration.<sup>58</sup>

For claims under Part C, the Medicare Advantage Plan makes the first determination followed by the "Independent Review Entity (IRE), which is an external review organization hired by CMS . . . which will issue the reconsideration decision."<sup>59</sup>

After the above steps for review, what follows is the same for Parts A, B, and C, a de novo review by an ALJ, then an on-the-record review of the ALJ's decision by the MAC, and where the amount in controversy is above a certain amount (it was \$1300 in 2011), a review in federal district court is available.<sup>60</sup>

- c. *The Complaint's Requests* - The Complaint (and Amended Complaint) requests that the Judge declare that the use of the Improvement Standard violates the Medicare statute and

regulations and requests that the Judge order that such use be both retroactively prohibited and prohibited in the future.<sup>61</sup>

#### **D. The First Settlement of *Jimmo*:**

After numerous motions, orders, responses, and status reports, a thirty- two-page Proposed Settlement Agreement was filed with the Court on October 16, 2012.<sup>62</sup> As reported in the New York Times, the Proposed Settlement would end a longstanding practice that required beneficiaries to show improvement before they could be covered under Medicare.<sup>63</sup> “Under the agreement, which amounts to a significant change in Medicare coverage rules, Medicare will pay for such services if they are needed to ‘maintain the patient’s current condition or prevent or slow further deterioration,’ regardless of whether the patient’s condition is expected to improve.”<sup>64</sup>

On November 20, 2012, Judge Christina Reiss, signed an order that preliminarily approved the Settlement Agreement,<sup>65</sup> and on November 29, 2012 a Notice of Proposed Settlement of Class Action and of Fairness Hearing was filed with the Court and was to be posted on the websites of numerous organizations, including those of the national organizations who were plaintiffs in the case, by December 10, 2012.<sup>66</sup>

The proposed settlement of the lawsuit provided that the class would be defined as all Medicare beneficiaries who:

- a. received Services in a HH, SNF, or OPT setting; and
- b. received a denial of Medicare coverage based not on a need for skilled care but based on a lack of improvement potential that became final and non-appealable on or after January 18, 2011; and
- c. seek Medicare coverage on his or her own behalf.<sup>67</sup>

In the proposed settlement of the lawsuit, the defendant agreed that CMS would agree to do the following:

- a. Revise portions of the Manual to clarify coverage standards when a patient needs skilled HH, SNF or OPT services to maintain his or her current condition and has no potential for restoration and improvement.
- b. Implement a nationwide educational campaign, using interactive forums, and national calls to communicate the corrective maintenance coverage standards to providers, suppliers, contractors, and adjudicators.
- c. Perform random samplings of QIC decisions to determine if the corrected Medicare coverage policy is being used.
- d. Allow the re-review of the claims of certain class members whose claims had been denied because they had no potential for improvement but who needed skilled Services to maintain their current condition or slow further deterioration.
- e. Pay Plaintiff’s Counsel reasonable attorneys’ fees, costs and expenses.<sup>68</sup>

The Court agreed to maintain jurisdiction over the case for up to three years after the end of the nationwide educational campaign. During that time period either party could ask the Court to

enforce provisions of the settlement if it believed that the other party was not complying with the terms of the agreement.<sup>69</sup>

On January 24, 2013, an Order Granting Final Approval of the settlement Agreement was signed by Christina Reiss, Chief Judge of the United States District Court for the District of Vermont.<sup>70</sup> The Judge reported that a fairness hearing was held on that day and that the class was defined as set forth in Section XI of the Agreement (this class is listed above).<sup>71</sup>

## E. Implementation of the First *Jimmo* Settlement

Right after the final order was approved in January 2013, newspaper articles and healthcare associations published the results of the settlement<sup>72</sup> and CMS put out its first Fact Sheet.<sup>73</sup> This was followed by fairly significant updates to the Manual about a year later.<sup>74</sup> These updates state clearly in bold in the general Information section that **“No “Improvement Standard” is to be applied in determining Medicare coverage for maintenance claims that require skilled care.”**<sup>75</sup> Transmittal 179 provided that contractors and providers shall review and be aware of the Manual revisions and sets forth information regarding available instruction and the provider education article, which shall be posted on their Web sites.<sup>76</sup> This requirement referred to a “MLN Matters” four-page summary that was a summary of Transmittal 179.<sup>77</sup> Transmittal 179, published in January 2014, provided extensive revisions to the Medicare Benefit Policy Manual for Chapter 1 (Inpatient Hospital Services), Chapter 7 (Home Health Services), Chapter 8 (SNF services under Hospital Insurance), and Chapter 15 (Outpatient Therapy Services), **to make clear that an Improvement Standard shall not be applied.**<sup>78</sup>

## F. Problems Arise With Implementation of the First *Jimmo* Settlement

Plaintiffs in the *Jimmo* case began in 2014 to request that CMS do more to educate the providers and contractors who make the decisions in the Medicare program but met resistance from CMS.<sup>79</sup> In February, 2016, it was reported that the *Jimmo* message had not sunk in and that many coverage decisions were still being made as they had been in a pre-*Jimmo* world.<sup>80</sup> In early 2016, many people with chronic conditions who need nurses or therapy to maintain their current condition were still being denied Medicare coverage.<sup>81</sup> In fact, the General Counsel of the Paralyzed Veterans of America released a statement saying that her organization “has not received any information about the *Jimmo* Settlement, written or otherwise, from the Center for Medicare & Medicaid Services,”<sup>82</sup> and the president of the American Physical Therapy Association, found that more than two years after the CMS educational campaign, “[w]e have found many providers who have not yet received any information regarding the settlement . . . or remain confused about the proper application of the skilled maintenance therapy benefit.”<sup>83</sup>

## G. Back to Court

On March 1, 2016, the Plaintiffs in the *Jimmo* case went back to the United States District Court for the District of Vermont to request that the Judge in the original case grant the Plaintiffs more time to have her enforce her January 24, 2013 Order and on April 19, 2016 more time was granted to the Plaintiffs.<sup>84</sup>

On August 17, 2016, Judge Christina Reis, issued an order that requires CMS to propose corrective

action for its failure to convey the “accurate provision of information regarding the maintenance coverage standard.”<sup>85</sup> The Court found that “this was what the Plaintiffs bargained for and their rights under the Settlement Agreement would be meaningless without it.”<sup>86</sup>

On February 1, 2017, the judge held that the Health and Human Services Secretary had not fully implemented the Educational Campaign required by the previous *Jimmo* settlement agreements and required that by September 4, 2017, CMS shall implement the following as a Corrective Action Plan:

- a. Publish a new CMS webpage dedicated to *Jimmo*;
- b. Publish a Corrective Statement disavowing the Improvement Standard and explaining the Maintenance Coverage Statement for all Services;
- c. Post Frequently Asked Questions;
- d. Develop and implement new training for contractors making coverage decisions; and
- e. Conduct a new national call to explain the policy behind the Corrective Statement.<sup>87 88</sup>

Judith Stein, Executive Director of CMA, noted that

With the imprimatur of CMS on the [Corrective] Statement, which specifically notes that the *Jimmo* settlement represents a ‘change in practice,’ Medicare adjudicators and providers should have no doubt about what the correct coverage policy is. This should open doors to critically important care for people with long-term debilitating and chronic conditions.<sup>89</sup>

#### H. CMS Complies with the New *Jimmo* Settlement

In complying with the *Jimmo* settlement above,<sup>90</sup> in August 2017, CMS issued a new webpage dedicated to *Jimmo*.<sup>91</sup> The website contains a one-page statement entitled “Important Message About the *Jimmo* Settlement,”<sup>92</sup> which clarifies that, provided that all other coverage criteria are met, Medicare will cover “skilled care in order to maintain function or to prevent or slow decline or deterioration,” of a beneficiary.<sup>93</sup> The CMS webpage states that the *Jimmo* Settlement, which applies to health care in HH, SNF, OPT and IRF settings, “may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers . . . these benefits only when a beneficiary is expected to improve.”<sup>94</sup>

Following the *Jimmo* webpage are fifteen frequently asked questions that dispel many mistaken beliefs including stating clearly that coverage “does not turn on the presence or absence of a beneficiary’s potential for improvement or restoration, but rather on the beneficiary’s” need for skilled care.”<sup>95</sup> In addition, CMA reports that CMS will now implement an educational campaign to ensure that Medicare determinations “turn on the need for skilled care and not on the ability of an individual to improve.”<sup>96</sup>

#### I. Mistakes Continue to be Made Even After New *Jimmo* Settlement

The *Jimmo* settlement discussed above found that Medicare will cover Services not only to improve a patient’s condition “but **equally to maintain or slow the decline** of a patient’s condition.”<sup>97</sup> Despite the careful and very complete work of CMA,<sup>98</sup> and the work of CMS as a result of the *Jimmo* case, “[s]adly, seven-years later, beneficiaries and their families are still being denied skilled care on the basis of an erroneous ‘Improvement Standard.’”<sup>99</sup> One case discussed by the CMA explored the case of a Medicare beneficiary whose son stated that his father’s Medicare coverage was

terminated in the year 2020 by a SNF because his father had ‘plateaued’ and was not making progress in skilled therapy.<sup>100</sup> “Myths die hard,” said the President of the National Association for Home Care in 2018 in an article in Home Health Care News, which stated, “[s]ome home health care providers believe that chronically ill patients who stand no chance of getting better don’t qualify for Medicare coverage – but they’re mistaken.”<sup>101</sup>

Another new issue that appears to be confusing some Medicare Providers is a recent confusion with the new Patient Driven Payment Model (PDPM) and the Patient-Driven Groupings Model (PDGM).<sup>102</sup> Although “these payment models do **not** change Medicare coverage and eligibility criteria,<sup>103</sup> it appears that these models are confusing some agencies into thinking that Medicare will no longer pay for necessary Services when a patient is not going to improve but still needs professional Services.<sup>104</sup> As CMA says, “patient care needs must still be based on clinical standards and judgment.”<sup>105</sup>

The Center for Medicare Advocacy is the place to turn for Medicare recipients or their families who believe that the Medicare recipient has been unfairly denied coverage for a condition that will not improve but requires professional or semi-professional help to maintain the patient’s condition or help prevent further decline. CMA has been very helpful to the author’s family and she thanks them for their dedication to this important cause for so many Americans.<sup>106</sup>

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<sup>1</sup> See **a.** *Jimmo v. Sebelius*, No. 5:11-CV-17, (D. Vt. filed January 18, 2011) [**hereinafter Complaint**]. <https://www.courtlistener.com/recap/gov.uscourts.vtd.19913.1.0.pdf> In this case the CMS was represented on behalf of the Secretary of Health and Human Services, then Kathleen Sebelius, who was responsible for the overall operation of the Medicare program through the Health and Human Service division known as CMS and CMA represented the class consisting of the following: Glenda Jimmo, KR, Miriam Katz, Edith Masterman, Mary Patricia Boitano, National Committee to Preserve Social Security and Medicare, National Multiple Sclerosis Society, Parkinson’s Action Network, Paralyzed Veterans of America, and American Academy of Physical Medicine and Rehabilitation, on behalf of themselves and all others similarly situated.

**b.** In an amended complaint, Document 13, filed March 3, 2011 <https://www.medicareadvocacy.org/wp-content/uploads/2012/11/Amended-Complaint-FILED.030311.pdf> [**hereinafter Amended Complaint**], the following class members were added to the Complaint: Alzheimer’s Disease and Related Disorders Association, Inc., Rosalie McGill, and United Cerebral Palsy.

**c.** *Jimmo v. Burwell*, No. 5:11-CV-17-CR, Opinion and Order Granting In Part And Denying In Part Plaintiff’s Motion For Resolution and Non Compliance With Settlement Agreement, (D. Vt. August 17, 2016) (Doc. 94). <https://www.courtlistener.com/recap/gov.uscourts.vtd.19913/gov.uscourts.vtd.19913.106.0.pdf>

**d.** *Jimmo v. Burwell*, No. 5:11-CV-17-CR, (D. Vt. February 1, 2017), Opinion and Order Adopting Defendant’s Corrective Action Plan and Mandating Two Additional Requirements (Doc. 111-114). <https://www.courtlistener.com/recap/gov.uscourts.vtd.19913/gov.uscourts.vtd.19913.115.0.pdf>

<sup>2</sup> Title 18 42 U.S.C. §1395 et. (Seq. Social Security Act)

<sup>3</sup> See THE OFFICIAL U.S. GOVERNMENT MEDICARE HANDBOOK, MEDICARE AND YOU, 2020, p 7-8

<sup>4</sup> See Physical therapy, occupational therapy, and speech-language pathology services, 42 C.F.R. § 409.23; Criteria for skilled services and the need for skilled services, 42 C.F.R. § 409.32; Examples of skilled nursing and rehabilitation services, 42 C.F.R § 409.33; Skilled services requirements, 42 C.F.R. § 409.44.

<sup>5</sup> *Fox v. Bower*, 656 F. Supp. 1236 (D. Conn. 1987), p1252-1253

<sup>6</sup> *Id.* at 1248

<sup>7</sup> *Smith on Behalf of McDonald v. Shala*, 855 F. Supp. 658 (D. Vt. 1994)

<sup>8</sup> *Id.* at 660



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<sup>9</sup> *Id.* at 664

<sup>10</sup> *Id.* at 665

<sup>11</sup> *See Id.* at 666

<sup>12</sup> Ctr. for Medicare Advoc., *Medical Necessity Determinations in the Medicare Program: Are the Interests of Beneficiaries with Chronic Conditions Being Met?* (Vicki Gottlich, Jan. 2003)

<sup>13</sup> *Id.* at 7, (The derivation of the term LMRP is discussed in Endnote 14 of Ms. Gottlich's paper).

<sup>14</sup> *Id.* at 7 (These LMRPs "are not binding on Administrative Law Judges in administrative appeals.)

<sup>15</sup> *Id.* at 28

<sup>16</sup> *Id.* at 28 and 30

<sup>17</sup> Ctr. for Medicare Advoc., *Illegal "Improvement Standard" for SNF Coverage Terminated*, (July 8, 2004)

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* Citing 42 C.F.R. § 409.32(c)

<sup>20</sup> *Supra* at Endnote 17

<sup>21</sup> How the 'Improvement Standard' Improperly Denies Coverage to Medicare Patients with Chronic Conditions – text of article printed in *Clearinghouse Review*, Vol. 43, No. 9-10, Jan-Feb. 2010, found in Ctr. for Medicare Advoc. article, (February 22, 2010)

<sup>22</sup> *Id.* at 1

<sup>23</sup> The Center for Medicare Advocacy, established in 1986, is a national nonprofit, nonpartisan law organization that provides education, advocacy and legal assistance to help older people and people with disabilities obtain access to Medicare and quality health care.

<sup>24</sup> Ctr. for Medicare Advoc., *A Brief Summary of Medicare Coverage for Home Health Care and the Improvement Myth*, at 3. This was part of the Center for Medicare Advocacy's Medicare Home Health Self Health Packet (2011).

<sup>25</sup> *Id.* at 5

<sup>26</sup> *Id.* at 5

<sup>27</sup> *Supra* at Endnote 23

<sup>28</sup> *See* Complaint and Amended Complaint.

<sup>29</sup> Complaint at 6-7 ¶21; Amended Complaint at 7 ¶ 24.

<sup>30</sup> Complaint at 2 ¶ 2; Amended Complaint at 2 ¶ 2.

<sup>31</sup> Complaint at 6-7 ¶21; Amended Complaint at 7 ¶ 24.

<sup>32</sup> Complaint at 6 ¶ 19; Amended Complaint at 7 ¶ 22

<sup>33</sup> *See* Complaint at 6 ¶ 19; Amended Complaint at 7 ¶ 22 (Class Action Allegations)

<sup>34</sup> Complaint at 14-15 ¶ 45; Amended Complaint at 15 ¶ 47.

<sup>35</sup> Complaint at 14-15 ¶ 45; Amended Complaint at 15 ¶ 47. These serious disorders included diabetes mellitus with circulatory disorder, transient cerebral ischemia, peripheral vascular disease, angina and diverticulitis.

<sup>36</sup> Complaint at 15 ¶ 46; Amended Complaint at 15-16 ¶ 49.

<sup>37</sup> Complaint at 15 ¶ 47; Amended Complaint at 16 ¶ 50

<sup>38</sup> Complaint at 15-16 ¶ 47-51; Amended Complaint at 16-17 ¶ 50-54

<sup>39</sup> Complaint at 16-17 ¶ 52; Amended Complaint at 17 ¶ 55

<sup>40</sup> Complaint at 17 ¶ 55; Amended Complaint at 18 ¶ 58

<sup>41</sup> Complaint at 17 ¶ 56-57; Amended Complaint at 17 ¶ 59-60

<sup>42</sup> Complaint at 18 ¶ 59; Amended Complaint at 16-17 ¶ 62

<sup>43</sup> Complaint at 18 ¶ 61; Amended Complaint at 19 ¶ 64

<sup>44</sup> Complaint at 19 ¶ 64; Amended Complaint at 19-20 ¶ 67

<sup>45</sup> *Id.*

<sup>46</sup> Complaint at 19 ¶ 66 & 67; Amended Complaint at 20 ¶ 69 &70

<sup>47</sup> Complaint at 19 -20 ¶ 67-68; Amended Complaint at 20 ¶ 70-71

<sup>48</sup> Complaint at 21 ¶ 75-76; Amended Complaint at 22 ¶ 78-80

<sup>49</sup> Complaint at 22 ¶ 76-78; Amended Complaint at 22 ¶ 79-81

<sup>50</sup> American Health Care Association (AHCA), Memorandum from Elise D. Smith, AHCA SVP Finance Policy and Legal Affairs to AHCA Members. The subject was the Final Settlement of *Jimmo v. Sebelius*, approved 1/24/2013, and the date of the Memorandum is February 7, 2013, [hereinafter AHCA Memorandum] p 10

<sup>51</sup> Complaint at 8 ¶ 27; Amended Complaint at 9 ¶ 30

<sup>52</sup> Complaint at 9 ¶ 29-30; Amended Complaint at 9-10 ¶ 30-33. See SNF requirements; 42 C.F.R. § 409.32(c) and 42 C.F.R. § 409.44(b)(i); HH Skilled Nursing Care requirements, 42 C.F.R. § 409.44(a) and 42 C.F.R. § 409.44(b)(3)(iii), HH; and Physical therapy, occupational therapy, and speech-language pathology services. Requirements, 42 C.F.R. § 409.44(c)(ii).

<sup>53</sup> Complaint at 9-10 ¶ 31; Amended Complaint at 10 ¶ 34 (Citing Internet only manual (IOM) 100-02, M.B.P.M., ch. 7, §§ 20.3, 40.2).

<sup>54</sup> Complaint at 10 ¶ 31; Amended Complaint at 10 ¶ 34 (Citing Internet only manual (IOM) 100-02, M.B.P.M., ch. 7, §§ 20.3, 40.1.1.).

<sup>55</sup> Complaint at 10 ¶ 32; Amended Complaint at 11 ¶ 35.

<sup>56</sup> *Id.*

<sup>57</sup> Complaint at 11-13 ¶ 33-40; Amended Complaint at 11-13 ¶ 36-43 (The Administrative Review Process).

<sup>58</sup> Complaint at 11 ¶ 33-35; Amended Complaint at 12 ¶ 36-38.

<sup>59</sup> Complaint at 12 ¶ 37; Amended Complaint at 12-13 ¶ 40.

<sup>60</sup> Complaint at 11-12 ¶ 36 and 38; Amended Complaint at 12-13 ¶ 39 and 41.

<sup>61</sup> Complaint at 32-34 ¶ 123- 131 and XVI, Prayer for Relief, 34-36; Amended Complaint at 41-44 ¶ 152- 160 and XVI, Prayer for Relief, 42-44.

<sup>62</sup> *Jimmo v. Sebelius*, No. 5:11-CV-17-CR, [Proposed] Settlement Agreement, (D. Vt. filed Oct. 16, 2012), Document 82-1.

<sup>63</sup> Robert Pear, Settlement Eases Rules for Some Medicare Patients, N.Y. Times, Oct. 22, 2012.

<https://www.nytimes.com/2012/10/23/us/politics/settlement-eases-rules-for-some-medicare-patients.html> (Accessed November 16, 2012)

<sup>64</sup> *Id.* This article is what made the author aware of the good work by the Ctr. for Medicare Advoc. The author was able to use the forms set out by the Ctr. for Medicare Advoc. to request payment for her mother's care by Genesis Healthcare in Lebanon, NH. Her mother had stopped improvement as of July 2012 and the author had been paying for her occupational therapy for several months. Fortunately, Genesis Healthcare reimbursements to the author's mother were made promptly. This unfortunately, was not the case for all beneficiaries.

<sup>65</sup> *Jimmo v. Sebelius* No. 5:11-CV-17-CR, Order Preliminary Approving Settlement Agreement, Preliminary Certifying the Class, Approving Class Notice, and Setting Fairness Hearing, (D. Vt. filed Nov. 20, 2012) Document 86.

<sup>66</sup> *Jimmo v. Sebelius*, No. 5:11-CV-17-CR, Notice of Proposed Settlement of Class Action and of Fairness Hearing, (D. Vt. filed Nov. 29, 2012) Document 87.

<sup>67</sup> *Id.* at 2

<sup>68</sup> *Id.* at 3-4

<sup>69</sup> *Id.* at 4

<sup>70</sup> *Jimmo v. Sebelius* No. 5:11-CV-17-CR, Order Granting Final Approval of Settlement Agreement and Directing Entry of Final Judgement, (D. Vt. Filed Jan. 24, 2013) Document 92 (signed by Christina Reiss, Chief Judge).

<sup>71</sup> *Id.* at 2

<sup>72</sup> See generally Susan Jaffe, Therapy Plateau No Longer Ends Coverage, N.Y. Times Feb. 4, 2013.

<https://newoldage.blogs.nytimes.com/2013/02/04/therapy-plateau-no-longer-ends-coverage/>; Elise D. Smith, Memorandum to American Health Care Ass'n Members; Jimmo Settlement Summary Feb. 7, 2013; MS, National Multiple Sclerosis Society, Judge Approves Settlement in Jimmo vs. Sebelius After Court Hearing, Jan. 24, 2013, <https://www.nationalmssociety.org/About-the-Society/News/Judge-Approves-Settlement-in-Jimmo-vs-Sebelius-Aft>.

<sup>73</sup> Cents. for Medicare & Medicaid Servs., *Jimmo v. Sebelius* Settlement Agreement Fact Sheet, April 4, 2013, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf> (accessed April 22, 2020). This was followed by a *Jimmo v. Sebelius* Settlement Agreement Program Manual Clarifications Fact Sheet updated Program Manual Clarifications Fact Sheet the next year, [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo\\_fact\\_sheet2\\_022014\\_final.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf) (accessed April 22, 2020)

<sup>74</sup> CMS Manual System Pub 100-2 Medicare Benefit Policy, Transmittal 179, Department of Health & Human Services, Cents. for Medicare & Medicaid Servs., Jan. 14, 2014, Change Request 8458.

<sup>75</sup> *Id.* at page 5

<sup>76</sup> *Id.* at page 8

<sup>77</sup> *Id.* at page 8. Referring to MLN Matters “Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*” <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf> (Accessed April 22, 2020)

<sup>78</sup> See *Supra* note 74 and changes to the Medicare Benefit Policy (Ch. 1, § 110.3); (Ch. 7, §§ 20.1.2, 40.1–40.2); (Ch. 8 §§ 30.2-30.4); (Ch. 15 §§ 220, 220.2-220.3, 230.1.2).

<sup>79</sup> Ctr. for Medicare Advoc., *Jimmo v. Sebelius* Judge Orders Medicare Agency to Comply with Settlement in “Improvement Standard” Case, Provide More Education, Aug. 2016. <https://www.medicareadvocacy.org/jimmo-motion-for-resolution-of-non-compliance/> (Accessed April 22, 2020)

<sup>80</sup> See PT In Motion News, *Jimmo Message Hasn’t Sunk In; CMS Needs to Do More*, (Feb. 6, 2016) <https://www.apta.org/PTinMotion/News/2016/2/8/JimmoDeclaration/> (Accessed April 22, 2020)

<sup>81</sup> Dan Colton, *Vermont Renews Medicare Suit*, The Barre Montpelier Time Argus, March 7, 2016, citing Michael Benvenuto, an attorney with Vermont Legal Aid, Inc. [https://www.timesargus.com/news/vermonter-renews-medicare-suit/article\\_c0f1a850-9ed3-51e3-a1f6-f99b546d0501.html](https://www.timesargus.com/news/vermonter-renews-medicare-suit/article_c0f1a850-9ed3-51e3-a1f6-f99b546d0501.html) (Accessed April 22, 2020).

<sup>82</sup> Dan Colton, *Vermont Renews Medicare Suit*, The Barre Montpelier Time Argus, March 7, 2016. [https://www.timesargus.com/news/vermonter-renews-medicare-suit/article\\_c0f1a850-9ed3-51e3-a1f6-f99b546d0501.html](https://www.timesargus.com/news/vermonter-renews-medicare-suit/article_c0f1a850-9ed3-51e3-a1f6-f99b546d0501.html) (Accessed April 22, 2020).

<sup>83</sup> *Id.*

<sup>84</sup> MOTION to Enforce Judgment for Resolution of Noncompliance with Settlement Agreement filed by Glenda Jimmo. March 1, 2016 (Document 94); ORDER Granting 99 Stipulated Motion for Extension of Time to File Response to 94 Motion to Enforce Judgment for Resolution of Noncompliance with Settlement Agreement. Signed by Chief Judge Christina Reiss on April 19, 2016. (This is a text-only Order) (Document 100).

<sup>85</sup> *Jimmo v. Burwell* No. 5:11-CV-17-CR, (D. Vt. Aug. 17, 2016), Opinion and Order Granting In Part And Denying In Part Plaintiff’s Motion For Resolution and Non Compliance With Settlement Agreement, (Doc. 94), p. 20-21. <https://www.courtlistener.com/recap/gov.uscourts.vtd.19913/gov.uscourts.vtd.19913.106.0.pdf>

<sup>86</sup> *Id.*

<sup>87</sup> *Jimmo v. Burwell* No. 5:11-CV-17-CR, (D. Vt. Feb. 1, 2017), Opinion and Order Adopting Defendant’s Corrective Action Plan and Mandating Two Additional Requirements (Doc. 111-114). <https://www.courtlistener.com/recap/gov.uscourts.vtd.19913/gov.uscourts.vtd.19913.115.0.pdf>

<sup>88</sup> See Patrick Connoles, *U.S. District Court Judge Orders CMS To Comply With Jimmo Settlement*, Provider, Long Term & Post-Acute Care, Feb. 3, 2017.

<http://www.providermagazine.com/news/Pages/2017/0117/FEBRUARY%202017/U-S--District-Court-Judge-Orders-CMS-To-Comply-With-Jimmo-Settlement.aspx?PF=1>

<sup>89</sup> Ctr. for Medicare Advoc., Court Orders Corrective Action Plan for Government’s Noncompliance with Settlement in *Jimmo v. Burwell*, Center for Medicare Advocacy, Feb. 2, 2017. <https://www.medicareadvocacy.org/court-orders-corrective-action-plan-for-governments-noncompliance-with-settlement-in-jimmo-v-burwell/>

<sup>90</sup> See note 87

<sup>91</sup> *Jimmo* Settlement; Important Message About the *Jimmo* Settlement, CMS.gov Centers for Medicare and Medicaid Services, Aug. 2017. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>

<sup>92</sup> *Id.*

<sup>93</sup> Ctrs. for Medicare & Medicaid Servs., *Jimmo* Settlement, Important Message About the *Jimmo* Settlement, August 2017. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>

<sup>94</sup> *Id.*

<sup>95</sup> Ctrs. for Medicare & Medicaid Servs., Frequently Asked Question (FAQs) Regarding *Jimmo* Settlement Agreement, Aug. 2017, *citing* Question 4. <https://www.cms.gov/Center/Special-Topic/Jimmo-Settlement/FAQs>

<sup>96</sup> Ctr. for Medicare Advoc., Improvement Standard and *Jimmo* News, *Jimmo* Corrective Action Plan Completed, CMS Adds Resources Regarding Medicare Coverage To Help People Who Need Skilled Maintenance Nursing or Therapy, March 2020, p.3 <https://www.medicareadvocacy.org/medicare-info/improvement-standard/>

<sup>97</sup> Ctr. For Medicare Advoc., Incorrect Implementation of the *Jimmo v. Sebelius* Settlement in A Skilled Nursing Facility: A Case Study, Jan. 2020. <https://www.medicareadvocacy.org/incorrect-implementation-of-the-jimmo-v-sebelius-settlement-in-a-skilled-nursing-facility-a-case-study/>

<sup>98</sup> See generally many references in this article.

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<sup>100</sup> *Id.*

<sup>101</sup> Tim Regan, *Home Health Industry Dogged by Improvement Standard Myths*, Home Health Care News, Jan. 17, 2018. <https://homehealthcarenews.com/2018/01/home-health-industry-dogged-by-improvement-standard-myths/>

<sup>102</sup> Ctrs. for Medicare & Medicaid Servs., *Patient-Driven Groupings Model* <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf>

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<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM>

<sup>103</sup> Ctr. For Medicare Advoc., *The Jimmo v. Sebelius Settlement Agreement: An Issue Brief for Medicare Providers*, Jan. 2020, <https://www.medicareadvocacy.org/jimmoproviderbrief/>

<sup>104</sup> Judith Graham, *Medicare Payment Change is Making it Harder for Some Patients to Get Home Health Care*, The Washington Post, Feb. 15, 2020 [https://www.washingtonpost.com/health/medicare-payment-change-is-making-it-harder-for-some-patients-to-get-home-health-care/2020/02/14/a8aaf43c-46ad-11ea-bc78-8a18f7afcee7\\_story.html](https://www.washingtonpost.com/health/medicare-payment-change-is-making-it-harder-for-some-patients-to-get-home-health-care/2020/02/14/a8aaf43c-46ad-11ea-bc78-8a18f7afcee7_story.html) (Accessed Feb. 16, 2020)

<sup>105</sup> See generally Ctr. For Medicare Advoc., *The Jimmo v. Sebelius Settlement Agreement: An Issue Brief for Medicare Providers*, January 2020. <https://www.medicareadvocacy.org/jimmoproviderbrief/>

<sup>106</sup> Ctr. for Medicare Advoc., *Improvement Standard and Jimmo v. Sebelius, Jimmo Corrective Action Completed*, March 2020. <https://www.medicareadvocacy.org/medicare-info/improvement-standard/>; Ctr. for Medicare Advoc., *Self-Help Resources for Improvement Standard Denials*, August 1, 2019. <https://www.medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals/>