Health Care Litigation | Alert

February 2017

Medicare Ordered to Provide Educational Outreach on Skilled Nursing Services

On Feb. 1, 2017, the U.S. District Court for the District of Vermont[1] adopted settlement terms proposed primarily by the Centers for Medicare & Medicaid Services (CMS) requiring the agency to implement a corrective action plan to ensure it educates health care providers, Medicare contractors, adjudicators, and other stakeholders that Medicare skilled nursing service beneficiaries do not need to show continued improvement in order to satisfy eligibility requirements—the so-called "Improvement Standard." The Medicare skilled nursing services benefit includes coverage of skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) services for Medicare parts A and B. The case is *Jimmo v. Burwell*.[2]

The Order and Corrective Action Plan (Order) are the result of a 2011 class action lawsuit filed against CMS by the Center for Medicare Advocacy, Inc. and Vermont Legal Aid, Inc., which alleged that CMS "impose[d] a covert rule of thumb" that beneficiaries must demonstrate "continued improvement" in order to be eligible for skilled nursing services. Plaintiffs alleged that CMS had failed to live up to obligations under the original settlement and sought to enforce that settlement. The Feb. 1, 2017, order was a result of that enforcement action.

The Improvement Standard's application to claims is alleged to have resulted in the termination, reduction, and or denial of coverage for thousands of Medicare beneficiaries.[3] Medicare must cover skilled care and therapy when they are "necessary to maintain the patient's current condition or prevent or slow further deterioration" (Maintenance Coverage Standard).

[1] It is unclear how one should characterize the court's order. If it is viewed as the equivalent of a preliminary or final injunction, then the Government (or plaintiff) could appeal within 60 days. If the court's order is viewed as judgment, then either party has until March 1, 2017 to seek an amendment or other form of reconsideration. The Government has until March 1, 2017, to file a motion pursuant to Rule 59 of the Federal Rules of Civil Procedure.

[2] *Jimmo v. Burwell*, No. 5:11-CV-17 (D. Vt. Aug. 17, 2016).

[3] *Jimmo v. Sebelius*, No. 5:11-CV-17 (D. Vt. Oct. 25, 2011).

In 2013, CMS entered into a settlement in which it agreed to educate its Medicare Administrative Contractors (MACs) who review and decide Medicare claims, that otherwise eligible Medicare beneficiaries receiving skilled nursing services do not need to show continued improvement in order to continue to receive the benefit.

In the present lawsuit, the plaintiffs alleged, and the court agreed, that CMS' educational campaign had been "so confusing and inadequate that little had changed." Providers and contractors have continued to deny claims when beneficiaries have not shown improvement. Specifically the court concluded that CMS had not adequately disavowed the use of the Improvement Standard or properly disseminated the Maintenance Coverage Standard.

Patients with chronic diseases—such as dementia, Parkinson's, arthritis, and heart failure—are particularly unlikely to improve over time and may have been particularly vulnerable to having their claims denied under the Improvement Standard. These types of patients particularly benefit from skilled nursing services because the benefit can help them maintain their functioning.

Under this second settlement, the court is requiring CMS to:

- "Disavow" the so-called "Improvement Standard" as improper under Medicare policy, including for Home Health.
- Issue a Technical Direction Letter to MACs directing them to conduct additional training on the manual clarification.
- Develop a new website devoted to the 2013 settlement that will include information on how claims should be handled, as well as a simple explanation that improvement is not a criterion for coverage.
- Provide a statement on the website that "the Medicare program will pay for skilled nursing care and skilled rehabilitation services when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met)."

Implications for Skilled Nursing Beneficiaries

While the court's order does not affect beneficiaries who have already been denied coverage, the court order may be helpful for claims presently under appeal if the claim denial appears to be based on the Improvement Standard being applied. Beneficiaries with chronic diseases should be particularly heedful of claims for skilled nursing services that have been denied.

Indications that a claim was denied based on the Improvement Standard may include notations from providers or MACs that the beneficiary is "not improving," has "reached a plateau," is "stable and chronic," or has achieved "maximum functional capacity."

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