

Lost in Translation: The *Jimmo* Case as Policy Implementation Failure

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Abstract

The *Jimmo* case involved a 2011 lawsuit against the Centers for Medicare and Medicaid Services (CMS) alleging they illegally used an improvement standard instead of a need standard to make coverage decisions for Medicare home health and other Medicare beneficiaries. In 2013 CMS and the plaintiffs reached a settlement with CMS agreeing to replace the improvement standard with a need standard and conduct an education campaign to ensure its proper implementation. A literature review indicates no studies on the nature, significance, or impacts of the *Jimmo* case in Medicare home health. The current study is an initial, exploratory study to address the literature gap, based on interviews of a convenience sample of 28 home care nurses between January 2019 and May 2019 in the New York City metropolitan area. Results indicate nurses believe they had little to no knowledge of the *Jimmo* case; there was limited communication about the case from their agencies; they lacked guidance on the implications of the case on intake and eligibility decisions; they received no guidance on the impact of the case on documentation; and that their lack of knowledge and guidance had adverse impacts on patients.

Keywords

Medicare, nurses, home health, *Jimmo* case, improvement standard, need standard, Medicare coverage

Establishing Context

According to the Centers for Medicare Advocacy (CMA),¹ on January 24, 2013, a federal district court approved a settlement agreement in *Jimmo v. Sebelius*, No. 5:11-CV-17 (D. VT). The *Jimmo Settlement* confirmed that Medicare home health coverage should be determined based on a beneficiary's need for skilled nursing or physical, speech or occupational therapy care (the so-called need standard), not on the individual's potential for improvement (the improvement standard). CMA and Vermont Legal Aid filed a national class action lawsuit January 18, 2011 alleging the improvement standard had been used as a rule of thumb to deny or terminate Medicare home health beneficiary coverage in violation of the Medicare law, Administrative Procedure Act, Freedom of Information Act, and the Due Process Clause of the Fifth Amendment of the United States Constitution. The lead plaintiff was Glenda Jimmo, a 78-year-old blind Medicare home health beneficiary and mother of four from Bristol, Vermont who had her right leg amputated due to complications from diabetes. She required a wheelchair and received multiple weekly home care visits. She was denied Medicare home health coverage because her condition was deemed unlikely to improve.

The *Jimmo* Settlement applies to all Medicare beneficiaries in home health, skilled nursing facilities, outpatient therapy, and inpatient rehabilitation hospitals and facilities, regardless of whether they are enrolled in traditional Medicare or a Medicare Advantage plan. The Settlement required the

Centers for Medicare & Medicaid Services (CMS) to confirm that coverage of skilled nursing or therapy is available to maintain or slow decline of an individual's condition for beneficiaries in home health, skilled nursing facility, or outpatient settings. According to CMA,¹ the Settlement required CMS to conduct an educational campaign to inform Medicare providers and decision-makers that Medicare-covered skilled services include care that improves, maintains, or slows decline of a patient's condition. The settlement emphasized that Medicare coverage should not be denied solely because an individual has an underlying condition that will not improve such as Multiple Sclerosis, Amyotrophic lateral sclerosis (ALS), Parkinson's disease, or paralysis. CMS published revisions to various chapters of the Medicare Benefit Policy Manual and began the educational campaign December 13, 2013. The campaign included transmittals, memoranda, national calls and other efforts to educate Medicare providers, contractors, and others to the fact coverage decisions should be based on need and that there is no improvement standard.

CMA went back to court in 2017 asserting that CMS had not properly implemented the educational campaign.¹ The court agreed and ordered CMS to implement a corrective

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action plan, which included creation of a CMS webpage dedicated to the *Jimmo* case on the CMS website; publication of a corrective statement disavowing the improvement standard; posting of Frequently Asked Questions (FAQs) and new training for Medicare contractors who are responsible for coverage decisions on claims submitted by home health agencies and other providers included in the *Jimmo* settlement.

On October 4, 2018 CMA² released a “recently completed” survey of providers and advocates which found almost 40% had not heard of the *Jimmo* decision; 30% remained unaware the Medicare coverage depends on need and not the beneficiary’s improvement potential; and 70% were unaware of CMS’ *Jimmo* educational campaign.

Study Purpose and Rationale

A literature review was conducted to determine the nature and extent of studies on implementation of the *Jimmo* case settlement by Medicare providers. The literature review used Cinahl, PubMed, Medline, Cochrane Library, Campbell Collaboration, PsycINFO, Sociological Abstracts, and Social Science Abstracts databases with a search period of January 1, 1965 through December 31, 2018, followed by an update after the study covering January 1, 2019 to December 31, 2019. Multiple keywords were used in the search: *Jimmo* case; Medicare home care; improvement standard; need standard; Medicare coverage; and home care nursing. The searches yielded multiple articles about the *Jimmo* case but no studies on its implementation in home health agencies, nursing homes, outpatient locations or inpatient rehabilitation hospitals or facilities.

The present study is the result of the gap in the existing literature. The study focus is specifically on implementation of the *Jimmo* case in Medicare-certified home health agencies. The article presents the results of an exploratory research study of 28 home care nurses in the New York City metropolitan area between January 2019 and May 2019. Nurses were selected because they are responsible for intake, eligibility, plan of care, and discharge decisions for home care patients. The study used interviews to probe nurses’ perceptions of the nature and extent of their knowledge of the *Jimmo* case; perceptions of the extent to which Medicare contract intermediaries’ coverage decisions have been based on need versus improvement standard; perceptions of the nature and extent of their agencies’ guidance on standards for coverage decisions; and the impact on patients of their resulting practice decisions, including developing and implementing plans of care and making coverage decisions.

Study Method

The study used a grounded theory approach.³ Grounded theory is the research methodology of choice because it was developed for interpreting qualitative data in the absence of a pre-existing theory. Data were collected through interviews

of the 28 home care nurses, selected from the New York City metropolitan area between January 2019 and May 2019. Participants were selected using a snowball convenience sampling technique, whereby home care industry professionals known to the author identified potential interviewees. The 28 nurses came from 22 different agencies. In-person interviews were conducted at locations convenient to participants and off-site from where they worked. An interview guide was used to help standardize the data collection, and all participants were assured of anonymity and confidentiality through an informed consent form they signed. Qualitative analysis began shortly after the initial data were collected and resulted in additional questions and probes that were applied to subsequent interviews, in an ongoing iterative process. Analysis followed the grounded theory three-stage coding of interview data: open, axial, and selective coding.

Open coding was used to fracture the data to “identify some categories, their properties, and dimensional locations” (p. 97).³ The coding and classification generated a list of 268 codes. Code and category labels were created, systematically sorted, compared, and contrasted until they were complete, with no new codes or categories produced and all data accounted for. Through axial coding, multiple phenomena were identified from the connected categories and subcategories. These phenomena included home care nurses’ perceptions of the nature and extent of their knowledge of the *Jimmo* case; perceptions of the extent to which Medicare contract intermediaries’ coverage decisions have been based on need versus improvement standard; perceptions of the nature and extent of their agencies’ guidance on standards for coverage decisions; and the impact on patients of their resulting practice decisions, including developing and implementing plans of care and making coverage decisions.

Finally, using selective coding, a “story line” was identified and a “story” written that integrated the axial coding phenomena.³ The story that emerged was the influence of Medicare home health’s lack of coverage of substance use and abuse on patients, caregivers, and payers.

In keeping with the grounded theory approach, the data analysis and interpretation were facilitated by analytical and self-reflective memo writing, which helped move empirical data to a conceptual level; expanded and refined the data and codes; developed core categories and interrelationships; and integrated the experiences, interactions, and processes embodied in the data.³ All initial abstraction, analysis, and interpretation were done by the author of this article. After the initial process, all abstraction, analysis, and interpretations were reviewed by two additional experienced qualitative researchers, each of whom had PhDs and over 15 years’ experience doing qualitative research. Any differences were discussed by the two external reviewers and the author to reach the final decisions used for the study results. All analyses were done using ATLAS.ti software.

Study Participants

Limited demographic data was collected from study participants using a short survey. The results appear in Table 1. Overall nurses were 45 to 55 years old (68%); female (95%); Caucasian (81%); had 6 to 10 years of home care experience (74%); and had an average caseload of 20 to 25 patient (83%). Statistical analysis of the demographic variables’ impact on study outcomes was not done due to the qualitative nature of the study.

Study Results

Five themes emerged from the interviews, which are detailed below with supporting quotes.

Little to No Knowledge of the Jimmo Case: “The Jimmo Case? What is that?”

That was the response of Nurse RD, “What is that?” All nurses interviewed had similar responses. Knowledge and clear communication of the *Jimmo* case seems important since many patients have chronic conditions which pre-*Jimmo* were considered not covered since potential for improvement could not be documented. Avalere Health⁴ reported several chronic conditions in the top twenty primary International Classification of Diseases, Version 10 (ICD-10), diagnoses for all home health claims in 2018, using Medicare data. The diagnoses included type 2 diabetes mellitus, like Mrs. Jimmo, at the highest with 6.85% of all claims; other chronic obstructive pulmonary disease, ranking third at 4.52% of all claims; chronic ischemic heart disease ranking 14th, with 1.66% of all claims; and Parkinson’s disease ranking 16th at 1.51% of all claims.

“I never heard of it [the *Jimmo* case],” said Nurse TF

“Well I vaguely remember someone mentioning it in some meeting a few years ago. Maybe it was my supervisor. I can’t really remember. Anyway, I can’t tell you what it was about; something about home care.” Nurse LF

“There was something a while ago about it. I remember it was about being able to cover more patient needs, but that’s about it. It was like a brief mention at some meeting.” Nurse RG

Poor Communication about the Decision: “We’ve barely heard anything”

All nurses also agreed there was poor communication about the *Jimmo* decision, which related to their limited knowledge of the case.

“We did not receive a memo or anything in writing that told us what that case was about and what it meant for our day-to-day

Table 1. Nurse Participant Demographic Characteristics.

Characteristic	Number	% of total
Gender		
Male	1	5
Female	27	95
Race/Ethnicity		
Caucasian, Non-Hispanic	23	81
Hispanic	2	8
African American	2	8
Asian American	1	3
Age Range		
>55	2	7
45-55	19	68
36-44	4	14
25-35	3	11
Years as a Home Care Nurse		
>10	2	8
6-10	21	74
1-5	5	18
Average Patient Caseload		
26-30	1	3
20-25	23	83
<20	4	14

work. Usually if it’s an important change—like something affecting admission or discharge or documentation criteria—we get very specific instructions in writing; and it’s often followed upon in supervisory meetings. No, we did not have any of that about this case.” Nurse SH

“No, there was nothing communicated.” Nurse TC

“Well, I recall something communicated but it was kinda by word-of-mouth; nothing official in writing. I think I heard it from a few nurse friends of mine who worked at another [home health care] agency.” Nurse VM

“Yes, there was some communication, but it wasn’t helpful. It was something like there was a court decision that affected coverage decisions, but we never received anything more specific on what it meant to our daily practice decisions.” Nurse LK

Lack of Guidance on Intake and Eligibility: “We’ve had no idea what this means in changing who is eligible”

Half of the nurses interviewed (n = 14) said they had been intake nurses where they made initial decisions on whether or not to accept a referral and route it to a nurse for an initial home visit to further assess eligibility for admission. All the intake nurses indicated they lacked guidance on how the *Jimmo* case affected their referral acceptance decisions.

“We’ve had no idea what this means in changing who is eligible. We heard a bit about the [*Jimmo*] case, but we did not receive anything from Medicare or our agency on new guidelines for accepting referrals; determining preliminary eligibility. That is what we do at intake. We make that initial decision, either to accept or reject the referral and, if we accept, we internally refer to a nurse to make a home visit to determine eligibility. Our primary focus has been, and remains, whether the person seems to require intermittent skilled care which can improve their primary condition. That has not changed. We always focus on that potential for improvement. No one told us to do otherwise.” Nurse LR

“Our intake process has not changed in the last decade. No one mentioned anything about a court decision changing the criteria we use to accept a referral. We try to look at everything based on the referral documents: Is the patient homebound? Do they require intermittent skilled nursing or PT [physical therapy]? Does it seem like the intermittent skilled care will lead to improvement in their condition or is it a chronic condition—we tend to reject chronic conditions? Is there a ready, willing, and able caregiver at home? That’s Medicare home care 101. We assess these factors as best as possible based on the paperwork, make a preliminary decision, and then, if we think they are eligible, we send out a nurse to do an initial admit assessment visit on-site, in the patient’s home. Nothing has changed.” Nurse AL

Most of the nurses interviewed (75% or 21 of 28 nurses) said they had done initial home care admission visits. All indicated they received no new guidance on assessing for eligibility based on the *Jimmo* case. “No. I heard nothing new. I heard something off-hand, informally about the *Jimmo* case.

As I recall there was some buzz about it for a short time. We never had a meeting or received any guidance of any type that told us to use new eligibility determination criteria for our home visits. We’ve had the same guidelines forever. If we have questions, we ask our supervisors. They never said a word about this case changing our [eligibility] criteria or admissions decisions.” Nurse GH

“Our eligibility criteria have not changed. Every so often we get oriented to pay more attention to certain criteria because we’ve received some [Medicare claim] denials. That’s usually about the homebound or intermittent skilled care criteria or, sometimes, that we did not properly assess the patient had a potential to improve. Yes, that [the potential for improvement] has always been something we assess for. That has not changed. No one said we should change. We are wary of people with chronic conditions and often do not admit them because they have no potential for improvement. They are chronic so the likelihood they can improve while with us is limited. Maybe, once in a while we’ll, admit someone with MS (Multiple Sclerosis) or Parkinson’s or Alzheimer’s for a limited time, but it’s always for some other acute problem they have like a wound or surgery follow-up. Nothing has changed.” Nurse HT

No Guidance on How to Document Under Jimmo: “We have not been told to alter how we document”

All nurses interviewed indicated they received no guidance of changing documentation requirements because of the *Jimmo* decision. Home care documentation requirements are detailed in the Medicare Policy Benefits Manual, Chapter 7.⁵

“We get our [documentation] guidance from Medicare. Our [home care] agency orients us to how we have to document to meet Medicare requirements. We have not been told to alter how we document because of that [the *Jimmo*] decision.” Nurse TY

“I remember we had all kinds of training when we went to PPS [Medicare home care prospective payment system in October 1, 2000]. That was a big change. We had a new assessment tool. There was a new reimbursement system. We had lots of training sessions. Our agency brought in experts. Some of our managers went to national or local seminars and then came back and oriented us. It was huge. We barely heard anything about this *Jimmo* case; definitely no orientation or guidelines on new documentation procedures.” Nurse AC

“I have not been told to change my documentation in any significant way for any reason since about five years ago. We are expecting some changes maybe under the new [payment] system, but I have not heard anything yet. I never heard anything related to that *Jimmo* case.” Nurse CV

The new payment system Nurse CV referred to is the Patient Driven Groupings Model (PDGM), which took effect for Medicare home health January 1, 2020.⁶

Adverse Impacts on Patients: “We continue to have huge gaps in meeting patient needs. Jimmo has made no difference. It hasn’t been communicated to us. We still decide based on improvement potential; not need. It’s ridiculous”

All nurses interviewed agreed that they still use the improvement standard to guide their practice decisions, despite the *Jimmo* decision. They also agreed that use of the improvement standard has and continues to have adverse impacts on patient care by neglecting needs.

“We continue to have huge gaps in meeting patient needs. *Jimmo* has made no difference. It hasn’t been communicated to us. We still decide based on improvement potential; not need. It’s ridiculous.” Nurse BR

“The improvement standard as you all it has always guided our admission and coverage decisions. Nothing has changed. We did not hear much about that *Jimmo* case until you asked. We definitely did not hear it meant we no longer should use potential to improve as one our key criteria for admission or developing our plans of care. Wow. Well someone official should tell us if

we are to change. We have lots of patients who have unmet needs because we can't give them care because they do not have potential to improve. It's sad so I'd love to be able to base care on need; not the improvement potential.' Nurse PL

"What? No way we were told to base care on need. We always were told home care 101 was the patient had to be homebound, need intermittent skilled care and need to have the potential to improve. That is it. It has always been that way. No one has ever said anything different. *Jimmo*? What's that anyway? We barely touch on patient needs now, especially patients with chronic conditions like MS, Parkinson's, Alzheimer's, even chronic diabetes or COPD. Even with COPD and diabetic chronic patients we limit care; maybe only treat an acute spike in their condition or admit for another acute condition—one we can address in one 60 day period, or 30 days I guess under the new [PDGM] system. We don't deal with the underlying condition. We do not treat chronic medical conditions and we definitely do not chronic mental health or substance use conditions. It leaves a lot of patient needs unmet and that only can increase patient problems."

Nurse KY

"Oh my God. This is the story of my life in home care. Actually, it's the story for a lot of [home care] nurses I know. We do not treat most patient needs. It's like we are still a post-hospital provider, even though most of our patients come from community referrals and live in the community. We are limited to intermittent care for homebound persons who we believe can improve while with us. We neglect so many needs. The result? Lots of unmet needs, increased caregiver burden, readmissions, readmissions, and readmissions to us and to hospitals. Why? Well the improvement standard limits what we can do. Yes, that would be great if we could base care on clinical needs of patients. Hopefully someone will tell us we can." Nurse CS

Limitations

The study was qualitative and exploratory. As such it does not address causality and has several limitations, including small sample size, lack of random sampling for selection, and interviews of only nurses.

Conclusions and Implications

Despite its limitations, the study does begin to address a gap in the literature and policy by exploring home care nurses' knowledge of the *Jimmo* decision, its impact on the nurses' home care practice, and the impact on meeting patient needs. The study supports the need for the original Center for Medicare Advocacy (CMA) lawsuit, CMA's 2017 court filing to ensure CMS' compliance, and the results of the 2018 CMA survey, adding qualitative insight to the issue. The story told in the nurse interviews also identifies some specific avenues for potential policy reform to benefit patients, home health professionals, and the Medicare program.

The nurse interviews were conducted in 2019, well after the 2017 court action and 2018 CMA survey, both of which indicated CMS' implementation was ineffective. While the current study is limited, it reinforces the court and CMA's findings. There are several actions which should be considered to more effectively implement the *Jimmo* decision and eliminate use of the improvement standard.

The primary strategy might focus on further action by CMA and Congress, given the significance of the issue to nurses, and indirectly their patients. CMA should return to the court and ask the court to impose more stringent requirements on CMS and the Medicare Appeals Council, the highest administrative appeals level for Medicare claim denial decisions. The rationale would be evidence from their 2018 survey, additional reports they have received, and the current study. These materials could be enhanced by CMA actively soliciting provider and beneficiary reports of cases of non-compliance with *Jimmo* and possibly another survey. There were seven advocacy groups that joined the original lawsuit: National Committee to Preserve Social Security and Medicare, National Multiple Sclerosis Society, Parkinson's Action Network, Paralyzed Veterans of America, American Academy of Physical Medicine and Rehabilitation, Alzheimer's Association, and United Cerebral Palsy.⁷ These organizations should be actively mobilized to collect evidence and support further legal and public advocacy actions. CMA's position might be strengthened if the National Association for Home Care and Hospice, other provider trade associations, and groups representing patients (i.e., American Association for Retired Persons, Justice in Aging, Families USA, and National Senior Citizens Law Center) joined in the lawsuit. These same organizations and CMA might simultaneously call for a Congressional hearing on the issue, possibly by the United States Special Committee on Aging.

In addition to requesting a renewed education campaign, there are additional requirements CMA should request the court to mandate. One would be that CMS specifically require that home health agencies include specific language in a required patient admission document stating that the agency cannot make any patient care decisions based on potential for improvement and that patient need should be the basis for care decisions, subject to other eligibility requirements. Second would be for CMS to require any claim denial appealed to an administrative law judge, up to the Medicare Appeals Council, must examine evidence of whether the improvement standard was used and incorporate the issue into its decision. A third requirement would be for CMS to create a new required claims review audit for intermediaries processing home health claims that would specifically review whether the improvement standard was used as a factor in any claim denial decisions. Such audits would require a reversal of any denial based in whole or part on the improvement standard. A fourth requirement would require CMS to place a boldfaced notice on the front page of all versions of the home care Outcome and Information Assessment Set (OASIS),⁸ the required national Medicare home health Assessment Instrument, stating that patients potential for

improvement may not be considered in making initial or ongoing decisions about eligibility, plan of care development and implementation, nature and extent of services, or discharge. Lastly, CMS should be required to explore the feasibility of adding an appropriate question(s) to the Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey,¹ to allow patients to indicate the degree to which they felt their potential for improvement was considered in the admission, discharge, plan of care or level of care (type and volume of services) decisions.

These recommended actions might also be proposed to CMS and in a Congressional hearing in an effort to avoid further lawsuits. However, the potential for further legal action seems an important consideration given the limited effectiveness in implementing the *Jimmo* decision since its original issuance over 7 years ago.

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