Washington — Tens of thousands of people with chronic conditions and disabilities may find it easier to qualify for Medicare coverage of potentially costly home health care, skilled nursing home stays and outpatient therapy under policy changes planned by the Obama administration.

In a proposed settlement of a nationwide class-action lawsuit, the administration has agreed to scrap a decades-old practice that required many beneficiaries to show a likelihood of medical or functional improvement before Medicare would pay for skilled nursing and therapy services.

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.

Federal officials agreed to rewrite the Medicare manual to make clear that Medicare coverage of nursing and therapy services “does not turn on the presence or absence of an individual’s potential for improvement,” but is based on the beneficiary’s need for skilled care.

Judith A. Stein, director of the nonprofit Center for Medicare Advocacy and a lawyer for the beneficiaries, said the proposed settlement could help people with chronic conditions like Alzheimer’s disease, multiple sclerosis, Parkinson’s disease, stroke, spinal cord injuries and traumatic brain injury. It could also provide relief for families and caregivers who often find themselves stretched financially and personally by the need to provide care.

“As the population ages and people live longer with chronic and long-term conditions,” Ms. Stein said, “the government’s insistence on evidence of medical improvement threatened an ever-increasing number of older and disabled people.”

In many cases, she said, the denial of coverage led to a denial of care because most people cannot afford to pay for these services on their own.

Neither she nor Medicare officials could say how much the settlement might cost the government, but the price of expanding such coverage could be substantial.
Dr. Lynn Gerber, director of the Center for Study of Chronic Illness and Disability at George Mason University in Virginia, called the settlement “a landmark decision for Medicare recipients with chronic illness and especially those with disability.”

“Disability frequently accompanies many chronic conditions,” Dr. Gerber said, “and we often have no cures, so people are likely to experience progressive disability. Rehabilitation, physical and occupational therapy and skilled care are incredibly important in maintaining a person’s functional ability, performance and quality of life.”

The lead plaintiff, Glenda R. Jimmo, 76, of Bristol, Vt., has been blind since childhood. Her right leg was amputated below the knee because of blood circulation problems related to diabetes, and she is in a wheelchair. She received visits from nurses and home health aides who provided wound care and other treatment, but Medicare denied coverage for those services, saying her condition was unlikely to improve.

Another plaintiff, Rosalie J. Berkowitz, 81, of Stamford, Conn., has multiple sclerosis, but Medicare denied coverage for home health visits and physical therapy, on the ground that her condition was not improving. Her family said she would have to go into a nursing home if Medicare did not cover the services.

The proposed settlement, negotiated with lawyers from the Justice Department and the Department of Health and Human Services, was submitted last week to Christina C. Reiss, the chief judge of the Federal District Court in Vermont. If she approves it, as expected, she would have authority to enforce it for up to four years.

Asked about the proposed settlement, Robert D. Reischauer, a public trustee of the Medicare program, said: “Unquestionably that would increase costs. How much, I can’t say.” Other independent experts expressed similar views.

While the settlement is likely to generate additional costs for the government, it might save some money too. For example, physical therapy and home health care might allow some people to avoid more expensive care in hospitals and nursing homes.

Charles S. Miller, a Justice Department spokesman, and Erin Shields Britt, a spokeswoman for the Health and Human Services Department, said government lawyers had no comment.

The changes will apply to the traditional Medicare program and to private Medicare Advantage plans. They apply to people 65 and older, as well as to people under 65 who qualify for Medicare because of disabilities.

The Obama administration initially urged the judge to dismiss the lawsuit. Medicare officials
denied that they had a formal policy requiring beneficiaries to show their conditions would improve.

However, in a separate lawsuit in Pennsylvania, Medicare officials argued the reverse. In order for Medicare to cover skilled nursing care, they said in a legal brief, “there must be an expectation that the beneficiary’s condition will improve materially in a reasonable and generally predictable period of time.”

The same standard, in nearly identical language, is found in guidelines used by some Medicare contractors, which review and pay claims on behalf of the government. In a typical case, Medicare terminated coverage of skilled nursing care and physical therapy for an 81-year-old woman because she had “exhibited a decline in functional status.”

Under the settlement, the federal court in Vermont will certify a nationwide class of more than 10,000 Medicare beneficiaries whose claims for skilled nursing and therapy services were denied before Jan. 18, 2011, when the lawsuit was filed. Many of them will have an opportunity to have their claims re-examined under the revised standards.

Plaintiffs in the case include the National Multiple Sclerosis Society, the Parkinson’s Action Network, Paralyzed Veterans of America and the National Committee to Preserve Social Security and Medicare, an advocacy group.

Neither the Medicare law nor regulations require beneficiaries to show a likelihood of improvement. But some provisions of the Medicare manual and guidelines used by Medicare contractors establish more restrictive standards, which suggest coverage should be denied or terminated if a patient reaches a plateau or is not improving or is stable. In most cases, the contractors’ decisions denying coverage become the final decisions of the federal government.