THE MEDICARE IMPROVEMENT STANDARD:
A BARRIER TO NECESSARY CARE

— THE PROBLEM —

Mrs. P, 68 years old, was diagnosed with Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig’s Disease) five years ago. She now needs a wheelchair, cannot stand on her own, needs assistance to move from bed to wheelchair, and is losing the use of her arms and hands. Mrs. P has been receiving home health care including nursing twice per month, OT twice per month and daily home health aide services. Despite her need for this care, Mrs. P’s Medicare Advantage plan and home health agency informed her that Medicare would no longer cover her home care because she is chronic and “stable in her disease state,” and will not improve. She was informed that she therefore does not need skilled care – a prerequisite for Medicare home health coverage.

BACKGROUND

For decades Medicare beneficiaries, particularly those with long-term, debilitating conditions and those who need rehabilitation services, have been denied necessary medical and rehabilitative care based on an “Improvement Standard.” Indeed, this is one of the leading rationales for unfairly restricting Medicare coverage for chronically ill people in need of health care and rehabilitative services.

Mrs. P’s story is based on a real case brought to the Center for Medicare Advocacy’s attention in August, 2008. The situation was so dire that, when the administrative process failed to reinstate coverage, the Center filed a complaint in federal district court and obtained a restraining order requiring that Medicare grant coverage and that home health care be provided as ordered by Mrs. P’s physician.

Similar denials of coverage and access to health care are encountered throughout the country by Medicare beneficiaries with other long-term and chronic conditions, including people enrolled in MA plans and in traditional Medicare. For example:

• **Mrs. B, 77, who has Multiple Sclerosis (MS):** Her home health agencies have repeatedly denied her need for nursing and physical therapy on the grounds that she is not making significant improvement, is chronic and stable, and is receiving maintenance therapy only which, they maintain, is not a covered skilled service.

• **Ms. K, 48, who has MS:** Her outpatient physical therapy was denied Medicare Part B coverage as it was said to be “maintenance only” and therefore not skilled.

• **Mr. S, 70, who has a spinal cord injury:** He was denied Medicare coverage for physical and occupational therapies to maintain his strength and status. The provider
• stated: “Medicare guidelines do not provide coverage for any type of maintenance therapy.”

• **Mr. M, 71, who has Alzheimer’s disease and recently had a stroke:** His nursing home care and physical therapy were denied on grounds that he is confused and not likely to make significant progress.

• **Mr. C, 57, who has a spinal cord injury and quadriplegia:** His Medicare Advantage plan ended his care three weeks after he returned home from a five-month hospitalization saying his condition was “chronic and stable.” He was readmitted to the hospital within two weeks of the loss of home care.

• **Ms. S, 38, who has muscular dystrophy:** Her home health agency refused to readmit her after she was hospitalized for pneumonia on the grounds that she had a chronic, long-term condition and therefore did not need skilled care.

• **Mr. C, 41, who has Diabetes:** His home health agency repeatedly terminated his nursing services on grounds that Mr. C’s diabetes was chronic and stable. As a result his blood sugars were wildly out of balance and he had to be admitted to the hospital three times within one six month period.

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THE IMPROVEMENT STANDARD CONFLICTS WITH THE MEDICARE ACT AND REGULATIONS

The “Improvement Standard” is used here as shorthand for coverage denials issued on the grounds that the individual’s condition is stable, chronic, or not improving, or that the necessary services are for “maintenance only.” This restrictive standard conflicts with the Medicare Act. Nonetheless, it has become deeply ingrained in the system, in all care settings, and is ardently followed by those who make coverage determinations throughout the Medicare decision-making continuum.

In fact the Medicare Act and federal regulations support coverage for maintenance health care and therapy. For example federal regulations state: “The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. …” 42 CFR §409.32(c); See also 42 CFR §409.44(c)(2)(iii) which supports coverage if the condition will improve “OR the skills of a therapist [are] necessary to perform a safe and effective maintenance program.” (Emphasis added.) The Medicare Act itself only refers to the need to improve in order to receive coverage once and that is with regard to a “malformed body member.”

THE IMPROVEMENT STANDARD IS HARMFUL TO THE CURRENT AND EMERGING AGING POPULATION, TO PEOPLE LIVING WITH CHRONIC CONDITIONS, AND TO LOW-INCOME AND MINORITY PEOPLE

The United States population is aging and living longer with chronic conditions. Thus the unfair Improvement Standard is affecting more and more older and disabled people. Most significantly, it keeps people with debilitating, long-term, and chronic conditions from receiving the care they need. The people most affected by this barrier include, but are not limited to, people with

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1 Medicare allows coverage when services are medically “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” 42 USC §1395(a)(1)(A).
Multiple Sclerosis, Alzheimer’s disease, ALS (Lou Gehrig’s disease), spinal cord injuries, diabetes, Parkinson’s disease, hypertension, arthritis and stroke. Further, the erroneous standard disproportionately affects people who have low-incomes, African-Americans and Hispanics.

Numerous reports and researchers have confirmed that more people are living with more chronic conditions:

… almost half of all Americans live with a chronic condition. … Many have multiple chronic conditions, including functional limitations and disabilities. … people with five or more chronic conditions have an average of almost 15 physician visits and fill over 50 prescriptions in a year…. .

[Chronic Conditions: Making the Case for Ongoing Care, Introduction, Partnership for Solutions, a joint project of Johns Hopkins University and the Robert Wood Johnson Foundation, (September, 2004)]

Unfortunately, people with chronic conditions often go without the care they truly need: Care to maintain their health or retard deterioration. As the Partnership for Solutions study finds:

People with chronic conditions are getting services, but those services are not necessarily in sync with one another, and they are not always the services needed to maintain health and functioning. … For health care providers, slowing disease progression should be as important as treating acute episodes of an illness. …

Likewise, health insurance should make standard coverage for these services that help people maintain their functional status. Many current benefits can be accessed only if medical improvement is expected. [Id.]

The Medicare Improvement Standard is exactly this kind of coverage barrier, serving as an obstacle to the coverage authorized by the Medicare Act and to care needed by beneficiaries. Further, the standard disproportionately affects low-income people and members of minority groups. Consider, for example:

• 46% of Medicare Beneficiaries have three or more chronic conditions, 63% have two or more chronic conditions, and 20% of beneficiaries have five or more chronic conditions. [Medicare: A Primer, Kaiser Family Foundation (January 2009); R. Berenson, MD, J. Horvath, Clinical Characteristics of Medicare Beneficiaries and Implications for Reform, www.medicareadvocacy.org/chronic, (2002)].

• Chronic conditions account for approximately 70% of all deaths in the United States.

• Most Medicare beneficiaries have very low incomes. 46% of Medicare beneficiaries have annual incomes less than 200% of the Federal Poverty Level. 16% of Medicare beneficiaries have incomes below 100% of the Federal Poverty Level. [Medicare: A Primer, Kaiser Family Foundation (January 2009)].

• Older people living in poverty are almost four times as likely as those living at twice the poverty level to consider their health as poor.
• Risk factors such as obesity, diabetes, and hypertension are significantly higher among poor older people than those who are not poor. Those living in and at risk of poverty get fewer health screenings and are unable to see a physician because of the cost. [Poverty & Aging in America, AARP (2008)].

• While these statistics demonstrate the importance of access to care for all people with chronic conditions, the need is particularly keen for African Americans, Hispanics, and other minority and low-income people. Further, while a majority of Medicare beneficiaries have very limited, fixed incomes, African American and Hispanic older people are disproportionately poor. For example, more than two thirds of African American beneficiaries have incomes below 200% of the federal poverty level. [Medicare: A Primer Kaiser Family Foundation, (January 2009) and Medicare Chart Book, 3rd Edition (Summer 2005); Revisiting ‘Skin in the Game’ Among Medicare Beneficiaries (February, 2009)].

• A study in the Journal of the American Medical Association (JAMA) reports that, “….vulnerable populations (African Americans, those living in HPSAs, [Health Professional Shortage Areas] and those living in poverty areas) were less likely than their counterparts to receive necessary care and preventive care and were more likely to have higher rates of avoidable outcomes.” [284 JAMA 2325, 2330 (11/8/2000)].

CONCLUSION

As the Johns Hopkins/Robert Wood Johnson, Partnership for Solutions study concludes:

… The challenge is to use our resources to provide people with access to high-quality care and appropriate services that maintain health and functioning in the face of [chronic conditions] and disease progression…. [Emphasis added.]

Medicare can begin to meet this challenge by eliminating all use of the illegal, unfair, and counter-productive Improvement Standard. Ideally this would be implemented by a clear directive from President Obama in an Executive Order stating that an ability to improve shall not be the deciding factor in making any Medicare coverage determinations. The Executive Order would require a cleansing of all CMS policies and guidelines that conflict with the Order, including those that allow coverage denials because the individual’s underlying condition will not improve, or the necessary services are “maintenance only.”

This action would go a long way towards removing a major barrier to Medicare coverage and necessary care for older and disabled people living with chronic conditions. Further, since Medicare standards often serve as models for private insurance, this action could also positively affect people with chronic conditions who are insured by other health insurance.

REFERENCES

• 42 U.S.C. §§1395y(a)(1)(A)
• 42 CFR §409.32(c); 409.44(c)(2)(iii)
• CMS Pub. 100-02 §30.4.1.2.E