

## Helping Clients Navigate Medicare's Home Health Benefit— Frequently Asked Questions

### 1. What is home health care?

Home health care includes a wide range of health and social services delivered in the home to treat illness or injury. Services covered by Medicare's home health benefit include intermittent skilled nursing care, skilled therapy services, and care provided by a home health aide.

### 2. When does Medicare cover home health care?

Medicare covers home health care for an individual who:

- Is homebound (see question 3), meaning it is extremely difficult for them to leave the home and they need help doing so.
- Needs skilled nursing services and/or skilled therapy care on an intermittent basis (see question 4).
  - Medicare defines skilled care as care that must be performed by a skilled professional, or under their supervision.
  - Skilled therapy services refer to physical, speech, and occupational therapy.
- Has a face-to-face meeting with a doctor within the 90 days before starting home health care, or the 30 days after the first day they receive care. This can be an office visit, hospital visit, or in certain circumstances a face-to-face visit facilitated by technology (such as video conferencing).
- Receives a signed home health certification from their doctor, confirming that they are homebound and need intermittent skilled care. The certification must also state that their doctor has approved a plan of care (see question 5) and that the face-to-face meeting requirement was met.
- Appropriately renews their home health certification and plan of care, as needed (see question 5).
- And, receives care from a Medicare-certified home health agency (HHA).

### 3. How does Medicare determine that someone is homebound?

A doctor should decide if someone is homebound based on their evaluation of the person's condition. Medicare considers someone homebound if:

- They need the help of another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, or their doctor believes that their health or illness could get worse if they leave home.

- And, it is difficult for them to leave home and they typically cannot do so.

Note that even if someone is homebound, they can still leave home for medical treatment, religious services, and/or to attend a licensed or accredited adult day care center without putting their homebound status at risk. Leaving home for short periods of time or for special non-medical events, such as a family reunion, funeral, or graduation, should also not affect someone's homebound status. A homebound individual may also take occasional trips to the barber or beauty parlor.

#### **4. What does intermittent mean?**

Intermittent means care is needed at least once every 60 days and at most once per day for up to three weeks. This period can be longer if the beneficiary needs more care, but their care needs must be predictable and finite.

#### **5. What is a plan of care?**

Generally, a plan of care will list:

- Types of health services and items the beneficiary needs
- How often the beneficiary will receive services
- Predicted outcomes of treatment

A doctor must sign the plan of care at the start of the beneficiary's care or soon after it starts. The plan of care is often paired with the home health certification form that the doctor must sign to show that the beneficiary needs care. The first time a beneficiary's doctor certifies their eligibility for home health care, they must have a face-to-face meeting to discuss the reason they need care. This meeting must take place within the 90 days before the beneficiary starts care, or the 30 days after the first day they receive care.

The initial plan of care and certification will last 60 days. If the beneficiary needs additional care, the certification and plan of care can be renewed for as many 60-day periods as necessary, as long as their doctor continues to sign them. A face-to-face meeting is not required for recertification.

#### **6. Which part of Medicare covers home health care?**

Beneficiaries can receive home health care coverage under either Medicare Part A or Part B. Under Part B, an individual is eligible for home health care if they are homebound and need skilled care. There is no prior hospital stay requirement for Part B coverage of home health care. There is also no deductible or coinsurance for Part B-covered home health care.

While home health care is normally covered by Part B, Part A provides coverage in certain circumstances after a beneficiary is in a hospital or skilled nursing facility (SNF). Specifically, if the individual spends at least three consecutive days as a hospital inpatient or has a Medicare-covered SNF stay, Part A covers their first 100 days of home health care. They

must still meet other home health care eligibility requirements, such as being homebound and needing skilled care. They also must receive home health services within 14 days of their hospital or SNF discharge to be covered under Part A. Any additional days past 100 are covered by Part B.

## **7. What services are covered under Medicare's home health benefit?**

Medicare covers the following services under the home health benefit:

**Skilled nursing services:** Services performed by or under the supervision of a licensed or certified nurse to treat injury or illness.

- Services may include injections (and teaching the beneficiary to self-inject), tube feedings, catheter changes, observation and assessment of the beneficiary's condition, management and evaluation of their care plan, and wound care.
- Provided up to seven days per week for generally no more than eight hours per day and 28 hours per week. In some circumstances, Medicare can cover up to 35 hours per week.

**Skilled therapy services:** Physical, speech, and occupational therapy services that are reasonable and necessary for treating illness or injury, and performed by or under the supervision of a licensed therapist.

- Physical therapy (PT) includes gait training and supervision of and training for exercises to regain movement and strength in a body area.
- Speech-language pathology (SPL) services include exercises to regain and strengthen speech and language skills.
- Occupational therapy (OT) helps the beneficiary regain the ability to do usual daily activities on their own, such as eating and putting on clothes.

Be aware that beneficiaries cannot qualify for Medicare home health coverage if they only need occupational therapy. However, if they qualify for home health care on another basis, they can also get occupational therapy. When their other home health needs end, they can continue receiving Medicare-covered occupational therapy under the home health benefit if they need it.

**Home health aide:** An aide to provide personal care services, including help with bathing, toileting, and dressing. However, Medicare will not cover an aide if the beneficiary only requires personal care and does not need skilled care (skilled nursing or therapy services). An aide if the beneficiary requires skilled care (skilled nursing or therapy services).

- Provided up to seven days per week for generally no more than eight hours per day and 28 hours per week. In some circumstances, Medicare can cover up to 35 hours per week.

**Medical social services:** Services ordered by a doctor to help with social and emotional concerns the beneficiary has related to their illness. This may include counseling or help finding resources in their community.

**Medical supplies:** Certain medical supplies, such as wound dressings and catheters, when provided by a Medicare-certified HHA.

**Durable medical equipment (DME):** Certain pieces of medical equipment, such as a wheelchair or walker.

Medicare should pay for these services regardless of whether the beneficiary's condition is temporary or chronic (see question 11).

## **8. What services are not covered under Medicare's home health benefit?**

Services excluded from Medicare coverage include:

- 24-hour-per-day care at home
- Prescription drugs
  - If the beneficiary needs prescription drug coverage, they should enroll in a Part D plan or a Medicare Advantage Plan that provides drug coverage.
- Meals delivered to the home
- Housekeeping services, including light cleaning, laundry, and meal preparation
  - Home health aides may perform some housekeeping services when visiting to provide other health-related services. However, aides cannot visit with the sole purpose of performing housekeeping duties.

**Note:** If the beneficiary is terminally ill, Medicare may cover some of the above services and items under its hospice benefit.

## **9. What are the costs of Original Medicare's home health benefit?**

Regardless of whether the beneficiary's care is covered by Part A or Part B, Original Medicare pays the full cost for home health care services, excluding DME. For DME, Original Medicare pays 80% of its approved amount, and the beneficiary pays a 20% coinsurance (plus up to 15% more if their home health agency does not take assignment).

## **10. How do Medicare Advantage Plans cover home health care?**

All Medicare Advantage Plans must provide at least the same level of home health care as Original Medicare, but they may impose different rules, restrictions, and costs. Depending on the beneficiary's plan, the individual may need to:

- Request prior authorization or a referral before receiving home health care.
- Get care from an HHA that contracts with their plan.

- Pay a copayment for their care (Original Medicare fully covers home health, see question 9).

Beneficiaries should contact their Medicare Advantage Plan if they need information about the costs and coverage rules for home health care, or if they are experiencing problems.

### **11. Does Medicare cover care for temporary and chronic conditions?**

Medicare should cover home health care regardless of whether a condition is temporary or chronic. Medicare covers skilled nursing and therapy services as long as they:

- Help the beneficiary maintain their ability to function.
- Help the beneficiary regain function or improve.
- Or, prevent or slow the worsening of the beneficiary's condition.

Providers and agencies may worry that Medicare will not cover home care if the beneficiary is no longer showing signs of improvement. However, Medicare should not deny home care because the beneficiary's condition is chronic or unchanging, or when additional care will not improve an individual's ability to function. As long as care is medically necessary to maintain an individual's condition or to prevent or slow deterioration, Medicare should cover it.

It may be hard for a beneficiary with chronic care needs to find an HHA willing to provide them with services (see question 13). If your client has Original Medicare, call 1-800-MEDICARE for a list of HHAs in their area. If they have a Medicare Advantage Plan, contact their plan for a list of in-network HHAs.

### **12. How does someone start receiving home health care?**

The process for starting the home health benefit changes depending on whether the beneficiary is currently in a hospital or if they are already at home. Remember, in both cases they must meet the eligibility requirements (see question 2) and qualify for coverage under either Part A or Part B (see question 6).

- If the beneficiary is in a hospital, a social worker or discharge planner should arrange for a Medicare-certified HHA to visit them and assess their condition before they are discharged. If the individual qualifies, they should receive home health care after discharge.
- If the beneficiary is at home or leaving a SNF, they should speak to their doctor about their home health needs and ask for a list of Medicare-certified HHAs. Beneficiaries should call an HHA directly and request an assessment of their condition.

### **13. Are HHAs required to provide care to anyone in their service area who qualifies for Medicare's home health benefit?**

Know that HHAs can choose who to accept as a patient or refuse to provide home health services if they do not believe they can ensure the patient's safety. They can also limit the kinds of services they provide and the types of conditions they will care for.

If a beneficiary is having trouble finding an HHA, they should contact their hospital discharge planning office, 1-800-MEDICARE, or the Eldercare Locator (1-800-677-1116).

Beneficiaries with Medicare Advantage Plans should contact their plan for a list of in-network HHAs. If no HHA in their plan's network will take them as a patient, they can ask their plan to cover out-of-network care. Plans must provide their members with home health care if a doctor says it is medically necessary. If no in-network HHA will provide care, but an out-of-network HHA will, the beneficiary's plan must provide coverage for the out-of-network home health care.

If no HHA in your client's area can provide them with care, suggest that they speak to their doctor about other options for receiving care.

#### **14. What options are there if an HHA decides to reduce care?**

HHAs may decide to reduce care if they believe that Medicare will no longer cover it. In these circumstances, beneficiaries have certain rights. Be aware that the process is slightly different depending on whether the beneficiary has Original Medicare or Medicare Advantage.

If your client has **Original Medicare**, and their HHA decides to reduce services prescribed by their doctor because it believes that Medicare will no longer cover these services, they should receive a notice explaining why services are being reduced. This notice is called a Home Health Advance Beneficiary Notice (HHABN). The HHABN will ask the beneficiary to choose one of the following three options:

- Request care and ask the HHA to bill Medicare (demand bill). If Medicare denies coverage, the beneficiary has the right to file an appeal. If their appeal is unsuccessful, they may be responsible for the cost of care.
  - An HHA may refuse to demand bill.
  - The HHA can bill the beneficiary for home health services while Medicare makes its decision.
- Request care but agree to pay for the care out of pocket.
- Turn down care. The beneficiary can look for another HHA that might cover the care.

Be aware that there are also situations when beneficiaries may receive an HHABN but do not have the right to request a demand bill. For example, if:

- Their doctor reduces the amount of care in their plan of care. In this case, the beneficiary will need to:

- Convince their doctor that services should not be reduced.
- Find another doctor to certify that they need to continue getting the same level of services.
- Or, go without these services.
- The HHA reduces care for staffing reasons, or does not think it is safe for the beneficiary to stay at home. The beneficiary will need to find another HHA to get home health care, investigate other care options in their community, or go without these services.

If your client is in a **Medicare Advantage Plan** and their HHA is reducing their home health services, they typically have to appeal. They can request a fast (expedited) review of this decision.