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The Center for Medicare Advocacy is pleased to share the following information based on questions that were received from the January 12, 2022 webinar on Medicare coverage of home health services. Recordings of that webinar and the follow-up session are available at **www.medicareadvocacy/webinars.**

- **What is a home health agency?**

During the webinar we were discussing "Medicare-certified home health agencies." This means they have been approved by Medicare to provide the home health services Medicare covers, and they have agreed to be paid by Medicare. Medicare only pays for home health services provided by Medicare-certified home health agencies.

- **How can I find Medicare-certified home health agency?**

Go to Medicare's "**Care Compare**" website and under "Provider Type," select "Home health services," to find Medicare-certified home health agencies that serve your area. The doctor or other provider ordering home health services may also have suggestions for home health agencies. Discharge planners from hospitals and nursing facilities may also be able to assist.

If you are in a Medicare Advantage plan (like an HMO or PPO) or another Medicare health plan (like a Program of All-inclusive Care for the Elderly), it may require that you use home health agencies that are in their network.

It may be useful to contact several different home health agencies that serve your area, if possible, as there can be significant differences in the services they offer.

- **Does Medicare pay family members or other private caretakers for home health services?**

Medicare only covers home health services that Medicare-certified home health agencies provide directly or "under arrangement" with another provider that furnishes the services and then looks to the primary home health agency for payment. The primary home health agency must bill Medicare for all covered services, and payment is made only to that agency. Thus, unlike many *Medicaid* or other state-based programs, in which beneficiaries can hire family members as personal care attendants, Medicare does not cover home health services in that manner. Nor does Medicare reimburse patients for private-pay home health services. All Medicare payments for home health services must go through a Medicare-certified home health agency.

The Center for Medicare Advocacy issued a brief about Medicare and family caregivers in June 2020, available **here**.

- **What if I have another form of insurance or payer besides Medicare, like my state Medicaid program, VA coverage, or a long-term care insurance policy? What if I am in an assisted living facility?**

The Medicare home health benefit can be used together with other benefit or insurance programs. Exactly how depends on those programs' individual rules. An example in Section 50.7.1 of **Chapter 7 of the Medicare Benefit Policy Manual** explains that if a patient requires *more* skilled nurs-

ing/home health aides than the allowable "part-time or intermittent" hours under the Medicare benefit, Medicare can cover its maximum amount (35 hours per week of nursing and aides combined), with the remainder billed to another payer. Inquire with the other programs to find out how they can be combined with Medicare's home health benefit.

For assisted living facilities, refer to Section 30.1.2 of **Chapter 7 of the Medicare Benefit Policy Manual**. As described in that section, an assisted living facility can count as a patient's place of residence and patients can receive Medicare-covered home health services there. But Medicare will not cover services that are duplicative of services furnished by the facility.

- **Are people with Parkinson's disease, MS, dementia, or other conditions or particular diagnoses eligible for Medicare-covered home health services?**

Coverage does not depend on the patient's diagnosis or condition. It depends on whether the person meets Medicare's standard for coverage of home health services. An individual determination must be made for each person. Some basic elements that must be met by the patient include:

- Being "homebound," as defined by Medicare law

-and-

- Requiring at least **one** of the "skilled services" offered under the benefit:
  - Part-time or intermittent skilled nursing;
  - Physical therapy;
  - Speech therapy; or
  - Occupational therapy (*to continue but not start services*).

If the beneficiary meets the above standards, then coverage of "dependent" services, including home health aides, is also possible.

See slides 5 through 16 of the 1/12/2022 webinar (emailed on 1/12/2022) for more details on Medicare's eligibility criteria. Note that the patient only needs to require one skilled service to be eligible for coverage, including coverage of dependent services like home health aides. In other words, it is not necessary to require *both* physical therapy and skilled nursing, for example, to be eligible for coverage of home health aides. Requiring either nursing or physical therapy would be a sufficient basis to be eligible for aide services.

- **Does receiving more skilled nursing visits reduce coverage for other types of services?**

When both skilled nursing and home health aide visits are provided, the two services combined cannot exceed the "part-time or intermittent" hourly limits per week. The limits for skilled nursing and home health aides combined are 28 or fewer hours per week, and on a case-by-case basis up to 35 hours per week. The weekly hour limits apply only to nursing and home health aide visits. Skilled nursing and home health aide visits are not combined in this way with any other type of service. So coverage of therapy visits is not affected by the number of skilled nursing visits. Similarly, when home health aide and therapy services are provided (with no skilled nursing ordered), the limit on home health aide hours is not combined with therapy.

- **Can a person be considered "homebound" based on a mental health condition even if the person does not have physical impairments?**

A person can meet Medicare's definition of "homebound" based on a mental, psychological, or other health condition that does not affect their physical mobility. As with the need for skilled care, an individualized determination must be made. The questions to ask are whether the person requires the aid of a device or another person to leave the residence, or whether the person has a condition that makes leaving home medically contraindicated. There must also be a normal inability to leave the home and it must require considerable taxing effort. (See slides 8-10 of the webinar for more detail on the homebound standard).

The **Medicare Benefit Policy Manual**, Chapter 7, Section 30.1.1 provides the following examples of patients who *are* considered homebound:

"A patient who is blind or senile and requires the assistance of another person in

leaving their place of residence."

"A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations."

The Manual also explains that:

"The aged person who does not often travel from home because of frailty and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions [referring to the standards for being considered homebound]."

- **Has the COVID-19 pandemic affected Medicare's definition of homebound?**

In April 2020, Medicare clarified that the when a doctor has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has confirmed or suspected case diagnosis of COVID-19, or , where a doctor has determined that it is medically contraindicated to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19, those patients may be considered homebound. Medicare also stated that a patient who is exercising "self-quarantine" for their own safety would not be considered homebound unless a doctor certifies that it is medically contraindicated for them to leave the home.

Medicare also noted that under CDC guidance about older adults and individuals with serious underlying health conditions, it expected that many Medicare beneficiaries could be considered homebound. It noted, however, that "determinations of whether home health services are reasonable and necessary, including whether the patient is homebound and needs skilled services, must be based on an assessment of each beneficiary's individual condition and care needs." 85 Federal Register 19230, 19247 (April 6, 2020).

- **What is the difference between physical and occupational therapy?**

A basic difference is that physical therapists focus on patients' ability to move their bodies, while an occupational therapist focuses on patients' ability to perform activities of daily living. Both services can be critical to either improving or maintaining function, and the ability to remain at home.

- **I've heard home health providers state they need to end physical therapy services to show that the patient would decline without that service. Is this true?**

That is incorrect. If a patient requires skilled care (including services from a physical therapist) in order to maintain their current function or to prevent or slow decline, Medicare coverage is available as long as all other coverage criteria are met. This coverage standard was clarified and reinforced by the settlement in *Jimmo v. Sebelius*. The following is taken from Medicare's **Frequently Asked Questions page** about *Jimmo*:

Q11: If a patient is not improving or is not expected to return to his or her prior level of function from skilled nursing or therapy, does Medicare coverage for skilled nursing or skilled therapy services stop unless the patient deteriorates?

A11: The Medicare program does not require a patient to decline before covering medically necessary skilled nursing or skilled therapy. For a patient who had been expected to improve, but is no longer improving, a determination as to whether skilled care is needed to maintain the patient's current condition or prevent or slow further deterioration must be made, and if such skilled care is needed, a plan of care to reflect the new maintenance goals must be developed. If, however, a patient is no longer improving and there is no expectation of improvement and skilled care is not needed to maintain the patient's current condition or to prevent or slow further deterioration, such skilled care services would not be covered.

Thus, if a patient is expected to decline without skilled physical therapy, that should be explained in the documentation and the plan of care should reflect maintenance of function or prevention of decline as the goal of the plan.

Medicare recently reminded providers and its contractors about the availability of coverage to maintain or to prevent or slow decline. See the Center for Medicare Advocacy's **Alert**

maintain or to prevent or slow decline. See the Center for Medicare Advocacy's **Alert**.

- **Where can I find more information about coverage of skilled services to maintain or prevent decline?**

More information about Medicare coverage of skilled nursing and therapy services to maintain function or to prevent or slow decline or deterioration can be found on Medicare's ***Jimmo* Settlement webpage**. The page includes an "Important Message" about *Jimmo*, as well as links to resources such as Frequently Asked Questions.

The Center for Medicare Advocacy's website also has **resources** about maintenance coverage and *Jimmo*, including our own set of **Frequently Asked Questions** and **self-help materials for appeals** when denials are based on an inappropriate "Improvement Standard."

- **Is coverage of home health different for people in traditional Medicare versus Medicare Advantage plans (also known as "Part C" of Medicare)?**

Medicare Advantage plans must, at a minimum, cover the same services as traditional Medicare (Parts A and B), which includes the clarified standard for coverage of skilled care under the *Jimmo* settlement.

Traditional Medicare does not have deductibles or co-insurance payments for home health care, known as patient cost-sharing. Each Medicare Advantage plan may impose different cost-sharing amounts, including deductibles and co-insurance payments. If a beneficiary is enrolled in Medicare Advantage they should confirm cost-sharing requirements with their plan.

As noted above, Medicare Advantage plans may require that you receive home health services from an in-network Medicare-certified home health agency. Medicare Advantage plans may also require prior authorization of services, that is, the plans may require that they approve the home health services before they are furnished, even if your doctor has ordered them. Each plan has different requirements, so people enrolled in Medicare Advantage plans should contact their plan to ask if/when prior authorization is needed.

- **How can a doctor try to ensure that I will receive the home health services I need?**

While there is no template for home health orders, doctors and other practitioners who can order home health services should keep in mind that the more specific they can be about the services you need, the better. For example, if you require physical therapy in order to maintain your current capabilities or to prevent decline, that should be expressly stated as a goal. If one of the services you require is home health aides, the doctor should specify which hands-on services you need the aides for. This might include not only bathing or showering but also toileting, assistance with medications that are normally self-administered, changing position in bed, transfers, and walking. (See the Center for Medicare Advocacy's **Fact Sheet on home health aides** for more details on the types of care home health aides may provide).

Doctors and other practitioners who order home health care may get most of their information about Medicare coverage from home health agencies and may have misconceptions or misunderstandings about what Medicare can cover. Materials from the webinar, our **website**, and other resources linked to in these questions and answers can be used to provide information and education.

- **Who has the authority to decide what services are provided and whether someone is eligible for coverage?**

A doctor (or other authorized practitioner) must order the home health services. Doctors should order what they consider to be reasonable necessary home health services for the individual patient, and they should be as specific as possible about what services the patient needs. Generally staff from the home health agency will come to the home to perform an assessment. The home health agency should work with the patient and doctor to develop a plan of care. Home health agencies must follow doctors' orders and provide all services listed in the plan of care.

The reality is that home health agencies sometimes have great influence over which services the doctor orders and what is listed in the plan of care. This can be caused by many factors including staffing constraints, financial incentives, and misconceptions about what Medicare covers. Try to work closely with the ordering doctor and provide information to the doctor and home health

work closely with the ordering doctor and provide information to the doctor and home health agency about Medicare coverage rules if needed. Trying different home health agencies, if possible, can be a useful strategy in advocating for the home health services you are eligible for.

See the question below about appeals for certain situations when patients have the right to appeal to Medicare about coverage.

- **What can I do to advocate for the home health services I am eligible for and who can help me?**

As we discussed during the webinar, there is often a large gap between the home health services Medicare is authorized to cover by law versus the services beneficiaries can actually access. There are many complex reasons for this, including Medicare's home health payment system and other policies like auditing and quality rating systems. While the COVID-19 public health emergency has exacerbated the situation, home health access problems are longstanding and pre-date the pandemic.

We encourage Medicare beneficiaries, their family members, caretakers, and other helpers, to try advocating for reasonable and necessary services that can be covered by Medicare. This may mean educating home health agencies, doctors, and other providers, and pushing back against misconceptions about the home health benefit. Discuss the need for home health services with the ordering doctor to ensure the necessary services are ordered and included in your plan of care. If the goal of the services is to maintain your condition or to slow decline, ensure this is stated in the order for services and plan of care.

Use resources such as Medicare's official booklet for beneficiaries about home health (**Medicare & Home Health Care**); Chapter 7 of the **Medicare Benefit Policy Manual (Home Health Services)** (a Medicare publication geared more to providers); information about the ***Jimmo* settlement**, and **other resources from our website**; and use Medicare's appeal system when possible.

Some local Legal Aid programs offer assistance to people facing problems with their Medicare coverage, particularly if an appeal is needed. Local **Area Agencies on Aging** (AAAs) may also be able to help with coordination of services, including screening for programs other than Medicare that provide services to help people remain in their homes.

While the Center for Medicare Advocacy generally does not provide representation to individual beneficiaries, we are interested in hearing your stories about Medicare and home health services, and we may be able to provide information. Visit our website, **www.MedicareAdvocacy.org**; call (860) 456-7790; or email **HomeHealthCare@MedicareAdvocacy.org**.

- **What are my appeal rights as a Medicare beneficiary trying to get coverage of home health services?**

Medicare has an appeal system that can be used in certain situations.

If you are receiving Medicare-covered home health services and all services are ending, you may have the right to an "**expedited**" (**fast**) appeal if you think the services are ending too soon. Your home health agency is required to give you a written notice called a "Notice of Medicare Non-Coverage" at least two days before all covered services end. Follow the instructions on the notice carefully to request a fast appeal. To appeal you will contact a certain type of Medicare contractor that looks at your case and decides if Medicare coverage of your home health services should continue. Expedited appeals can only be used if all services are ending, not if one type of service (like physical therapy or home health aides) is ending but other services are continuing. If you succeed in an expedited appeal, services and coverage may continue.

You have a right to pursue a **standard** appeal for coverage of services you have *received*. In these cases, the home health agency must give you a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) before giving you a home health service or supply that the agency thinks Medicare won't cover. This may be because the home health agency thinks you are not homebound, thinks the care is not reasonable and necessary for you, or thinks you do not require any skilled service. To appeal to Medicare in this situation you need to keep getting the service in question, which means you may have to pay the home health agency for it. This is not affordable for many people, and the Center for Medicare Advocacy has observed that home health agencies are often reluctant to continue providing services they do not believe will be covered. However, sometimes patients can pay for services for a short amount of time. If the agency *will* continue to provide services and you would like to appeal for Medicare coverage of them, you should request

provide services and you would like to appeal for Medicare coverage of them, you should request that the home health agency send your claim to Medicare so that Medicare will make a decision about coverage (called a “demand bill”). When you receive an official denial of coverage from Medicare, you have the right to appeal it by following the instructions on the Medicare Summary Notice.

Detailed information on pursuing a home health expedited appeal is on the Center for Medicare Advocacy’s website **here** and **here**. Information on the difference between expedited and standard appeals is **here**. For people in Medicare Advantage plans, the appeals process may be different from traditional Medicare. Contact your plan for details.

In any type of appeal the doctor is the patient’s most important ally. Ask your doctor to help demonstrate that the standards for Medicare coverage of home health care met. In particular, ask the doctor to explain in writing why you are homebound (as defined by Medicare) and why you require skilled care and other services that are reasonable and necessary for you. At the Center, we would like to hear from people who are trying to appeal for coverage of home health services, whether it is expedited or standard.

Please contact us at HomeHealthCare@MedicareAdvocacy.org to let us know if you are trying to pursue an appeal to Medicare about your home health services.

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