Center for Medicare Advocacy

Home Health Care

medicareadvocacy.org/medicare-info/home-health-care

The Center has been hearing from people unable to access Medicare-covered home health care, or the appropriate amount of care, despite meeting Medicare coverage criteria.

In particular, people living with long-term and debilitating conditions find themselves facing significant access problems. For example, patients have been told Medicare will only cover one to five hours per week of home health aide services, or only one bath per week, or that they aren't homebound (because they roam outside due to dementia), or that they must first decline before therapy can commence (or recommence). Consequently, these individuals and their families are struggling with too little care, or no care at all.

Home health access problems have ebbed and flowed over the years, depending on the reigning payment mechanisms, systemic pressures, and misinformation about Medicare home health coverage. Regrettably, if recent policies and proposed rules are fully implemented, it appears these access problems will only get worse.

To respond to this crisis, the Center is building a coalition to support a *Home Health Access Initiative*. This *Initiative* is working to oppose inappropriate restrictions on Medicare to open doors to Medicare-covered, necessary home care, but we need your help.

If you or someone you know has experienced home health care access issues, submit the story today.

In addition, it is important for beneficiaries and advocates to know what Medicare home health coverage **should** be under the law, especially for those with long term, chronic, and debilitating conditions. See our detailed information below, and download our **Infographic**, **Fact Sheet**, and **Toolkit: Medicare Home Health Coverage & *Jimmo v. Sebelius***.

- When does Medicare cover home health care?
- What services are covered?
- What if I attend religious services once a week; am I still considered "homebound" for the purpose of Medicare coverage?
- The home health agency told me my aide services would be reduced. My doctor hasn't given me this information. What are my rights?

For other information, follow one of the links below or scroll down the page.

- Quick Screen for Home Health Coverage
- Advocacy tips for Home Health Terminations and Reductions
- Self-Help Packet for Home Health Denials
- Infographic: The Road to Medicare-Covered Home Health Coverage
- Fact Sheet – Medicare Home Health Coverage In Light of *Jimmo v. Sebelius*
- Medicare Home Health Provision Enhances Homebound Definition
- Medicare Home Health Coverage is Not a Short Term Benefit
- Ossen Medicare Outreach, Education and Advocacy Project
- White Paper: *The Promise and Failure of Medicare Home Health Coverage*
- Issue Brief Series: Medicare Home Health Care Crisis
- CMS Policy for Determining Homebound Status
- Submit a Home Health Access Issue Story
- Articles & Updates

A QUICK SCREEN TO AID IN IDENTIFYING COVERABLE CASES

Home health claims are suitable for Medicare coverage, and appeal if they have been denied, if they meet the following criteria:

1. A physician has signed or will sign a care plan, certifying that the services are medically necessary; the physician must also certify that there has been a face-to-face encounter with the patient' within 90 days prior to the start of care or within 30 days after the start of care.
2. The patient is homebound. This criterion is generally met if non-medical absences from home are infrequent and leaving home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance, or the help of a wheelchair or crutches, etc. Occasional "walks around the block" are allowable. Attendance at an adult day care center or religious services is not an automatic bar to meeting the homebound requirement.
3. The patient needs skilled nursing care on an intermittent basis (less than 7 days per week but at least once every 60 days) or skilled physical therapy, speech therapy, or continuing occupational therapy. Daily skilled nursing care is available for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional daily skilled nursing is finite and predictable).
4. The care must be provided by, or under arrangements with, a Medicare-certified provider.

Coverable Home Health Services

If the triggering conditions above are met, the beneficiary is entitled to Medicare coverage for home health services. There is no coinsurance or deductible. Home health services include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational, or speech therapy;
- Medical social services;
- Part-time or intermittent services of a home health aide, and;
- Durable medical equipment (DME) and medical supplies

ADDITIONAL HINTS:

1. Medicare coverage should not be denied simply because the patient's condition is "chronic" or "stable." "Restorative potential" is not necessary.

2. Resist arbitrary caps on coverage imposed by the intermediary. For example, do not accept provider or intermediary assertions that aide services in excess of one visit per day are not covered, or that daily nursing visits can never be covered.
3. There is no legal limit to the duration of the Medicare home health benefit. Medicare coverage is available for medically necessary home care even if it is to extend over a long period of time.
4. The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the criteria above are met. Home care services should not be ended or reduced unless it has been ordered by the doctor.
5. In order to be able to appeal a Medicare denial, the home health agency must have filed a Medicare claim for the patient's care. Request, in writing, that the home health agency file a Medicare claim even if the agency insists that Medicare will deny coverage.

SOME IMMEDIATE ADVOCACY STEPS:

1. Review the Medicare home health qualifying criteria in the Center's Home Health Quick Screen above. If you meet these criteria follow the advocacy steps below.

2. Contact your treating physician, inform him or her of what is happening, and ask for support of the need for the services currently ordered. The treating physician should be the person who decides whether home health services are necessary and whether they should be reduced or terminated.

> If the physician is able to help, request a written statement explaining the on-going need for the services and that the medical circumstances leading to the doctor's order for services are still present. Ask the physician not to sign a discharge order for home health services if s/he continues to think the services are medically appropriate.

3. If your home health care will be inappropriately discontinued, follow the steps outlined in the home health expedited appeal Self Help Packet.

4. Request that the home health agency hold a meeting with the patient and family prior to any termination or reduction in services to discuss the appropriateness of the proposed action.

5. If the home health agency has provided poor care or has treated the patient inappropriately, contact your state's Quality Improvement Organization (BFCC-QIO) (site visited September 24, 2015).

MEDICARE HOME HEALTH PROVISION ENHANCES HOMEBOUND DEFINITION

Sections 501-508 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended 42 U.S.C. ” 1395f(n), 1395(n), 1395fff(b), 1395(x)(v) to modify the Medicare home health benefit. (Public Law 106-554, 12/21/2000.) The provisions discussed below clarified the threshold “homebound” criteria, making clear that individuals who attend adult day care or religious services may also qualify for Medicare home health coverage. These changes became effective upon date of enactment, December 21, 2000.

Homebound Definition

The statutory language clarified and broadened the homebound eligibility criterion in two ways:

Absences attributable to the need to receive health care treatment, including regular absences to participate in therapeutic, psychosocial, or medical treatment at a licensed or accredited adult day-care program, will not disqualify a beneficiary from being considered homebound. For many years beneficiaries who attended adult day-care programs were routinely denied home health services.

Absences for the purpose of attending a religious service are deemed to be absences of infrequent or short duration. (Generally a beneficiary whose absences from the home are not considered infrequent or of short duration will not be considered to be homebound.)

The Current Homebound Definition in the Medicare Act reads as follows:

An individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive devise (such as crutches, a cane, a wheelchair or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home”, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish

adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to an absence of infrequent or short duration. [42 U.S.C. 1395n(a)(2)(F)]

CENTER FOR MEDICARE AND MEDICAID SERVICES POLICY FOR DETERMINING HOMEBOUND STATUS.

In 2013, CMS made a significant revision to its homebound policy. The change reformulated the language from the agency's old policy into a two-part criteria for determining whether a patient meets the definition of being confined to the home in order to be eligible for the Medicare home health benefit:

1. Criteria-One:

The patient must either:

– Because of illness or injury, need the aid of supportive devices such as

crutches, canes, wheelchairs, and walkers; the use of special transportation; or

the assistance of another person in order to leave their place of residence

OR

– Have a condition such that leaving his or her home is medically

contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet

two additional requirements defined in Criteria-Two below.

2. Criteria-Two:

– There must exist a normal inability to leave home;

AND

– Leaving home must require a considerable and taxing effort.

We believe that the problem with this new policy is that some patients may be homebound even if they do not require some sort of assistance to leave their residences. For example, a patient might have severe chronic obstructive pulmonary disease (COPD) that makes it difficult for her to breathe when she exerts herself. If this patient does not require a supportive device like a cane or walker, special transportation, or assistance of another person, she would be ineligible for the Medicare home health benefit under the new rule because she cannot meet Criteria-One (assuming that leaving home with COPD is not contraindicated). Under the prior rule, which made the "normal inability to leave home" and "considerable and taxing effort" language the main criteria in defining homebound, the patient's pulmonary difficulties might have been enough on its own to establish homebound status.

When contesting denials of care or coverage based on homebound status, we encourage beneficiaries and their advocates to utilize the helpful examples of conditions in the policy manual that may indicate that a patient cannot leave the home. We also believe it could be useful to refer home health agencies and contractors to CMS' earlier guidance to take a more flexible, fair, and realistic approach to evaluating whether a chronically disabled individual is homebound.

In 2002, the Secretary of the United States Department of Health and Human Services, Tommy Thompson, made changes to the Medicare Home Health Agency Manual and directed Medicare providers and contractors to be more flexible in applying the Medicare homebound criteria.

In particular, the Medicare Home Health Agency Manual, § 30.1.1, was amended to provide additional, not all inclusive examples of non-medical absences (e.g., family reunion, funeral, graduation) that would not disqualify a person from being considered homebound. The Manual currently includes the following language:

In determining whether the patient has the general ability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (meeting both criteria listed above) more frequently during a short period when the patient has multiple medical appointments with health care professionals and medical tests in 1 week. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to home.

This direction from CMS to look at a long view, not a limited snapshot, to determine whether the beneficiary meets the homebound standard is significant. Advocates have long maintained that cases should be reviewed, and qualification for coverage judged, by looking at services provided over the course of a year, not in fragmented 1-2 month segments.

While the additional language does not alter the existing homebound criteria, it provides important direction that the criteria are to be applied flexibly and with a broad view of the patents' condition. Advocates should use the Secretary's press release language (see here: http://archive.hhs.gov/news/press/2002pres/20020726d.html (site visited October 7, 2015) and the manual language to help make these points when clients are erroneously denied coverage.

THE IMPROVEMENT STANDARD AND HOME HEALTH

The Medicare Benefit Policy Manual highlights that any physical, speech, or occupational therapy is a skilled therapy service if the complexity of the service is such that it can only be performed safely and/or effectively under the supervision of a skilled therapist. In order for a therapy to be considered reasonable and necessary, the skilled therapy must be consistent with the severity and nature of the illness or injury as well as the beneficiary's particular needs. (MBP Manual, Ch. 7, § 40.2.1, *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf, site visited September 24, 2015).

The case *Jimmo v. Sebelius* guarantees in law that homebound skilled nursing or therapy is appropriate for the purposes of maintenance as well as to slow down a patient's quick decline. Even as CMS said that it never had an "improvement standard," many Medicare denials continue to be based on the expectation that a patient will not improve. Despite this, the ***Jimmo*** case made clear that a patient's restorative potential is not required by law and homebound skilled nursing and therapy for the purposes of maintenance and slowing a steep declination in health are perfectly acceptable.

- The Center for Medicare and Medicaid Services' manual provision that refutes the Improvement Standard can be found here (site visited September 24, 2015)
- For more information on *Jimmo* and the Improvement Standard, see here (site visited September 24, 2015)

The Improvement Standard, however, continues to be used to justify denying homebound nursing and therapy services. Should care be improperly denied, you can access a re-review form here (site visited September 24, 2015). Our website also includes various self-help packets should an appeal become necessary (site visited September 24, 2015).

Articles and Updates

Infographic: The Road to Medicare-Covered Home Health Coverage

- Home Health Webinar Q & A January 21, 2022
- CMA Home Health Survey | Medicare Beneficiaries Likely Misinformed and Underserved December 15, 2021
- Center Responds to CMS Proposed Rules That Would Diminish Access to Medicare Home Health Care August 5, 2021
- CMA Comments on CY 2022 HH Prospective Payment System & More August 5, 2021
- New Medicare Home Health Fact Sheet – Focus on Home Health Aides July 29, 2021
- 79 Organizations Call on CMS and ACL to Ensure Access to Medicare-Covered Home Health Care June 3, 2021
- New Factsheet | Medicare Home Health Coverage and *Jimmo v. Sebelius May 27, 2021*
- *Shrinking Medicare Home Health Coverage: It's Time to Act April 22, 2021*
- *Issue Brief | Medicare Home Health Coverage: Reality Conflicts with the Law April 7, 2021*
- *CMS Plans to Expand Program that Interferes with Patient Access to Medicare Covered Home Health Care January 14, 2021*
- *Comments Submitted Regarding Medicare Home Health Proposed Rule for 2021 August 27, 2020*
- *Center Comments on Proposed Home Health Rules August 27, 2020*
- *Medicare Home Health Case Settled with Full Coverage for Beneficiary with Chronic Conditions July 23, 2020*
- *Issue Brief: Medicare Payment vs. Coverage for Home Health & Skilled Nursing Facility Care March 3, 2020*
- *Medicare Coverage of Home Health Care Has Not Changed Under the New Payment System (PDGM) February 20, 2020*
- *Home Health Practice Guide January 7, 2020*
- *Potential Impacts of New Medicare Payment Models On Skilled Nursing Facility and Home Health Care October 31, 2019*

- *Proposed Home Health Rules – Payment Shouldn't Impede Access September 12, 2019*
- *Center Comments on 2019 Proposed Home Health Rule September 12, 2019*
- *As Home Care Needs Increase, Access Issues Must Be Addressed September 5, 2019*
- *CMS Proposed Medicare Home Health Rules Raise Concerns for Access to Care – Comments due September 9, 2019 August 29, 2019*
- *More Doors to Medicare Home Health Closing, More Harm for Observation Status Patients July 18, 2019*
- *New Medicare Home Health Fact Sheet June 20, 2019*
- *Inadequate Personal Care at Home Increases Overall Medicare Costs June 13, 2019*
- *Study Finds Home Health Lowers Costs and Readmission Rates Compared to Hospital Care March 28, 2019*
- *Home Infusion Therapy Services March 13, 2019*
- *Home Health Aide Coverage Continues to Shrink: Attention Must Be Paid February 21, 2019*
- *Case Spotlight: A Medicare Beneficiary in Need of Home Health Aides February 21, 2019*
- *Keep Medicare Home Health Care an Age-Friendly Benefit December 27, 2018*
- *Medicare Home Health Coverage Booklet November 29, 2018*
- *Cobertura De Medicare Para Salud Domiciliaria November 29, 2018*
- *Home Health Telephone Survey November 15, 2018*
- *Successful Advocacy for Home Health Beneficiary in Need of Maintenance Physical Therapy November 15, 2018*
- *Home Health Aide Coverage Continues to Shrink in Traditional Medicare While CMS Enhances it in Medicare Advantage November 15, 2018*
- *Home Health Issue Brief November 15, 2018*
- *Plans to Address and Resolve the Medicare Home Care Crisis October 18, 2018*
- *Checklist for Medicare Home Health Care "Improvement Standard" Denials October 18, 2018*
- *Center Comments on Harmful Proposed Home Health Rule August 30, 2018*
- *Re-Review of Some Home Health Denials Now Available August 30, 2018*
- *Statistical Trends and Published Articles with Studies and Research from 2002-2017 August 23, 2018*

- *Proposed Home Health Rule Affirms Medicare Coverage and Payment for Patients Who Will Not Improve and May Need More Care than the Norm July 12, 2018*
- *Medicare Home Health Rules Proposed by CMS to "Improve Access to Solutions" Will Further Reduce Patient Access to Care July 5, 2018*
- *Home Health Pre-Claim Review Demonstration Model, Take Two June 14, 2018*
- *Home Health Highlight: People Can Leave Home and Still Receive Medicare-Covered Home Care May 17, 2018*
- *Medicare Home Health Coverage is Not a Short Term Benefit – Congress Reiterated This in the Balanced Budget Act of 1997 (BBA '97) May 3, 2018*
- *Fact Sheet – Medicare Home Health Coverage In Light of Jimmo v. Sebelius April 12, 2018*
- *Proposed CMS Payment Rules Will Worsen the Home Care Crisis March 15, 2018*
- *Medicare Home Health Highlight March 1, 2018*
- *Medicare Home Health Highlight February 22, 2018*
- *Toolkit: Medicare Home Health Coverage & Jimmo v. Sebelius February 15, 2018*
- *Team Gleason – Center for Medicare Advocacy Home Health Initiative February 13, 2018*
- *Barriers to Home Care Created by CMS Payment, Quality Measurement, and Fraud Investigation Systems February 7, 2018*
- *Medicare Home Health Access Problems Continue January 17, 2018*
- *Beneficiary Protections Expanded in Revised Home Health Conditions of Participation January 3, 2018*
- *Alert – Spotlight on Medicare Home Health Care; Tax Cuts Set Stage for Medicare/Medicaid Cuts; ACA News November 8, 2017*
- *CMA Alert – It's Enrollment Season; CMS Reissues HH Booklet; "Homebound" Case Settlement; More November 1, 2017*
- *CMA Alert – Changes to Help QMBs; Home Health Updates; ACA Sabotage October 4, 2017*
- *CMA Alert – Harmful Proposed Home Health Rules; Equitable Relief Ending Soon; ACA Sabotage September 27, 2017*
- *Center Comments on Proposed Home Health Payment Rules September 25, 2017*
- *CMA Alert – Critical Issue Roundup: MA Overpayment; HH Payment; Observation; More August 16, 2017*
- *The Home Care Crisis: An Elder Justice Issue August 2, 2017*

- *CMA Alert – Senate Health Bill, Again; Medicare Trustees Report; HH CoPs; More July 13, 2017*
- *Misleading and Inaccurate CMS Medicare Home Health Publications June 21, 2017*
- *Medicare Coverage for Home Care Is Based On a Need For Skilled Care – Improvement Is Not Required May 31, 2017*
- *CMA Issue Brief Series: Medicare Home Health Care Crisis May 31, 2017*
- *Brief Description of Medicare Home Health Coverage Under the Medicare Act May 3, 2017*
- *April is National Minority Health Month April 26, 2017*
- *Overview: The Crisis in Medicare Home Health Coverage and Access to Care April 19, 2017*
- *The Promise and Failure of Medicare Home Health Coverage December 15, 2016*
- *Medicare Home Health Benefit's Face-to-Face Encounter Requirement November 8, 2016*
- *An Open Letter to CMS About Fraud September 28, 2016*
- *Center for Medicare Advocacy Launches Home Health Access Initiative To Open Doors to Home Health Care September 15, 2016*
- *Submit Your Home Health Access Story September 15, 2016*
- *The Promise of Medicare Home Health Coverage September 13, 2016*
- *Proposed Rules Will Add to Problems Accessing Necessary Home Health Care August 24, 2016*
- *Center Comments on Medicare Prior Authorization of Home Health Services Demonstration April 6, 2016*
- *Medicare's Home Health Benefit Under Threat March 2, 2016*
- *Comments on Proposed Rules: CY 2016 Home Health Prospective Payment System Rate Update; home Health Value-Based Purchasing Model; and Home Health Quality reporting Requirements September 1, 2015*
- *Case Study: Home Health Coverage and Medicare Advantage Plan Responsibilities August 13, 2015*
- *New CMS Proposed Homebound Policy Would Leave Medicare Beneficiaries Without Coverage November 7, 2013*
- *Caution: Home Health Episode Payment Caps October 10, 2013*
- *Self-Help Packet for Home Health Care Appeals Including "Improvement Standard" Denials February 22, 2013*
- *Warning: Medicare Payment Limits Are Bad for Health! December 13, 2012*

- *Annual Medicare Payment Limits for Home Health – Even Worse Than Co-Pays for Beneficiaries December 5, 2012*
- *A Client Profile January 1, 2010*

For older articles, please see our archive