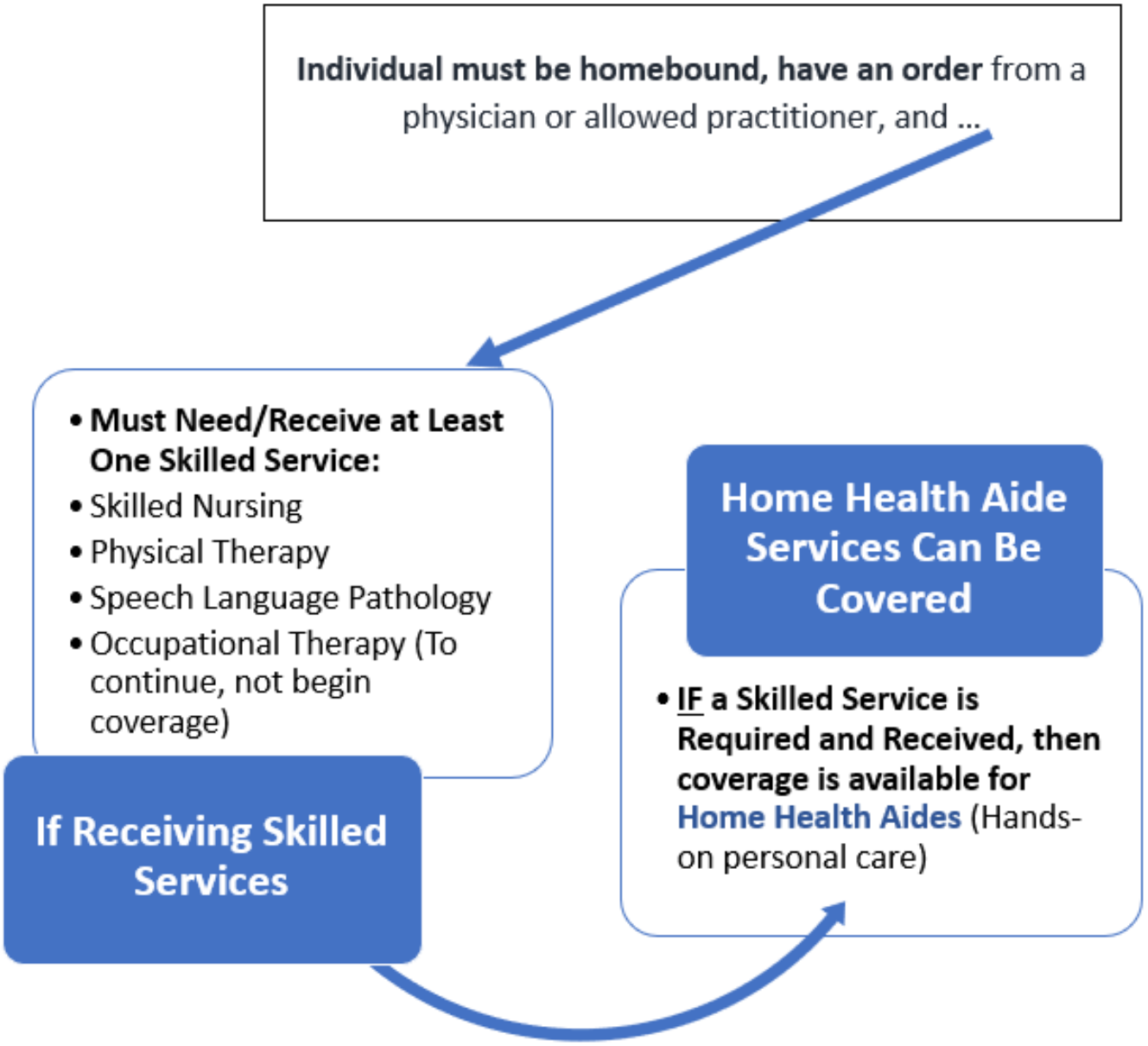
Medicare Coverage for Home Health Aides



Medicare Coverage for Home Health Aide Care

PRACTICE TIP • August 2021

Center for Medicare Advocacy

NATIONAL CENTER ON LAW & ELDER RIGHTS

Medicare coverage can help older adults and people with disabilities obtain necessary home care. When individuals meet the home health benefit criteria, Medicare-covered care can include home health aide services. As defined by federal law, home health aides provide hands-on personal care, including assistance with the activities of daily living. This care is often critical to beneficiaries' health, safety, and ability to remain at home.

Who Qualifies for Medicare-Covered Home Health Aide Care?

- People who meet Medicare's home health coverage criteria can qualify for coverage of home health aides.
- The eligibility criteria for Medicare-covered home health services include being "homebound" and requiring a "skilled" service. Medicare defines home health **skilled services** as nursing, physical therapy, speech-language pathology services, and occupational therapy (to continue coverage).
- Home health aide services must be furnished by, or under arrangement with, a Medicare-certified home health agency. The home health aides must meet certain training and competency requirements.

What Medicare Home Health Aides Services are Covered by Medicare?

To be covered by Medicare, a doctor or other allowed practitioner must order the home health aide services in the plan of care and indicate the frequency of home health aide services required.[1] The reason for the home health aide visits must be to provide hands-on personal care to the beneficiary, services that are needed to facilitate treatment, or to maintain the beneficiary's health,[2] such as:

- Bathing, toileting, dressing, grooming, changing bed linens of an incontinent beneficiary, assistance with walking, changing positions in bed, and transfers;
- Assistance with medications that are ordinarily self-administered;
- Assistance with dressing changes that do not require a nurse;
- Assistance with activities that support skilled therapy such as routine maintenance exercises;
- Routine care of prosthetic and orthotic devices; and
- Services that are "incidental" to a visit for the above-listed services, such as personal laundry or preparing a light meal.[3]

1 42 C.F.R. § 409.45(b)(1).
2 42 C.F.R. § 409.45(b)(1).
3 42 C.F.R. §§ 409.45(b)(1)(i)-(v), 409.45(b)(4).

How Much Home Health Aide Services Can be Covered by Medicare?

Under the law, Medicare covers home health aide services any number of days per week as long as they are provided less than 8 hours per day and 28 or fewer hours per week. On a case-by-case basis, services may be covered up to 35 hours per week.[4] When both home health aide and skilled nursing services are provided, the two services combined cannot exceed these hour limits. 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.

Challenges to Receiving Medicare-Covered Home Health Aide Care

Although Medicare law authorizes coverage of 28-35 hours per week of home health aide care for a wide variety of services, with no time limit as long as eligibility criteria continue to be met,[5] such care is currently almost never available.[6]

Beneficiaries, particularly those with chronic and/or debilitating conditions, are rarely able to find a Medicare-certified agency that will provide the amount or duration of home health aides they require. Home health agencies often tell beneficiaries that Medicare will only cover aides to provide one or two baths per week for a limited amount of time, although there is no basis for this in the law. Many agencies will not provide any home health aide services at all.

PRACTICE TIP

- Discuss the need for home health care and aides with the individual's treating provider to ensure the necessary services are ordered and included in the Plan of Care.
- If the goal of the services is to maintain the individual's condition or slow decline, ensure this is stated in the order and Plan of Care.
- Obtain care from a Medicare-certified home health agency as recommended by a trusted provider or by finding Medicare-certified home health agencies that serve the individual's zip code.

Advocates who are working with beneficiaries who are being denied access to legally-covered home health aide services can contact ConsultNCLER@acl.hhs.gov for free case consultation assistance.

Additional Resources

- NCLER Legal Trainings: Health & Long Term Services and Supports
- Information and assistance is also available at the Center for Medicare Advocacy or email: HomeHealth@MedicareAdvocacy.org.

4 42 U.S.C. § 1395x(m); 42 C.F.R. § 409.45(b)(2)(ii); Medicare Benefit Policy Manual, Chapter 7, § 50.7

5 42 C.F.R. § 409.48(a)-(b); Medicare Benefit Policy Manual, Chapter 7, § 70.1; see also CMS, MLN Booklet, Home Health Prospective Payment System at 9 (Mar. 2018) ("Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the home health benefit.").

6 Home health aide visits per 60-day episode of home care declined by 90% from 1998 to 2019, from an average of 13.4 visits per episode to 1.3 visits. MedPAC, Report to the Congress: Medicare Payment Policy at 236 (Mar. 2021). As a proportion of total home health visits from 1997 to 2019, home health aides declined from 48% of total services to 6% of total services. MedPAC, Report to the Congress: Medicare Payment Policy at 234 (Mar. 2019); MedPAC Mar. 2021 Report at 245.

You do not need a hospital stay before applying for Medicare home health benefits. But the individual would need to meet a number of 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.

**Homebound definition expanded to include that leaving home would be medically contraindicated based on:
Confirmed or suspected diagnosis of COVID-19, or
That patient has a condition that may make the patient more susceptible to contracting COVID
The record must indicate:
A physician certification that it is medically contraindicated for a person to leave home
Documentation as to why the individual condition of the patient is such that leaving home is medically contraindicated
Documentation that the medical contraindication makes it such that there exists a normal inability for an individual to leave home and leaving home safely would require considerable and taxing effort
Source: Interim Final Rule, 19246-19247.

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