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IssueBrief

Staying at Home: A Guide to the Medicare Home Health Benefit

Remaining in one's own home is the desire of virtually everyone, especially those who are living with disabilities or who are frail elders. Yet our fragmented long-term care system all too often makes that goal hard to achieve. Medicaid and Medicare, the two major public resources for long-term care reimbursement, do not always work together as seamlessly as is necessary to support people at home. And cost can become prohibitive. Sadly, institutional long-term care options often seem easier to access than home-based care.

This issue brief explores Medicare coverage for home-based care. It also discusses how advocacy interventions may be used to enable beneficiaries living with disabilities to obtain the care they need while remaining in their own homes and thus avoid unwanted and unnecessary institutional long-term care placement.

I. Medicare Home Health Coverage

Medicare home health coverage is Medicare's only true long-term care benefit. With no durational time limits, Medicare beneficiaries are entitled to receive Medicare home health care for as long as they meet the coverage criteria.[1] Moreover, unlike the Medicare hospital and skilled nursing facility benefits, the Medicare home health benefit does not impose out-of-pocket cost-sharing such as a deductible or a copayment. However, the coverage criteria are exacting.

Two substantive coverage criteria must be met in order to obtain Medicare coverage for home health services:

1) The beneficiary must be *homebound*;[2] and
2) The beneficiary must be in need of *a skilled service*, consisting of either intermittent skilled nursing or speech or physical therapy (ongoing occupational therapy constitutes a skilled service, which may be used to keep Medicare home health care services in place).

A. The Medicare Homebound Requirement

A Medicare beneficiary must be "confined to home" in order to qualify for home health benefits. The standard is subjective, with no quantitative test applied in measuring a beneficiary's homebound status.

In order to be considered homebound, it must be very difficult, due to a condition or injury, for the beneficiary to leave home. Generally, if a beneficiary must use an assistive device, such as a wheelchair, or requires the assistance of another person to leave home, this statutory requirement has been satisfied. The statute provides that if it is contraindicated to leave home, a beneficiary is considered homebound, even if the beneficiary has no physical functional limitations on mobility. For example, it might be dangerous for a dementia patient to leave home due to cognitive impairment caused by dementia.

Non-medical absences from the home must generally be short and infrequent. However, medical absences, such as to receive

[1] 42 U.S.C. § 1395f(a)(20(c); 42 C.F.R. § 409.31 et. seq.
[2] 42 U.S.C. § 1395f (a)(8).

care and treatment not available in the beneficiary's home setting, do not "count" in determining homebound status.[3] The Medicare policy expressly recognizes that an occasional walk around the block or a trip to get a haircut does not preclude a finding that a beneficiary is homebound.[4]

The homebound provision was amended by Congress, effective December 21, 2000, to expressly permit Medicare beneficiaries to qualify for the home health benefit, notwithstanding attendance at adult day care programs.[5] Adult day care provides social and medical services for those with physical and cognitive impairments. As such, it is a boon to dementia patients residing in their own homes and offers respite for caregiving families and friends. The statutory amendment put an end to the previous painful choice many Medicare beneficiaries were forced to make between the two critical services that helped them avoid institutional placement: Medicare-covered home health services *or* adult day care.

The same statutory amendment provides that absences from home to attend a religious service are *deemed* to be short and infrequent. Therefore, any absence from home for the purposes of attending a religious service is permissible for an otherwise homebound Medicare beneficiary.[6] Prior to this change, each year, Medicare beneficiaries discovered that going to church on Christmas or synagogue for the Jewish New Year could disqualify them from entitlement to home health benefits.

In July, 2002, the federal government reviewed policy related to the homebound requirement. In a noteworthy administrative move, the U. S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) issued a transmittal with a significant clarification of policy on the homebound requirement. The transmittal states that attendance at family gatherings, such as reunions, funerals, graduations, and other unique or infrequent events, should not result in a determination that a beneficiary has lost homebound status as

[3] Id.
[4] *Medicare Home Health Agency Manual* (CMS Pub. 11), available at http://www.cms.hhs.gov/manuals/11_hha/hh00.asp.
[5] Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act, P.L. 106-554 § 507, amending 42 USC§1395f(a)(8).
[6] Id.

long as the overall homebound criteria remain satisfied. Homebound status should be withheld only if the absences demonstrate that the beneficiary is able to obtain the care offered by the home health provider outside his or her home.[7]

Moreover, CMS clarified that homebound status should be determined by reviewing the beneficiary's functional status "over a period of time."[8] This directive means that Medicare coverage should not be terminated on the basis of an isolated absence from the home. The family gatherings explicitly mentioned in the transmittal are good examples of occasional absences, accomplished with great difficulty, which never should have resulted in terminations of home health benefits but did cause discontinuances in the past. It should now be even clearer that each case must be evaluated on its own merits.

B. The Skilled Care Requirement

In order to receive Medicare home health services, a beneficiary must need *skilled rehabilitation therapy* or *skilled nursing care* at home.[9] These terms are defined to mean those services

> . . . which require the skills of technical or professional personnel such as registered nurses, licensed practical nurses, physical therapists, and occupational therapists.[10]

A service is not considered skilled merely because trained personnel provide it. In addition to skilled nursing, the specific skilled rehabilitation services that will trigger eligibility for services are speech and physical therapy. Ongoing need for skilled occupational therapy may be used to renew orders for care, thereby keeping home health services in place.[11]

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[7] *Medicare Home Health Agency Manual Transmittal 302*, CMS, July 26, 2002, available at http://www.cms.hhs.gov/manuals/pm_trans/R302HHA.pdf.
[8] Id.
[9] 42 U.S.C. § 1395f(a)(2)(C).
[10] 42 C.F.R. § 409.44.
[11] 42 U.S.C. § 1395f(a)(2(C).

1. Skilled Nursing Requirements

In order to be deemed skilled care, the care must be "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel."[12] Skilled nursing care must be needed and received on an intermittent basis, which means that the need for the nursing services must be less than daily.[13] An exception to the intermittency rule may be made for short periods of daily skilled nursing, generally not to exceed 21 days.[14] Additional daily care by a nurse may only be authorized in "exceptional circumstances," which the statute does not articulate.[15] Often, for example, daily wound care is needed for longer periods of time than 21 days. Careful documentation by the visiting nurse and the treating physician is essential to the continuation of Medicare coverage in such cases.

2. Skilled Rehabilitation Therapy

No intermittency requirement is applied when the skilled service is physical or speech therapy. However, as a practical matter, these therapy services, as well as occupational therapy, are generally not provided daily. Rather, the therapist usually visits the patient several times each week, often leaving the patient with a home exercise regime to complete between the therapy visits.

3. Technical Requirements

Home health care must be ordered by a physician and provided pursuant to a written plan of care.[16] The plan of care is generally prepared by a nurse or therapist at the home health agency. The patient's treating physician certifies the order for service by signing the plan of care. Additionally, the physician's signature satisfies the requirement that the doctor must certify the patient's homebound status.[17] The physician must review the plan and renew the orders for home health services at least once every 60 days.[18]

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[12] 42 C.F.R. § 409.32.
[13] 42 U.S.C. § 1395x(m).
[14] Id.
[15] Id.
[16] 42 C.F.R.§§ 409.33; 424.22.
[17] Id.
[18] Id.

II. Advocacy Tips

A. The "Chronic and Stable Myth"

A common misunderstanding is that Medicare will not cover home health care for patients whose condition is chronic and stable. The applicable regulations are very clear that chronicity and stability are not determinative factors for Medicare coverage:

> The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal or expected to last a long time. [19]

As long as the coverage criteria are met, Medicare coverage should continue.

B. Skilled Care for Dementia Patients

CMS has clarified that a diagnosis of dementia should never preclude Medicare coverage for skilled care.[20] Indeed, dementia patients may well have a greater need for skilled interventions in order for rehabilitation therapy, nursing services, and other forms of Medicare treatment to be provided safely and effectively. As cognition declines, much of the care dementia patients require is custodial in nature. However, skilled care such as physical therapy to regain mobility after a fall, speech therapy to maintain the ability to swallow, or various psychological interventions to deal with a patient's depression or agitation are all services that should not be precluded from Medicare coverage solely because of a dementia diagnosis. Dementia patients, like all Medicare beneficiaries, are entitled to Medicare coverage of reasonable and necessary care and treatment.

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[19] 42 C.F.R.§ 409.44(c)(3)(iii).

[20] Program Memorandum Transmittal AB-01-135, (September 25, 2001), *Medical Review for Patients With Dementia*, available at http://www.cms.hhs.gov/manuals/pm_trans/AB01135.pdf.

C. The "Plateau Myth"

A common misperception that affects Medicare beneficiaries in need of rehabilitation therapy is that the patient must continually make measurable progress in order for the therapy services to be Medicare-covered. Beneficiaries are often erroneously told that Medicare only covers the therapy services if improvement can be documented. The Medicare regulation is clear in its directive that therapy to maintain function is Medicare-covered as long as the patient requires skilled interventions and the other coverage criteria are met.[21] The pertinent regulation addressing this issue reads in part:

> There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based upon the physician's assessment of the beneficiary's restoration potential and unique condition, . . . **or the skills of a therapist must be necessary to perform a safe and effective maintenance program.**[22] (Emphasis added.)

Another regulatory provision states:

> Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capacities."[23]

When the skills of a trained therapist are needed to assure the safety and efficacy of a therapy program in order to prevent deterioration or maintain function, those services should be Medicare-covered.

[21] 42 C.F.R. § 409.44(c)(2)(iii).
[22] 42 C.F.R. § 409.44(c)(2)(iii).
[23] 42 C.F.R. § 409.32(c).

D. What Does Medicare Home Health Cover?

For beneficiaries who meet the coverage criteria, Medicare covers intermittent nursing and home health aide care. Nursing services covered by Medicare include

- ♦ observation and assessment of a patient's changing condition;
- ♦ management of the overall plan of care, even if each individual component of the plan is unskilled; and
- ♦ nursing education, as in the case of a newly diagnosed diabetic who needs to learn how to manage the many aspects of diabetic care and treatment.[24]

Medicare-covered skilled therapy includes therapeutic activities that must be accomplished in the presence of the therapist in order to be effectively and safely carried out. Examples of skilled rehabilitation therapy include physical therapy for gait training and evaluation or speech therapy needed to restore speech or hearing.[25] Repetitive motion exercises generally do not qualify as skilled rehabilitative therapy services, as they do not need to be done with or under the direct supervision of a trained therapist.[26] Home health aide services primarily consist of "hands-on" personal care services, such as assistance with dressing, bathing, toileting, transferring, and eating, and may include associated light housekeeping for the patient. [27]

E. When Services Are Denied, Reduced, or Discontinued

It is not uncommon for Medicare home care benefits to be denied or threatened with termination. Informal advocacy in the form of discussions with the home health agency may help. The formal appeals process is time-consuming and unwieldy but may enhance the potential for an award of Medicare coverage. Appropriate advocacy interventions may prove very helpful when informal channels do not succeed.

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[24] 42 C.F.R. § 409.33(a)(3).
[25] 42 C.F.R. § 409.33(c).
[26] 42 C.F.R. § 409.33(c)(3).
[27] 42 C.F.R. § 409.45(b).

F. Resources for Consumer Education and Assistance

The State Health Insurance Assistance Programs (SHIPs) provide information, education, and assistance to Medicare beneficiaries. SHIP programs are available in every state and in the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. SHIP program contact information may be found on the Health Assistance Partnership Program Locator, by clicking on the "Program Locator" button on the homepage of the Health Assistance Partnership Web site (www.healthassistancepartnership.org). The Legal Services Corporation (http://www.lsc.gov/fundprog.htm) maintains a directory of federally funded legal aid organizations. Two Medicare advocacy organizations—the Medicare Rights Center (www.mrc.org) and the Center for Medicare Advocacy (www.medicareadvocacy.org) offer self-help material and information. To support advocacy and assistance on behalf of Medicare beneficiaries.

III. Conclusion

Homebound Medicare beneficiaries can experience significant improvement in the quality of their lives through effective use of the home health benefit, and the Medicare home health benefit can make a critical difference in enabling them to live their lives as they wish, independently, in their own homes and communities for as long as possible. Their advisors and advocates can help them by understanding the home health benefit and assisting them to make the most of it.

The **Health Assistance Partnership** provides support to the approximately 1,300 consumer health assistance programs across the country. The Health Assistance Partnership's mission is to help these programs to serve and educate health care consumers and to advocate for consumers' health care rights. These programs provide services to individuals and families whether they are privately insured, publicly insured, or uninsured. A project of Families USA, the Health Assistance Partnership is funded by the Robert Wood Johnson Foundation and has as its partners the Alliance of Community Health Plans, the American Hospital Association, and the American Nurses Association.

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