Medicare's Coverage of Home Health Care – Frequently Asked Questions

Program Overview

1. **What is home health care?**
   Home health care is a health service program that provides a range of skilled and personal care services to individuals in their home. The goal is to treat illness or injury while helping the individual recover and regain independence.

   Services are provided by a Medicare-certified home health agency (HHA) and may include skilled nursing care, therapy, and assistance from a home health aide.

2. **Who is eligible for Medicare-covered home health care?**

   To qualify for Medicare's home health benefit, a beneficiary must:

   - Be **homebound**, meaning they require assistance to leave the home or leaving home could worsen their condition
   - Need **intermittent** skilled nursing care, physical therapy, speech-language pathology services, or continued occupational therapy
   - Have a **face-to-face visit** with a doctor within 90 days before or 30 days after starting home health care
   - Have a **doctor certify** that they are homebound and need skilled care, and approve a plan of care
   - Receive care from a **Medicare-certified home health agency**

3. **What is considered "intermittent" skilled care?**
   Intermittent care means the beneficiary needs care at least once every 60 days and at most once a day for up to three weeks. This period can be extended if necessary, if the need for care is predictable and finite.

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4. **How is "homebound" defined by Medicare?**
   A person is considered homebound if:

   - They need help from another person or medical equipment to leave their home
   - Their doctor believes that leaving home could worsen their condition
   - They typically do not leave home except for brief outings, such as medical appointments, religious services, family events, or occasional errands like going to the barber

5. **What services are covered under Medicare's home health benefit?**
   If eligibility requirements are met, Medicare may cover the following services:

   - **Skilled nursing care** (e.g., injections, catheter care, wound treatment)
   - **Skilled therapy services** (physical, occupational, and speech therapy)
   - **Home health aide services**, when provided in conjunction with skilled care
   - **Medical social services** to assist with social and emotional concerns
   - **Medical supplies** (e.g., wound dressings, catheters)
   - **Durable medical equipment (DME)**, such as walkers or wheelchairs (covered at 80%)

6. **What services are excluded from Medicare home health coverage?**
   Medicare does not cover:

   - 24-hour care at home
   - Meals delivered to the home
   - Prescription drugs (unless covered separately under Part D)
   - Custodial care such as housekeeping, meal preparation, or bathing, unless it is part of a skilled care visit

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7. **Does Medicare cover home health care for chronic conditions?**
   Yes. Medicare should cover skilled home health care even if the beneficiary's condition is chronic or does not improve, if the services are medically necessary to maintain function or slow deterioration.

8. **How does a plan of care work?**
   Before starting care, the home health agency must assess the beneficiary's needs and create a **plan of care** that lists the services needed, their frequency, and expected outcomes. A doctor must sign and approve this plan, and it must be recertified every 60 days.

   A face-to-face visit with a doctor is required before the initial certification, but not for recertifications.

9. **What are the limits on home health care hours?**
   Medicare typically covers:

   - Up to **8 hours per day** and **28 hours per week** of combined skilled nursing and home health aide services
   - In special cases, up to **35 hours per week**

   The services must be reasonable and necessary, and the plan of care should reflect the appropriate number of hours.

10. **How do beneficiaries start home health care?**

    If hospitalized, a social worker or discharge planner can help coordinate care with a home health agency.

    If at home, the beneficiary should speak with their doctor, who can provide a referral to a Medicare-certified agency. The agency will assess the beneficiary and create a plan of care for approval.

11. **What should Medicare Advantage enrollees know about home health coverage?**

    Medicare Advantage Plans must provide the same level of home health coverage as Original Medicare but may:

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- Require prior authorization
- Use in-network agencies
- Charge a copayment for services

If no in-network agency will provide care, the plan must arrange out-of-network coverage or offer an alternative.

12. What happens if a home health agency denies care?

A home health agency can refuse to provide care if they believe they cannot meet the beneficiary's needs. If this occurs, beneficiaries should speak with their doctor and their Medicare plan to explore other options.

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