



## **NASW Practice Alert**

### **Home Health: NASW Advocacy for Telehealth During the COVID-19 Pandemic and Clarifications Regarding the Patient-Driven Groupings Model**

**August 2020**

The Medicare home health benefit, which includes medical social services, has long been essential to beneficiaries living with acute, chronic, and advanced health conditions. Access to home health services is of utmost importance during the coronavirus 2019 (COVID-19) pandemic. This Practice Alert provides an overview of the Medicare home health benefit; describes NASW’s advocacy on behalf of both home health social workers and beneficiaries served during the COVID-19 pandemic; and clarifies the status of home health social work under the Patient-Driven Groupings Model.

#### **Overview of the Medicare Home Health Benefit**

All home health services must be ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant to be eligible for Medicare coverage. Either skilled nursing, occupational therapy (OT), physical therapy (PT), or speech–language pathology (SLP)—or some combination thereof—must be ordered to initiate home health services (Hospital Insurance Benefits, 2020, § 409.44).

The Medicare home health benefit includes medical social services, which the Code of Federal Regulations (C.F.R.) describes in the following manner:

**Title 42: Public Health**  
**PART 409—HOSPITAL INSURANCE BENEFITS**  
**Subpart E—Home Health Services Under Hospital Insurance**  
**§409.45 Dependent services requirements.**

(c) *Medical social services.* Medical social services may be covered if the following requirements are met:

- (1) The services are ordered by a physician and included in the plan of care.
- (2)(i) The services are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the beneficiary's medical condition or to his or her [*sic*] rate of recovery.

- (ii) If these services are furnished to a beneficiary's family member or caregiver, they are furnished on a short-term basis and it can be demonstrated that the service is necessary to resolve a clear and direct impediment to the effective treatment of the beneficiary's medical condition or to his or her [*sic*] rate of recovery.
- (3) The frequency and nature of the medical social services are reasonable and necessary to the treatment of the beneficiary's condition.
- (4) The medical social services are furnished by a qualified social worker or qualified social work assistant under the supervision of a social worker as defined in §484.115 of this chapter.
- (5) The services needed to resolve the problems that are impeding the beneficiary's recovery require the skills of a social worker or a social work assistant under the supervision of a social worker to be performed safely and effectively. (Hospital Insurance Benefits, 2020)

Similar to OT, PT, SLP, and skilled nursing, medical social services are considered a “skilled professional service” within the Medicare home health benefit (Home Health Services, 2020, § 484.75). Yet, medical social services are also a “dependent service,” similar to home health aide services (Hospital Insurance Benefits, 2020, § 409.45). In other words, medical social services are not provided automatically to each Medicare beneficiary who uses home health.

Complicating this scenario is another factor: Skilled nursing is the only service every home health agency (HHA) *must* require. Along with skilled nursing, HHAs must offer at least one of the following services: home health aide services, medical social services, OT, PT, and SLP. As stated in the C.F.R., “An HHA must provide at least one of the services described in this subsection directly, but may provide the second service and additional services under arrangement with another agency or organization” (Home Health Services, 2020, § 484.105). This means that Medicare-certified HHAs do not need to employ staff to provide medical social services. However, if a physician or other prescribing practitioner orders medical social services for a Medicare beneficiary, an HHA must either arrange with another agency to provide those medical social services or forgo serving that particular beneficiary (K. Holt, personal communication, Apr. 28, 2020). The C.F.R. specifies that when medical social services are ordered for beneficiaries, the personnel who provide those services—whether directly or under arrangement—must participate in the coordination of care (Home Health Services, 2020, § 484.75).

The CMS tool Home Health Compare (<https://www.medicare.gov/homehealthcompare/search.html>) enables beneficiaries and other individuals to search for HHAs by geographic area. Each HHA listing specifies which services the particular agency offers.

Title 42 of the C.F.R. delineates the following personnel qualifications for people who provide medical social services in HHAs:

**PART 484—HOME HEALTH SERVICES**  
**Subpart C—Organizational Environment**  
**§484.115 Condition of participation: Personnel qualifications.**

HHA staff are [sic] required to meet the following standards:

(l) *Standard: Social Work Assistant.* A person who provides services under the supervision of a qualified social worker and:

(1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or

(2) Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that the determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

(m) *Standard: Social worker.* A person who has a master's or doctoral degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting. (Home Health Services, 2020)<sup>1</sup>

HHAs receive Medicare reimbursement for medical social services as part of a bundled payment structure known as a Prospective Payment System (Home Health Services, 2020, § 484.205). Reimbursement is based on 30-day episodes of care. For each episode of care, a prescribing practitioner must order specific services and a range of visits for each service. When only a small number of in-person (home) visits are made within a beneficiary's episode of care, the Medicare reimbursement to the HHA is reduced. This reduction is known as a Low-Utilization Payment Adjustment (LUPA) (Home Health Services, 2018, § 484.230). The specific LUPA threshold (between two and six visits) is based on each beneficiary's case mix—which, in turn, is based on several variables (Home Health Services, 2018, § 484.220; Stein & Holt, 2020). These variables have been altered by the PDGM, which is addressed subsequently.

For more than two decades, medical social services have been used much less than any other Medicare home health service, constituting (on average) only 0.1 home health visit of 17.8 visits per episode of care in 2018 (Medicare Payment Advisory Commission [MedPAC], 2020, p. 255). On average, then, only one in 10 beneficiaries received a medical social service visit per episode of care. (In reality, that number is probably less, because some beneficiaries might have received more than one medical social services visit per episode.) In contrast, skilled nursing constituted 8.2 visits per episode; OT, PT, and SLP, combined, constituted 8.0 visits; and home health aide services constituted 1.4 visits (MedPAC, 2020, p. 255). This disparity presents significant implications for social work staffing.

### **Clarification of “Homebound” Status During COVID-19**

Access to home health services is especially critical during the current public health emergency (PHE). Home health services help prevent hospitalization and stays in skilled nursing facilities, inpatient rehabilitation facilities, and other inpatient settings. Similarly, home health services are essential when beneficiaries transition home from the hospital and postacute settings—whether they have received inpatient care for COVID-19 or for other conditions.

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<sup>1</sup> For the remainder of this Practice Alert, the term *home health social worker* refers to social workers with baccalaureate, master's, or doctoral degrees who work in HHAs.

In response to the PHE, the Centers for Medicare & Medicaid Services (CMS) has clarified the nature of “homebound” status required for Medicare home health eligibility, as described in an emergency interim final rule released in early April:

The definition of “confined to the home” (that is, “homebound”) allows patients to be considered “homebound” if it is medically contraindicated for the patient to leave the home. . . . As an example for the PHE for COVID–19 pandemic, this would apply for those patients: (1) Where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she [*sic*] has a confirmed or suspected diagnosis of COVID–19; or (2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID–19. A patient who is exercising “self-quarantine” for one’s own safety would not be considered “confined to the home” unless a physician certifies that it is medically contraindicated for the patient to leave the home. For the PHE for the COVID–19 pandemic, the CDC is currently advising that older adults and individuals with serious underlying health conditions stay home (CDC’s guidance is interim and is expected to continue to be updated as warranted). As such, we expect that many Medicare beneficiaries could be considered “confined to the home”. However, 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. (Medicare and Medicaid Programs; Policy and Regulatory Revisions, 2020, p. 19247)

This clarification, with additional context and examples, applies to all services provided on or after March 1, 2020, and for the duration of the PHE. NASW expressed its support for the clarification in its June 2020 comments regarding the interim final rule (Mangum, 2020).

Moreover, as a member of the Leadership Council of Aging Organizations, NASW urged Congress in mid-March to provide “legislative language reinforcing implementation of the Jimmo v. Sebelius settlement (2013), which clarified that Medicare covers skilled home health care to maintain or prevent decline” (Aging Life Care Association et al., 2020, p. 4). This position is consistent with NASW’s participation in the Jimmo Implementation Council, which is convened by the Center for Medicare Advocacy (CMA) and supported by the John A. Hartford Foundation. Since 2015, NASW and other Jimmo Implementation Council members have been educating Medicare beneficiaries, beneficiary advocates, health care practitioners, provider organizations, payers, and other stakeholders regarding the implications of the Jimmo settlement agreement (CMA, 2020a; Herman, 2017).

### **Access to Telehealth During COVID-19**

NASW has learned that some Medicare beneficiaries have declined in-person visits from home health personnel during the PHE because they fear contracting COVID-19 from home health staff, as has occurred in at least one widely reported incident (Miller, 2020). This fear is exacerbated by the recognition that home health staff often travel to multiple clients’ homes per day.

During the past several months, NASW has also learned that some home health social workers lack sufficient personal protective equipment (PPE) to conduct home visits safely. Some of these have also informed NASW that their agencies are not permitting them to use telehealth. Instead, some social workers have been encouraged or required to continue in-person visits, risking both their own health and safety and that of the beneficiaries whom they serve.

To address these concerns, NASW has analyzed various materials from CMS and has communicated extensively with the National Association for Home Care and Hospice (NAHC) and CMA. These actions have yielded the following information regarding HHAs' use of telehealth during the PHE:

- In late March, CMS stated that HHAs may use telehealth at any point during the 30-day home health episode of care, provided such telehealth “is part of the patient’s plan of care and does not replace needed in-person visits as ordered on the plan of care” (CMS, 2020a, Further promote telehealth in Medicare section, para. 5). More detailed guidance from CMS (2020c), last updated in mid-May, stated,

We acknowledge that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care. Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and 2-way audio-video technology that allows for real-time interaction between the clinician and patient. However, only in-person visits can be reported on the home health claim. (p. 1)

CMS reiterated the preceding information in its interim final rule addressing COVID-19 (Medicare and Medicaid Programs; Policy and Regulatory Revisions, 2020, Section G).

- NAHC has clarified that no threshold of in-person visits is needed before qualifying for telehealth usage during the PHE (C. McDaniel, personal communication, Apr. 14, 2020). NAHC has further clarified that (1) any home health discipline’s in-person visit can count toward the LUPA threshold and (2) home health social workers are not required to do home visits as long as the LUPA threshold has been met by one or more other disciplines (C. McDaniel, personal communication, May 8, 2020). This information notwithstanding, the number of home health social workers who have reported *not* being permitted to use telehealth during the PHE has led NASW to conclude that some HHAs might be using the LUPA threshold to justify—erroneously—the need for in-person social work visits and to discourage provision of medical social services via telehealth.
- The interim final rule made clear that home health nurses may use telehealth during the PHE (Medicare and Medicaid Programs; Policy and Regulatory Revisions, 2020, p. 19248). Furthermore, CMS granted telehealth flexibility to occupational therapists (OTs), physical therapists (PTs), and speech–language pathologists (SLPs) in late April (CMS, 2020d, 2020e). In the two latter communications, CMS did not make clear whether such flexibility extended to OT, PT, and SLP services provided in a home health context or solely to OT, PT, and SLP services provided by independent licensed practitioners. When

NASW raised this question during a National Medicare Education Program call with CMS in mid-May, staff recognized the validity of the question and stated that additional guidance would be forthcoming (E. Yoder, personal communication, May 13, 2020). As of this writing, NASW awaits clarification regarding this matter.

In its June 2020 comments to CMS on the interim final rule, NASW expressed appreciation for CMS's flexibility regarding Medicare-certified HHAs' use of technology during the PHE and explained that some HHAs were not allowing home health social workers to use telehealth during the PHE. The association urged CMS to

allow home health social workers and social work assistants to provide services via telehealth (both audio-only and two-way audio–video) during the PHE . . . [to] ensure ongoing access to home health services while protecting the health and safety of Medicare beneficiaries, family caregivers, and home health staff. (Mangum, 2020, p. 2)

On June 25, CMS announced a proposed rule to make permanent the emergency rule enacted in late March (CMS, 2020b; Medicare and Medicaid Programs; CY 2021 Home Health, 2020). In its announcement, CMS (2020b) noted that the proposed rule, if finalized, would enable HHAs to

continue to utilize telecommunications technologies in providing care to beneficiaries under the Medicare home health benefit beyond the COVID-19 PHE, as long as the telecommunications technology is related to the skilled services being furnished, is outlined on the plan of care, and is tied to a specific goal indicating how such use would facilitate treatment outcomes. (para. 4)

CMS (2020b) went on to explain:

The use of technology may not substitute for an in-person home visit that is ordered on the plan of care and cannot be considered a visit for the purpose of patient eligibility or payment; however, the use of technology may result in changes to the frequencies and types of in-person visits as ordered on the plan of care. This rule also proposes to allow HHAs to continue to report the costs of telecommunications technology as allowable administrative costs on the home health agency cost report beyond the PHE for the COVID-19 pandemic. (para. 5)

Comments on this proposed rule are due on August 24. NASW is analyzing the rule and encourages members to submit their own comments directly to CMS.

In addition to regulatory advocacy, the association is exploring legislative strategies to enhance access to home health medical social services via telehealth. As a member of the Eldercare Workforce Alliance (EWA), NASW successfully advocated for inclusion of the following priority in EWA's late April letter to Congress: "Authorize Medicare reimbursement for home health medical social services provided via telehealth, including audio-only telehealth, during the COVID-19 pandemic" (Lundebjerg & Saunders, 2020, p. 3). This request was similar to one put forward by the American Hospital Association during the same month (Nickels, 2020). Although

Congress is considering various mechanisms to implement such a change, details regarding specific legislative proposals were not available at the time of this publication.

## **Other Advocacy for Social Workers in Home Health**

In addition to the preceding actions, NASW has advocated for various measures to protect the health and safety of social workers and clients in HHAs during the COVID-19 pandemic:

- implementation of workplace protections by the Occupational Safety and Health Administration (Better Balance, Advocating Opportunity, AFSCME, et al., 2020; NASW, 2020b)
- enhanced access to PPE (AFL-CIO et al., 2020; American Academy of Audiology, American Academy of Nursing, et al., 2020; Lundebjerg & Saunders, 2020; McClain, 2020; Whitman, 2020)
- widespread COVID-19 testing (AFL-CIO et al., 2020; American Academy of Audiology, American Academy of Nursing, et al., 2020; American Academy of Audiology, American Academy of PAs, et al., 2020; Lundebjerg & Saunders, 2020; McClain, 2020; Whitman, 2020)
- support for contact tracing to mitigate community transmission of COVID-19 (Whitman, 2020)
- designation of social workers as “essential personnel” in all states (Lundebjerg & Saunders, 2020)
- hazard pay, also known as premium pay, for all workers deemed “essential personnel” (American Academy of Audiology et al., 2020; Lundebjerg & Saunders, 2020; McClain, 2020; NASW, 2020a)
- guidance from the U.S. Department of Labor for returning to site-based work settings (Better Balance, Advocating Opportunity, AFL-CIO, et al., 2020)
- free COVID-19 vaccines, when available (Public Citizen et al., 2020).

The preceding list is not comprehensive. Please refer to the NASW COVID-19 Advocacy page (<https://www.socialworkers.org/Advocacy/Policy-Issues/COVID-19-Advocacy>) for additional information.

## **Patient-Driven Groupings Model (PDGM)**

PDGM is a Medicare payment system that applies to all home health services provided on January 1, 2020, or later (Medicare and Medicaid Programs, 2019). The system categorizes episodes of care into 432 payment groups based on the following characteristics: episode timing,

admission source, clinical category, functional–cognitive level, and presence of comorbidities (MedPAC, 2020, p. 256).

Although detailed information about the new payment system is beyond the scope of this Practice Alert, it is essential for social workers to understand that PDGM has *not* changed the Medicare home health benefit (CMA, 2020b; CMS, 2020f). Nonetheless, in the months since PDGM implementation, CMA has learned that the new payment system is limiting access to care in a few ways:

- PDGM unfairly reduces access to OT, PT, and SLP services for beneficiaries who qualify for these services (Stein & Holt, 2020, slide 24). In fact, CMA has noted, PDGM implementation has resulted in job loss or reduced hours for many OTs, PTs, and SLPs. This effect is consistent with a spring 2019 survey conducted by NAHC (Threlkeld, 2020), which found that one-third of the 685 responding HHAs planned to reduce therapy staffing under PDGM (as cited in Stein & Holt, 2020, slides 14–15).
- PDGM provides financial incentives for HHAs to serve beneficiaries with short-term needs, thereby reducing access for people with long-term home health needs—such as those who require OT, PT, SLP, or skilled nursing to maintain or prevent decline (Stein & Holt, 2020, slide 24).
- PDGM provides financial incentives for HHAs to serve beneficiaries who are referred following a stay in an inpatient hospital, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility. This prioritization decreases access for community-admitted beneficiaries—that is, for people who are at home when the physician or other prescribing practitioner orders home health services and have not had a recent inpatient stay. (Stein & Holt, 2020, slide 24)

CMA has also reported that some HHAs and Medicare contractors have provided inaccurate information regarding PDGM (K. Holt, personal communication, Apr. 28, 2020; Stein & Holt, 2020, slide 24). NASW has received similar reports and is concerned about how PDGM could be misused to reduce social work staffing. For example, some home health social workers have been told by their HHAs that Medicare no longer covers medical social services under PDGM. *NASW encourages social workers who receive such inaccurate information to convey it to the author of this publication ([cherman.nasw@socialworkers.org](mailto:cherman.nasw@socialworkers.org)), copying CMA ([homehealth@medicareadvocacy.org](mailto:homehealth@medicareadvocacy.org)).* The association also encourages social workers to use the following resources, all free of charge, to educate their colleagues and clients regarding home health benefits, eligibility, and coverage.



## Resources

### CMS

- Information for beneficiaries
  - General contact information  
1-800-MEDICARE or <https://www.medicare.gov/>
  - Medicare coverage of home health services  
<https://www.medicare.gov/coverage/home-health-services>
  - *Medicare & You 2020* handbook  
<https://www.medicare.gov/medicare-and-you>
  - Home Health Compare  
<https://www.medicare.gov/homehealthcompare/search.html>
  - Telehealth information during the COVID-19 PHE  
<https://www.telehealth.hhs.gov/>
  
- Information for providers
  - Proposed rule (comments due on August 24, 2020)  
<https://www.cms.gov/index.php/newsroom/fact-sheets/cms-proposes-calendar-year-2021-payment-and-policy-changes-home-health-agencies-and-calendar-year>
  - Home Health Agency Center  
<https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center>
  - Questions about home health payment policy  
[HomehealthPolicy@cms.hhs.gov](mailto:HomehealthPolicy@cms.hhs.gov)
  - Jimmo settlement  
<https://www.cms.gov/Center/Special-Topic/Jimmo-Center>
  - COVID-19 and other public health emergencies  
<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

- Emergency waivers and flexibilities  
<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities>
- Home health flexibilities during the PHE  
<https://www.cms.gov/files/document/covid-home-health-agencies.pdf>
- Telehealth guidance during the PHE  
<https://www.telehealth.hhs.gov/>
- Online manual system  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index>
- Medicare Learning Network  
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index>
- National Training Program  
<https://cmsnationaltrainingprogram.cms.gov/>
- Open Door Forum for home health, hospice, and durable medical equipment  
[https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF\\_HHHDME](https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HHHDME)

## CMA

- Home health care page  
<https://medicareadvocacy.org/medicare-info/home-health-care/>
- Jimmo settlement and implementation  
<https://medicareadvocacy.org/medicare-info/improvement-standard/>
- COVID-19 and Medicare  
<https://medicareadvocacy.org/covid-19-and-medicare-post/>
- Tool kits, checklists, and self-help packets  
<https://medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals/>
- Webinars (no continuing education credit provided)  
<https://medicareadvocacy.org/webinars/>
- Stories of Medicare and health care  
<https://medicareadvocacy.org/voices-of-medicare/>

- Registration for CMA alerts  
<https://medicareadvocacy.org/join/>

## NAHC

- Home care basics  
<https://www.nahc.org/consumers-information/home-care-hospice-basics/>
- National Agency Location Service  
<https://agencylocator.nahc.org/>
- Coronavirus resources  
<https://www.nahc.org/resources-services/coronavirus-resources/>
- PDGM Resource Center  
<https://pdgmrc.nahc.org/>

## NASW

- Comments to CMS regarding use of telehealth by HHAs  
<https://bit.ly/nasw-cms-hh-tele20>
- Blog: Jimmo settlement overview (2012)  
<http://www.socialworkblog.org/practice-and-professional-development/2012/12/cms-advocates-reach-proposed-settlement-agreement-to-eliminate-improvement-standard/>
- Practice Alert: Jimmo update (2017)  
<https://bit.ly/nasw-jimmo2017>
- Aging microsite  
<https://www.socialworkers.org/Practice/Aging>
- Other aging-related resources from NASW  
[https://bit.ly/nasw\\_aging\\_resources](https://bit.ly/nasw_aging_resources)
- COVID-19 microsite  
<https://www.socialworkers.org/Practice/Infectious-Diseases/Coronavirus>
- Advocacy microsite  
<https://www.socialworkers.org/Advocacy>

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**Prepared by Chris Herman, MSW, LICSW  
Senior Practice Associate—Aging**

*The author acknowledges Kathy Holt (CMA) and Calvin McDaniel (NAHC) for their collaboration on Medicare home health issues.*