Frequently Asked Questions
Home Health Compare

1. Who is eligible to get Medicare-covered home health care and what is covered?

All Medicare beneficiaries can get home health care benefits, if you meet the following conditions:

a) Your doctor must decide that you need medical care at home, and make a plan for your care at home; and

b) You must need at least one of the following: intermittent (and not full time) skilled nursing care, or physical therapy or speech language pathology services or continue to need occupational therapy; and

c) You must be homebound, or normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services. A need for adult day care does not keep you from getting home health care for other medical conditions; and

If you meet all of the conditions above for home health care, Medicare will cover

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

- Home health aide services on a part-time or intermittent basis. A home health aide does not have a nursing license. The aide provides services that support any services that the nurse provides. These services include help with personal care such as bathing, using the toilet, or dressing. These types of services do not need the skills of a licensed nurse. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your illness or injury.

- Physical therapy, speech language pathology services, and occupational therapy for as long as your doctor says you need it. Medicare covers these types of therapy:

  1) **Physical therapy**, which includes exercise to regain movement and strength to a body area, and training on how to use special equipment or do daily activities, like how to get in and out of a wheelchair or bathtub.

  2) **Speech-language pathology services**, which includes exercise to regain and strengthen speech skills.

  3) **Occupational therapy**, which helps you become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. You may continue to receive occupational therapy even if you no longer need other skilled care.

- **Medical social services** to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.

- **Certain medical supplies** like wound dressings, but not prescription drugs or biologicals.

- **Medical equipment***, Medicare usually pays 80 percent of the approved amount for certain pieces of medical equipment, such as a wheelchair or walker.

Currently, Medicare does not cover (does not pay) for the following:
- 24-hour per day care at home
- Prescription drugs
- Meals delivered to your home
- Homemaker services like shopping, cleaning and laundry
- Personal care given by home health aides like bathing, using the toilet, or help in getting dressed <u>when this is the only care you need</u>

Most of the time, your doctor, a social worker, or a hospital discharge planner will help arrange for Medicare-covered home health. However, you have a say in which home health care agency you use. For long-term home health care that is not covered by Medicare, you may make your own arrangements.

2. What does Medicare pay for and what can I be billed for?

Medicare pays the full approved cost of all covered home health visits. The home health agency sends bills to Medicare. Before your care begins, the home health agency must tell you how much of your bill Medicare will pay. The agency must also tell you if any items or services they give you are not covered by Medicare, and how much you will have to pay for them. This must be explained both by talking with you and in writing.

You may be charged for

- Medical services and supplies that Medicare does not pay for, such as prescription drugs.
- 20 percent coinsurance for Medicare-covered medical equipment such as wheelchairs, walkers, and oxygen equipment. If the home health agency doesn't supply medical equipment directly, they will arrange for a home equipment supplier to get you the items you need.

3. How long can I get home health services?

Medicare pays for your home health services for as long as you are eligible and your doctor says you need these services. However, the skilled nursing care and home health aide services are paid for only on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services.

To decide whether or not you are eligible for home health care, Medicare defines "intermittent" as

- Skilled nursing care that is needed or given on fewer than seven days each week or less than eight hours each day over a period of 21 days (or less).

Hour and day limits can be increased by your doctor in special cases where the number of hours per when the need for more care is limited and can be planned ahead.

> **For example**, Jane's doctor says that she needs a nurse to visit her every day for the next 15 days to care for a wound. The total time that the nurse will be at Jane's house will be less than an hour each day, and Jane only needs the nurse to come for 15 days. Jane's need for home health care meets the Medicare definition of "intermittent."

Once you are getting home health care, Medicare uses the following definition of part-time or intermittent to make decisions about your coverage:

- Skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week.

> **For example**, Fred has been getting home health care for 3 weeks. Fred's condition is improved, but his doctor would like Fred to continue to get home health care. Fred's doctor says that he needs a nurse to come in 3 days a week for 2 hours each day (a total of 6 hours) and a home health aide to come in 5 days a week for 3 hours each day (a total of 15 hours). This means that Fred is getting a total of 21 hours of home care per week, which meets Medicare's definition of "part-time or intermittent" home health care.

Medicare pays your home health agency a set amount of money for each 60 days that you need care. (This 60-day period is called an "episode of care.") The payment is based on what kind of health care an average person in your situation would need. Medicare has paid hospitals in this way for many years.

4. Does a doctor oversee my home health care services?

Your doctor will oversee your home health care by
- deciding you need care at home,
- helping to develop your care plan, and
- communicating with the home health agency about your progress.

A care plan describes what kind of services and care you must get for your health problem. Your doctor will work with a home health care nurse to decide

- what kind of services you need,
- what type of health care professional should give these services, and
- how often you will need the services.

Your care plan may also include things like the kind of home medical equipment you need, what kind of special foods you need, and what your doctor expects from your treatment.

Your doctor and home health agency staff review your care plan as often as necessary, but at least once every 60 days. If your health problems change, your care plan will be reviewed and may change. Home health agency staff must tell your doctor right away if your health changes. You will continue to get home health care as long as you are eligible and your doctor says you need it.

Only your doctor can change your care plan. Your home health agency cannot change your care plan without getting your doctor's approval. You must be told of any changes in your care plan. If you have a question about your care, you should call your doctor. If your agency changes your care plan without your doctor's approval, you have the right to appeal. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

If you feel your medical needs are not being met, you should talk to both your doctor and the home health agency.

5. What do I do if Medicare is not paying for an item or service that I feel should be paid for?

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

6. What do I do if Medicare stops paying for my home health care?

Home health agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you get this notice and your doctor believes you still need home health care and that Medicare should keep paying, you can ask Medicare for an official decision.
To get an official decision, you must:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Understand you may have to pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any coinsurance for durable medical equipment.

7. What if I want to change home health agencies?

Medicare will only pay for you to get care from one home health agency at a time. You may choose to end your relationship with one agency and choose another at any time. You must tell both the agency you are leaving and the new agency that you choose that you are changing home health agencies.

8. Where can I get help with my home health care questions?

If you have questions about your Medicare home health care and you are in the Original Medicare Plan, you should call your Regional Home Health Intermediary. Please, go to the **Helpful contacts** section of our website, select your State, pick Billing Medicare, then click on the view results button at the bottom. The resulting page will contain the phone number for the Regional Home Health Intermediary (RHHI) in your State.

If you have questions about home health care and you are in a Medicare Managed Care Plan, call your plan. If you are covered by another kind of supplemental insurance plan, call the plan's member services office.

Your State Health Insurance Assistance Program (SHIP) is another resource that is available to you. SHIP counselors should be able to answer your questions about home health care and what Medicare, Medicaid, and other types of insurance pay for. In addition, these counselors will help you with Medicare payment questions; questions on buying a Medigap policy, or long-term care insurance; dealing with payment denials and appeals; Medicare rights and protections; sending complaints about your care or treatment; or choosing a Medicare health plan. Please, go to the **Helpful contacts** section of our website, select your State, pick General Medicare Information, then click on the view results button at the bottom. The resulting page will contain the phone number for the SHIP for your State.

9. Can I choose any home health agency if I am in a Medicare Managed Care Plan?

Medicare managed care plans are health care choices that are available in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Medicare managed care plans must cover all Medicare Part A and Part B health care, including home health care.

If you belong to a Medicare managed care plan, you can only choose a home health agency that works with the managed care plan. Call your managed care plan if you have questions about the plan's home health care rules, coverage, appeal rights, and your costs. If you get services from a doctor or a home health care agency that doesn't work with the managed care plan, neither the plan nor Medicare will pay the bill.

If you are not sure if you are in a Medicare managed care plan, you can call your local Social Security Administration (SSA) office, or call SSA at 1-800-772-1213.

If you would like more information about Medicare managed care plans that are available in your area, please visit the **Medicare Personal Plan Finder** section of **www.medicare.gov**.

10. What can I do if I have a complaint about the quality of my home health care?

If you believe that the home health agency is not giving you good quality care, or you have a complaint about your home health agency, you should call your State home health hotline. Your home health agency should give you this number when you start getting home health services. Or you can call the Quality Improvement Organization (QIO) in your State to file a complaint. Please, go to the **Helpful Contacts** section of our website, select your State, pick Quality of Care/Complaints, then click on the view results button at the bottom. The resulting page will contain the phone number for the Quality Improvement Organization (QIO) in your State.

11. How do I recognize and report suspected fraud with a home health care agency?

Most home health agencies are honest, and use correct billing information. Unfortunately, fraud can occur in the home health industry. It wastes Medicare dollars and takes money used to pay claims. You are important in the fight to prevent fraud, waste, and abuse in the Medicare program.

The best way to protect your home health benefit is to know what Medicare covers, and to know what your doctor has planned for you. If you do not understand something in your care plan, ask questions.

To report suspected home health care or Medicare fraud, call 1-800-447-TIPS (1-800-447-8477) or, send a note to **HHSTips@oig.hhs.gov** by e-mail. Suspected home health care fraud can also be reported to your Regional Home Health Intermediary (RHHI). Please, go to the **Helpful contacts** section of our website, select your State, pick Billing Medicare, then click on the view results button at the bottom. The resulting page will contain the phone number RHHI in your State.

You should look for

- Home health visits that your doctor orders that you never get.
- Visits by home health staff that are not needed.
- Bills for services and equipment you never get.
- Faking your signature or your doctor's signature.
- Pressure to accept items and services that you do not need.
- Items listed on your Medicare Summary Notice or Explanation of Medicare Benefits that you do not think you received.

You also should be careful about the following activities:

- Home health services your doctor did not order. The doctor who approves home health services for you should know you, and should be involved in your care. If your care plan changes, make sure that your doctor was involved in making those changes.

- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give

your Medicare or Medicaid number to people who tell you a service is free, but they need your number for their records.

12. What is risk adjustment?

Risk adjustment is a scientific method of accounting for differences between home health agencies and how sick their patients are (called case-mix) to present a fairer comparison of the data. Risk adjustment takes into consideration certain patient characteristics, which may predispose the patient to a condition. Risk adjustment also accounts for home health agencies admitting practices, which may affect a home health agency's overall patient case mix. This risk adjustment will help to "level" the playing field for home health agencies that treat a more acute or dependent patient population.

14. Why do the results in Home Health Compare show home health agencies (HHAs) whose business offices are outside the area of my search criteria? (Answer ID 1979)

The search in Home Health Compare (HHC) is based on the places where a HHA has provided services in the past, not the physical location of the agency or it's Certificate of Need area.

Any HHA that has provided services in a selected zip, county or state will be included in the search results, this includes HHAs that crossed county and/or state lines.

15. How often is the data for Home Health Compare updated?

Information such as names and addresses of Home Health Agencies is updated monthly. The quality measure data will be updated quarterly beginning with the national rollout.