Metrolina Vascular Access Care
Comments in Opposition to
Certificate of Need Applications to Add ORs in
Mecklenburg County
November 1, 2018 CON Review Cycle

Introduction

The 2018 State Medical Facilities Plan ("2018 SMFP") recognized a need for six operating rooms ("ORs") in Mecklenburg County. Five applicants have filed Certificate of Need ("CON") applications for ambulatory surgery centers ("ASCs") or additional hospital ORs in response to the identified need including Project I.D. F-011612-18- Metrolina Vascular Access Care, LLC ("MVAC"). The other four applicants include:

- F-011619-18 Waveco, LLC d/b/a Carolina Center for Specialty Surgery ("CCSS")
- F-011620-18 Charlotte Mecklenburg Hospital Authority ("CHMA") d/b/a Carolinas Medical Center ("CMC")
- F-011621-18 Mercy Hospital Inc. d/b/a Carolinas HealthCare System Pineville ("CHS-Pineville")
- F-011624-18 The Presbyterian Hospital d/b/a Novant Health Huntersville Medical Center ("NHHMC")

Each of the above projects proposes to implement the proposed ORs in different ways as follows:

Metrolina Vascular Access Care, LLC

MVAC is unique among the applicants for ORs in Mecklenburg County in that it represents the only new and innovative model for healthcare delivery in an ASC setting. All other applicants represent extensions of existing hospital services or expansion of hospital-based OR capacity for which there are numerous choices in Mecklenburg County. As an ASC, MVAC will change the paradigm of care for a unique, large, and growing base of patients with ESRD, for which there is no other coordinated system of care in which they can receive the percutaneous and surgical services needed to maintain their ongoing schedule of dialysis. The proposed project provides a cost-effective environment for ESRD patients to receive the specialized care they require.

The ESRD population in the proposed service area (Mecklenburg, Gaston, and Union Counties) is growing significantly. From 2017 to 2018, the ESRD population grew by 5 percent. ESRD patients have typically received their vascular access care in a very fragmented and costly delivery model, through a combination of physician practice-based procedures, expensive emergency department visits, and hospital inpatient and outpatient surgery procedures. MVAC will be able to very cost-effectively provide ESRD or late stage chronic kidney disease (CKD) patients' vascular access needs in one location—from vein mapping and surgical planning, venography and access creation, to fistula maturation and access maintenance (through thrombectomy, angioplasty, and stenting). In so doing, MVAC will raise the level of the clinical care of an increasing patient population with very specific needs. The ESRD patients to be

served by MVAC are unusual from an ambulatory surgery perspective because their access care tends to be chronic in nature, as opposed to episodic, and patients will typically receive multiple percutaneous and surgical procedures per year, each year during their ongoing dialysis treatment. They are also unique due to the urgent/semi-emergent nature of their procedures, often required to be performed the same day in order to maintain vascular access and continue routine dialysis treatment. None of the existing hospitals or ambulatory surgery options in Mecklenburg County are currently focused on or designed to meet the specific vascular access needs of this population.

As shown below, none of the OR projects proposed by the four other applicants in this batching cycle will address the needs identified by MVAC. MVAC and its Azura Vascular Care ("AVC") affiliate have fully documented the demands of this population. Further, MVAC and AVC have shown the benefits of raising the level of care for vascular access procedures to licensed ASCs, and better coordination of care through focused, dedicated ASCs. This is a trend that is occurring nationally and MVAC proposes to be the first center of its kind in the greater Charlotte area.

Charlotte Mecklenburg Hospital Authority d/b/a Atrium Health

It is important to note that, of the five applications in this review, three are affiliated with the Charlotte Mecklenburg Hospital Authority d/b/a Atrium Health ("Atrium Health").

The three concurrent and complementary applications submitted by Atrium Health and its affiliates include:

- CCSS' application to add one OR to an existing two-OR joint venture ASC focused on neuro/spine surgery;
- CMC's application to add four hospital-based ORs; and
- CHS-Pineville's application to add one hospital-based OR.

Ultimately, Atrium Health proposes that it is entitled to all six ORs identified in the 2018 SMFP in Mecklenburg County. Atrium Health explains it is entitled to all six ORs by contending that the need identified in the 2018 SMFP for Mecklenburg County is driven by the utilization across the Atrium Health facilities in the county. It is well settled that a need identified in the SMFP is not pre-determined to be limited to an entity or entities that may generate a quantitative need or petition for a need. In multiple circumstances, CON applications have been awarded to applicants that did not generate the need or petition for a need. Just like any applicant, Atrium Health must demonstrate that each of its applications is the best application independently to meet the SMFP need without presumption of preference. Further, the approval of all ORs within the Atrium Health system does not ensure the benefits of competition recognized under Criterion 18a.

Carolina Center for Specialty Surgery

Waveco, LLC owns and operates Carolina Center for Specialty Surgery, an existing freestanding ASC with two licensed operating rooms located in Charlotte. The ASC is a joint venture between the Charlotte-Mecklenburg Hospital Authority (CHMA) d/b/a Atrium Health and NeuroSpine,

LLC; each member owns an equal 50 percent share in the ASC. NeuroSpine, LLC is comprised of individual physician owners affiliated with Carolina Neurosurgery and Spine Associates (CNSA). The CCSS application proposes to develop one additional operating room in space currently utilized for sterile supply and storage.

Along with neurosurgery (including spine and brain), CCSS also provides orthopedic surgery, including arthroscopies and foot and ankle surgery, as well as pain management treatment. CCSS bases the need for the proposed project based on the following factors:

- Demand for surgical services across sites of care and in North Carolina and Mecklenburg County
- Need for additional capacity for Atrium Health patients
- Growth and aging of the Mecklenburg County population

CCSS contends that the need for operating rooms in the 2018 SMFP for Mecklenburg County was triggered by the utilization of Atrium Health facilities. Further, CCSS states that it has exceeded the capacity of its two operating rooms. Thus, in order to continue shifting ASC-appropriate cases from a higher cost hospital-based setting to CCSS, CCSS claims that additional capacity is needed. This theory of the need to shift cases to a lower-cost ASC setting is completely contradictory to Atrium Health's other two applications to collectively add five more hospital-based ORs to Mecklenburg County.

CCSS does not propose to add anything new that does not exist within Mecklenburg County. ASC services including neurosurgery, spine surgery, orthopedic surgery, and pain management are readily available at numerous ASCs and hospitals throughout the county. Unlike MVAC, CCSS does not bring a new service to the area to meet a need demonstrated for a chronic, highly fragile patient population allowing them to be served in the highest quality, most cost-effective setting.

Carolinas Medical Center

In the second of three concurrent and complementary applications affiliated with Atrium Health, CMC proposes to develop four additional operating rooms at CMC pursuant to the need identified for Mecklenburg County in the 2018 SMFP and to acquire one additional Da Vinci robot. All four operating rooms will be developed in existing, renovated space.

CMC currently operates a total of 26 shared operating rooms, five dedicated open heart operating rooms, and one trauma room. In this application, CMC proposes to add two operating rooms to its shared operating room in its main surgical suite and two operating rooms in CMC's One Day Surgery space. Through a series of relocations, CMC has been previously approved to relocate two ORs from the CMC One Day Surgery department to Randolph Surgery Center (Project ID # F-11106-15) and relocate a third operating room from CMC One Day Surgery to the CMC Mercy location (Project ID # F-11268-16).[1] CMC explains that these two projects are expected

[1] Note that CMC-Mercy is licensed as a part of CMC, and its operating rooms are included as part of CMC in the 2018 SMFP. CMC proposes to backfill the two operating rooms vacated as a result of the relocation to Randolph Surgery Center.

to be complete in January 2019 and October 2019, respectively. Ultimately, CMC will be left with 10 operating rooms in its One Day Surgery department, in comparison to its current inventory of 11 ambulatory operating rooms in One Day Surgery, and will increase its shared OR capacity by one room. Ultimately, this project simply backfills ORs previously approved for relocation presumably in contradiction to the prior arguments by Atrium Health affiliates that the ORs were not needed at CMC and rather were needed at CMC-Mercy and Randolph Surgery Center.

CMC cites exactly the same factors influencing the need for the proposed project as it did for its CSCC project:

- Demand for surgical services across sites of care and in North Carolina and Mecklenburg County
- Need for additional capacity for Atrium Health patients
- Growth and aging of the Mecklenburg County population

CMC highlights its efforts to shift lower acuity patients from the hospital-setting to the ASC setting by submitting the aforementioned concurrent and complimentary applications; however, this application results in a net increase of 4 ORs in a hospital-based setting, which is contradictory to the suggested need to shift more OR capacity to less costly ASCs.

Like the CCSS application, the CMC application does not propose to add anything new that does not exist within Mecklenburg County. Unlike MVAC, CCSS does not bring a new service to the area to meet a need demonstrated for a chronic, highly fragile patient population allowing them to be served in the highest quality, most cost-effective setting. Notably, this application represent replacement of existing hospital-based OR capacity, an admittedly high-cost setting, and apparently ORs that were not claimed to be needed at CMC in its prior CON applications.

Carolinas HealthCare System Pineville

The last of three concurrent and complementary applications submitted by Atrium Health proposes to develop one additional operating room at CHS-Pineville pursuant to the need identified for Mecklenburg County in the 2018 SMFP.

According to the application, in 2005, Atrium Health initiated a series of projects to relocate resources from CMC and CMC-Mercy to expand the inpatient capacity and tertiary services at CHS-Pineville. CHS-Pineville contends in its application that demand for services has outpaced that which was projected when the relocations were proposed. As such, CHS has not only submitted an application for an additional OR on site but also submitted a separate application for the development 50 additional acute care beds to accommodate expected growth at the medical center.

CHS-Pineville currently operates 10 existing operating rooms within its main surgical suite, which includes one dedicated open heart room and nine shared operating rooms. The proposed additional operating room will be developed in renovated space that is currently used for equipment storage.

The Applicant establishes the need for an additional OR at CHS-Pineville based on service area population growth and high utilization of services. CHS-Pineville does not explicitly indicate the types of services it proposes to provide; thus, it is assumed that CHS-Pineville will continue to provide the same surgical services it currently provides. Again, CHS-Pineville's application will not provide any new services to the area nor will it promote cost-effective care by adding more shared, hospital, OR capacity. Further, adding more services at CHS-Pineville and within the Atrium Health system will not enhance competition in the county.

Novant Health Huntersville Medical Center

The Presbyterian Hospital d/b/a Novant Health Huntersville Medical Center proposes to add 12 new acute care beds and one operating room. More specifically, the proposed project will require the conversion of 12 existing unlicensed labor, delivery, recovery (LDR) rooms to licensed acute care labor, delivery, recovery, and post-partum (LDRP) rooms and up-fit existing space in the NHHMC surgical suite to create one new OR for a total of 151 acute care beds and 8 ORs (7 shared ORs and 1 dedicated C-Section OR). As such, this project triggers a change of scope for a previously-approved project to relocate 48 acute care beds and one OR from Novant Health Presbyterian Medical Center to NHHMC for a total for 139 beds and 7 ORs (Project ID #F-11110-15). The Previously-Approved Project is on track to be completed in July 2019. The additional OR will be created by remodeling existing space in the NHHMC surgical suite.

NHHMC cites several reasons for its proposed project including:

- Significant population growth
- Significant growth in obstetrical services at NHHMC
- Increasing number of total births in the service area and increasing NHHMC market share
- Recruitment of OB/GYN staff at NHHMC
- Addition of the Nocturnist Program at NHHMC

NHHMC contends that based on assumptions published in the 2018 SMFP for average OR staffing hours, the sixth OR scheduled to come online in July 2019 will be fully utilized the day that it opens. At an average of 1,500 scheduled hours per operating room specified in the SMFP, NHHMC states that it will need eight shared operating rooms, more than the seven it is requesting in its application. NHHMC indicates that the additional OR will enable the hospital to better manage its surgical volumes and avoid the necessity to "bump" scheduled surgeries for emergency and other unscheduled surgeries. NHHMC does not indicate that it intends to expand its current offering of surgical services. As such, it is assumed that, if approved, NHHMC will continue to offer the surgical services it currently provides. Further, NHHMC proposes less cost-effective shared hospital OR capacity. Finally, the NHHMC application will not address the need identified by MVAC to serve fragile patients with ESRD.

Summary of Proposed ORs and Procedure Rooms

The following table summarizes the proposed ORs and procedure rooms for all applicants and the intent of patients that will be served. This summary further confirms the unique nature of the proposed MVAC. All other applicants propose an expansion of the services currently offered by their hospital system. MVAC proposes a new and innovative ASC, focused on meeting and elevating care to a unique patient population and expanding the continuum of care offered to ERSD patients in the Charlotte area.

Applicant/System	ORs Proposed	Procedure Rooms Proposed	Intent of Patients to be Served
Carolina Center for Specialty Surgery	2	0	Multi-specialty Outpatient Campus
Carolinas Medical Center	4	0	Multi-specialty Hospital Shared ORs (2) Multi-specialty Outpatient Service (2)
Carolinas HealthCare System Pineville	2	0	Multi-specialty Hospital Shared ORs
TOTAL Atrium Health Affiliates	**6**	**6**	
Metrolina Vascular Access Care	1	1	ESRD/Vascular patients not historically served in existing Mecklenburg County hospitals or ASCs
Novant Health Huntersville Medical Center	1	0	Multi-specialty Hospital Shared ORs

Note that Atrium Health proposes that all six ORs be granted to Atrium Health-affiliated facilities. While it is acknowledged that the utilization at Atrium Health facilities was a key component in the 2018 SMFP need determination, granting all six ORs to Atrium Health would only perpetuate access to the same patient base that is currently receiving care in an OR setting. It is important that the available ORs are distributed in a way that provides optimal, diverse access to patients in need within the Mecklenburg County area. MVAC is clearly the only applicant proposing to bring new services and thereby a new patient base to the OR setting.

Comparative Factors

Project Cost and Cost per OR

In terms of capital cost and cost per OR, CCSS is the lowest in capital cost, and NHHMC is the highest in capital cost.

Applicant	Capital Expenditure	Operating Rooms	Cost per Room
Metrolina Vascular Access Care, LLC	$ 2,900,000	1	$2,900,000
Novant Health Huntersville Medical Center	$ 7,110,815	1	$7,110,815
Carolina Center for Specialty Surgery	$ 1,912,512	2	$ 956,256
Carolinas Medical Center	$15,030,099	4	$3,757,525
Carolinas HealthCare System Pineville	$ 2,800,000	2	$1,400,000

That being said, there are additional factors that cannot be explicitly quantified, although they ultimately influence the comparative factors between all applicants:

- NHHMC has included 12 acute care beds in its proposal for an additional OR. These expenditures are included in the capital cost. The cost of the proposed additional OR is not presented separately from the overall project cost.

- MVAC is the only applicant who proposes to develop a procedure room.

- All but two projects (MVAC and CCSS) are hospital-based projects. This must be balanced with typically higher charges, costs to patients and payors, and cost of care in a hospital setting.

- All applicants except for MVAC are existing providers who are expanding their services; MVAC is proposing to build a new facility, whereas all other applicants are proposing to renovate existing space.

In consideration of capital cost and cost per OR as well as the broad influence of the aforementioned factors, MVAC is among the most cost-effective projects and is the third lowest capital cost overall. Not only must one consider the capital cost for the proposed projects, but also operating costs should be taken into account. It is clear that the hospital setting requires higher operating costs than the ASC setting which most certainly further diminishes the cost-effectiveness of the proposed hospital-based projects.

Financial Accessibility

In terms of financial accessibility, MVAC, by far, projects to provide the highest combined percentage of patients in the Medicare, Medicaid, and Charity Care payor categories. This high level of financial accessibility is important for the chronic patient population that MVAC proposes to serve. MVAC should receive favorable consideration based on its projected level of financial accessibility. It is important to note that patients are eligible for Medicare upon the determination that they are ESRD patients. See Attachment A. Thus, MVAC's patient base listed as Medicare includes patient of all ages and includes low income individuals that would also typically be covered by Medicaid or charity care. Thus, an exact "apples-to-apples" comparison cannot be made by individual payor category between the other applicants and MVAC.

Mecklenburg County OR Applicants
Year 2 Projected Payor Mix – Operating Rooms

Applicant	Medicare %	Medicaid %	Charity Care %*	Total
Metrolina Vascular Access Care	65.6%	5.1%	1.0%	71.7%
Novant Health Huntersville Medical Center	41.9%	3.8%	2.3%	48.0%
Carolina Center for Specialty Surgery	22.8%	0.6%	0.6%	24.0%
Carolinas Medical Center	27.3%	19.9%	6.0%	53.2%
Carolinas HealthCare System Pineville	40.0%	5.1%	3.4%	48.5%

**includes Self-Pay Patients*

While there are several other factors that can be compared among the projects, some are not meaningful, such as charges, because no patients or payors actually pay charges. Further, the wide variety of types of procedures proposed to be performed by various applicants renders such a comparison meaningless.

Most important from a comparative factor is the type of patients to be served and whether each applicant contributes to the range of surgical options available to Mecklenburg County residents. Only MVAC provides a new and innovative type of surgery center focused on serving one of Mecklenburg County's and North Carolina's most vulnerable populations.

Conclusion

None of the proposed projects discussed above address the needs that MVAC identifies in its application for ESRD patients. Without an ASC that is focused on ESRD patients as MVAC proposes, these vulnerable patients are hospitalized for their vascular access needs. Hospitalization creates major health risks for this vulnerable population and is the most expensive setting for vascular access care. For instance, in comparison to hospital-based fistula

creation and revision, the proposed ESRD-ASC is a more cost-effective site of service. These patients are better cared for in a licensed ASC setting focused solely on the ESRD patient needs.

MVAC is seeking one OR and one procedure room to provide services specifically to the growing ESRD patient population. As previously established, this patient population is vulnerable and requires coordinated, specialized care. Many of the other applications propose to provide services that are currently already offered in the service area by one provider or another. Further, three out of the four other applications are hospital-based projects. As detailed in MVAC's application, the hospital setting is much more costly and exposes ESRD patients with weakened immune systems, potentially risking patient safety. The only other proposed ASC does not offer the types of services that MVAC proposes to offer to meet the needs of the ESRD population.

ESRD patients are unique. They require coordinated care under the supervision of a nephrologist and a team of individuals who understand how to manage not only the renal disease itself but also the multiple co-morbidities that all too often caused the ESRD. This is not a patient population that can be adequately cared for in a multispecialty setting. On the contrary, patients in existing ASCs are all pre-scheduled, usually weeks in advance, and these ASCs simply cannot accommodate the unpredictable and urgent nature of ESRD patients' vascular access needs. Further, ESRD patients also have significant co-morbidities, which may cause concern to staff, physicians and facility administrators not experienced with this patient population. Lastly, existing ASCs lack the presence of a dedicated on-site interventionalist available to provide same day or next day service so that patients avoid missed dialysis treatments.

These patients require unique, individualized ESRD-focused care. MVAC proposes to provide vascular access procedures performed by the same team that manages the patients' overall ESRD care. The location of the vascular access procedures is just minutes from the location of where these patients receive their dialysis treatment. Essentially, an ESRD patient could have their vascular access procedure and conveniently report immediately for their dialysis treatment.

The ESRD patient population brings new volume that is currently not offered in the ASC setting in Mecklenburg County. Further, no other applicant specifically proposes to provide these specialized vascular access services to ESRD patients. Metrolina Vascular Access Care, LLC contends that its proposed project for an ASC with one OR and one procedure room should be approved in order to ensure that ESRD patients in Mecklenburg County have access to the services they need and that no other applicant proposes to serve.

Attachment A

Medicare Coverage for ESRD Patients

CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Coverage of Kidney Dialysis & Kidney Transplant Services

This official government booklet explains:

- ★ The basics of Medicare
- ★ How Medicare helps pay for kidney dialysis and kidney transplants
- ★ Where to get help

The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

"Medicare Coverage of Kidney Dialysis & Kidney Transplant Services" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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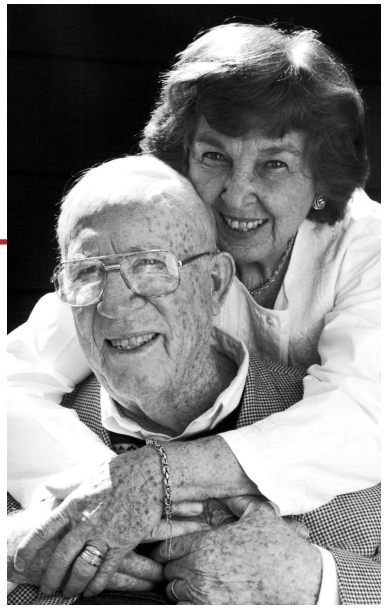
Introduction



This booklet explains what Medicare covers and how Medicare helps pay for kidney dialysis and kidney transplant services in Original Medicare.

In most cases, you can't join a Medicare Advantage Plan (like an HMO or PPO) if you have End-Stage Renal Disease (ESRD) (see pages 8–9) for exceptions to this rule). If you're in a Medicare Advantage Plan or another Medicare health plan, other than Original Medicare, your plan must give you at least the same coverage that Original Medicare gives, but your costs, rights, protections, and/or choices of where you get your care may be different. You may also be able to get extra benefits. Read your plan materials or call your benefits administrator for more information.

Talk with your health care team to learn more about permanent kidney failure and your treatment options. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team.

Your health care team can help you decide what's best for you based on your situation. If you have questions about Medicare or need more information, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Section 1: Medicare basics

What's Medicare?

Medicare is health insurance for:

- People 65 and older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

What does Medicare cover?

Medicare Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Inpatient care in skilled nursing facilities (not custodial or long-term care)
- Hospice care
- Home health care

Medicare Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Many preventive services

For more details about what Medicare covers, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Words in red are defined on pages 49–52.

Determine if you're eligible

You can get Medicare no matter how old you are if your kidneys no longer work, you need regular dialysis or have had a kidney transplant, and one of these applies to you:

- You've worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee.
- You're already getting or are eligible for Social Security or RRB benefits.
- You're the spouse or dependent child of a person who meets either of the requirements above.

You must also file an application and meet any waiting periods that apply.

If you qualify for Medicare Part A, you can also get Medicare Part B. Most people must pay a monthly premium for Part B. See page 31. Enrolling in Part B is your choice, but **you'll need both Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services.**

If you don't qualify for Medicare, you may be able to get help from your state to pay for your dialysis treatments. See pages 41–42.

Call Social Security at 1-800-772-1213 for more information about the required amount of time needed under Social Security, the RRB, or as a government employee to be eligible for Medicare based on ESRD. You can also visit socialsecurity.gov. TTY users can call 1-800-325-0778.

If your child has ESRD

Medicare covers people of all ages who have ESRD. Your child can be covered if you or your spouse has worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee. Your child can also be covered if you, your spouse, or your child gets Social Security or RRB benefits, or is eligible to get those benefits.

Medicare can help cover your child's medical costs if your child needs regular dialysis because his or her kidneys no longer work, or if he or she has had a kidney transplant.

Use the information in this booklet to help answer your questions, or visit Medicare.gov/publications to view the brochure "Medicare for Children with End-Stage Renal Disease: Getting Started." You can also contact your local Social Security office, or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Medicare plan choices

Medicare generally offers different choices for how you can get your health and prescription drug coverage, although the choices may be limited if you have ESRD. Your costs will vary depending on your coverage and the services you use.

Medicare plan choices (continued)

If you have ESRD & you're new to Medicare

You'll most likely get your health care through Original Medicare. You can go to any doctor or supplier that's enrolled in and accepts Medicare and is accepting new Medicare patients, or to any participating hospital or other facility.

You pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance or copayment) for covered services and supplies.

When you have Original Medicare, you can add Medicare prescription drug coverage (Part D) by joining a Medicare Prescription Drug Plan. Different plans cover different drugs, but most medically necessary drugs must be covered. See page 27 for more information.

Medicare Advantage Plans & other options

You usually can't join a Medicare Advantage Plan (like an HMO or PPO) if you already have ESRD and haven't had a kidney transplant. However, you may be able to join a Medicare Special Needs Plan (SNP), if one is available in your area for people with ESRD.
A Medicare SNP is a type of Medicare Advantage Plan for people who have a severe or disabling chronic disease, who are institutionalized, or who are entitled to Medicaid. These plans must provide all Medicare Part A and Medicare Part B health care and services, as well as Medicare prescription drug coverage.

You also may be able to join a Medicare Advantage Plan if you're already getting your health benefits (for example, through an employer health plan) through the same organization that offers the Medicare Advantage Plan. While you're in a Medicare Advantage Plan, your plan will be the primary provider of your health care coverage.

If you had ESRD, but have had a successful kidney transplant, and you still qualify for Medicare benefits (based on your age or a disability), you can stay in Original Medicare, or join a Medicare Advantage Plan.

If you have ESRD and are enrolled in a Medicare Advantage Plan that stops being offered in your area, you have a one-time right to join another Medicare Advantage Plan if one is available in your area.

For more information about your Medicare plan choices, look at your "Medicare & You" handbook. You can also call 1-800-MEDICARE (1-800-633-4227) to get more information. TTY users can call 1-877-486-2048.

How to sign up for Medicare

If you're eligible for Medicare because of ESRD, you can enroll in Medicare Part A and Medicare Part B by visiting your local Social Security office or by calling Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: If you're already enrolled in Medicare based on age or disability, and you're already paying a higher Part B premium because you didn't enroll in Part B when you were first eligible, the penalty will stop when you become eligible for Medicare based on ESRD. Call your local Social Security office to make an appointment to re-enroll in Medicare based on ESRD.

When Medicare coverage begins

Eligibility for Medicare coverage based on ESRD works differently than other types of Medicare eligibility. If you're eligible for Medicare based on ESRD and don't enroll right away, you may be eligible for up to 12 months of retroactive coverage, once you're enrolled in Medicare. For more information on how the 12 month period of retroactive coverage works, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you're on dialysis

When you enroll in Medicare based on ESRD **and you're on dialysis**, Medicare coverage usually starts on the first day of the fourth month of your dialysis treatments. For example, if you start dialysis on July 1, your coverage will begin on October 1.

July	August	September	October
First month of dialysis.	Second month of dialysis.	Third month of dialysis.	Fourth month of dialysis. **Medicare coverage begins.**

Medicare coverage can begin the first month of a regular course of dialysis treatments if you meet both of these conditions:

- You participate in a home dialysis training program offered by a Medicare-approved training facility during the first 3 months of your regular course of dialysis.
- Your doctor expects you to finish training and be able to do your own dialysis treatments.

Important: Medicare won't cover surgery or other services needed to prepare for dialysis (like surgery for a blood access (fistula)) before Medicare coverage begins. However, if you complete home dialysis training, your Medicare coverage will start the month you begin regular dialysis, and these services could be covered.

If you're already getting Medicare due to age or disability, Medicare will cover physician-ordered fistula placement or other preparatory services before dialysis begins.

If you're getting a kidney transplant

Medicare coverage can begin the month you're admitted to a Medicare-certified hospital for a kidney transplant (or for health care services that you need before your transplant) if your transplant takes place in that same month or within the next 2 months.

Example: Mr. Green will be admitted to the hospital on March 11 for his kidney transplant. His Medicare coverage will begin in March. If his transplant is delayed until April or May, his Medicare coverage will still begin in March.

Medicare coverage can begin 2 months before the month of your transplant if your transplant is delayed more than 2 months after you're admitted to the hospital for the transplant or for health care services you need before your transplant.

Example: Mrs. Perkins was admitted to the hospital on May 25 for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15. However, her transplant was delayed until September 17. Therefore, Mrs. Perkins' Medicare coverage will start in July—2 months **before** the month of her transplant.

When Medicare coverage ends

If you're eligible for Medicare only because of permanent kidney failure, your Medicare coverage will end:

- 12 months after the month you stop dialysis treatments.
- 36 months after the month you have a kidney transplant.

Your Medicare coverage will resume if:

- You start dialysis again, or you get a kidney transplant within 12 months after the month you stopped getting dialysis.
- You start dialysis or get another kidney transplant within 36 months after the month you get a kidney transplant.

How Medicare works with employer or union group health plan coverage

If you're eligible for Medicare only because of permanent kidney failure, your coverage usually can't start until the fourth month of dialysis (also known as a "waiting period"). This means if you have coverage under an employer or union group health plan, that plan will be the only payer for the first 3 months of dialysis (unless you have other coverage).

> If your employer or union plan doesn't pay all costs for dialysis, you may have to pay some of the costs. You may be able to get help paying these costs. See pages 39–42.

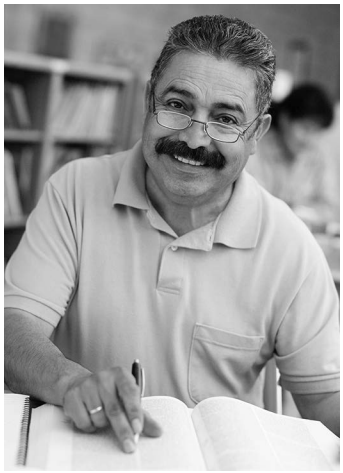
Once you become eligible for Medicare because of permanent kidney failure (usually the fourth month of dialysis), there will still be a period of time, called a "coordination period," when your employer or union group health plan will continue to pay your health care bills.

If your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs. This is called "coordination of benefits," under which your plan "pays first" and Medicare "pays second." During this time, Medicare is called the secondary payer. **This coordination period lasts for 30 months.** See below for more information.

The 30-month coordination period

The waiting period for eligibility will start even if you haven't signed up for Medicare. The same is true of the 30-month coordination period, which starts the first month you would be eligible to get Medicare because of permanent kidney failure (usually the fourth month of dialysis), **even if you haven't signed up for Medicare yet**.

Example: If you start dialysis and are eligible for Medicare in June, the 30-month coordination period will start September 1, the fourth month of dialysis, even if you don't have Medicare.



If you take a course in home dialysis training or get a kidney transplant during the 3-month waiting period, the 30-month coordination period will start earlier. During this 30-month period, Medicare will be the secondary payer.

Important: If you have employer or union group health plan coverage, tell your health care provider that you have this coverage. This is very important to make sure that your services are billed correctly. At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. Your employer or union group health plan coverage may still pay for services not covered by Medicare. Check with your plan's benefits administrator.

There's a separate 30-month coordination period each time you enroll in Medicare based on permanent kidney failure. For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end (unless you have Medicare based on your age or disability).

If after 36 months you enroll in Medicare again because you start dialysis or get another transplant, your Medicare coverage will start right away. There will be no 3-month waiting period before Medicare begins to pay. However, there will be a new 30-month coordination period if you have employer or union group health plan coverage.

Do I have to get Medicare if I already have an employer or union group health plan?

No, but think carefully about this decision. If you get a kidney transplant, you'll need to take immunosuppressive drugs for the rest of your life, so it's important to know if they'll be covered. Medicare only covers immunosuppressive drugs in specific circumstances (see pages 25–26).

> **Note:** If you don't meet the conditions for Medicare Part B coverage of immunosuppressive drugs, you may be able to get coverage by joining a Medicare Prescription Drug Plan. See pages 27–30.

If your group health plan coverage has a yearly deductible, copayment, or coinsurance, enrolling in Medicare Part A and Part B could help pay those costs during the coordination period. If your group health plan coverage will pay for most or all of your health care costs (for example, if it doesn't have a yearly deductible), you may want to delay enrolling in Part A and Part B until the 30-month coordination period is over.

If you delay enrollment, you won't have to pay the Part B premium for coverage you don't need yet. After the 30-month coordination period, you should enroll in Part A and Part B. **Your Part B premium won't be higher because you delayed your enrollment in this situation.** If your group health plan benefits are decreased or end during this period, you should enroll in Part A and Part B as soon as possible.

For more information about how employer or union group health plan coverage works with Medicare:

- Get a copy of your plan's benefits booklet.
- Call your benefits administrator, and ask how the plan pays when you have Medicare.

Section 2: Kidney dialysis

What's dialysis?

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful waste, extra salt, and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments may help you feel better and live longer, but they aren't a cure for permanent kidney failure.

Dialysis treatment options

There are 2 types of dialysis treatment options:

1. **Hemodialysis** uses a special filter (called a dialyzer) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the dialyzer to clean out wastes and extra fluids. Then the newly-cleaned blood flows through another set of tubes back into your body.
2. **Peritoneal dialysis** uses a special solution (called dialysate) that flows through a tube into your abdomen. After a few hours, the dialysate takes wastes from your blood and can be drained from your abdomen. After draining the used dialysate, your abdomen is filled with fresh dialysate, and the cleaning process begins again.

You should work with your health care team to decide which type of dialysis you need based on your situation. The goal is to help you stay healthy and active.

Words in red are defined on pages 49–52.

Dialysis services & supplies covered by Medicare

Service or supply	Covered by Medicare Part A	Covered by Medicare Part B
Inpatient dialysis treatments (if you're admitted to a hospital for special care).	✔	
Outpatient dialysis treatments (if you get treatments in a Medicare-approved dialysis facility).		✔
Outpatient doctors' services. See page 33.		✔
Home dialysis training (includes instruction for you and the person helping you with your home dialysis treatments).		✔
Home dialysis equipment and supplies (like the machine, water treatment system, basic recliner, alcohol, wipes, sterile drapes, rubber gloves, and scissors). See page 20.		✔
Certain home support services (may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and to check your dialysis equipment and water supply). See page 20.		✔
Most drugs for home and in-facility dialysis.		✔
Other services and supplies that are a part of dialysis (like laboratory tests).		✔

To find out what you pay for these services, see pages 31–36.

Dialysis services & supplies NOT covered by Medicare

Medicare doesn't cover these services or supplies:

Service or supply	Not covered
Paid dialysis aides to help you with home dialysis	✗
Any lost pay to you or the person who may be helping you during home dialysis training	✗
A place to stay during your treatment	✗
Blood or packed red blood cells for home dialysis unless part of a doctors' service	✗

There are some types of coverage that may pay some of the health care costs that Medicare doesn't pay. See pages 39–42. For more information on Medicare prescription drug coverage, see pages 27–30.

Dialysis facilities

Dialysis can be done at home or in a Medicare-certified dialysis facility. For Medicare to pay for your treatments, the facility must be Medicare-certified to provide dialysis (even if the facility already provides other Medicare-covered health care services).

At the dialysis facility, a nurse or trained technician may give you the treatment. At home, you can treat yourself or ask a family member or friend for help.

Every year we use many different quality measures to evaluate dialysis facilities. These quality measures show how often dialysis facilities use best practices when caring for you. Based on our evaluation of these quality measures we give each dialysis facility a score. Dialysis facilities are required to display that score in an area that is easy for you to find, and in a format and language you understand.

This score can range from 0-100 (a higher score indicates a better quality facility) and is based on how the facility performed on the quality measures. To get more information about this score and the quality measures used to evaluate Dialysis Facilities you can ask the facility to show you their full report, or visit Medicare.gov/dialysis.

How to find a facility

In most cases, you'll get your dialysis treatments at the facility where your kidney doctor works. However, you have the right to choose to get your treatments from another facility at any time, but this could mean changing doctors.

You can use "Dialysis Facility Compare" at Medicare.gov/dialysis to find a dialysis facility that's close to you, or call your local ESRD Network (see pages 46-47).

"Dialysis Facility Compare"

Dialysis Facility Compare helps you find detailed information about Medicare-certified dialysis facilities (also known as dialysis centers). You can compare dialysis facilities based on their star ratings, as well as, the services and the quality of care that facilities provide. It also has other resources for patients and family members who want to learn more about chronic kidney disease and dialysis. Visit Medicare.gov/dialysis.

You can find and compare this information about dialysis facilities:

- Addresses
- Phone numbers
- Hours of operation
- Maps and directions
- What kind of dialysis services the facilities offer
- Quality of patient care information

Helpful websites, publications, and phone numbers are also available. You can discuss the information on the Dialysis Facility Compare website with your health care team.

If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also contact your local State Health Insurance Assistance Program (SHIP) (see pages 46–47) or call 1-800-MEDICARE (1-800-633-4227) to get help with comparing dialysis facilities. TTY users can call 1-877-486-2048.

If you have a problem finding a dialysis facility that's willing to take you as a patient, you haave the right to file a complaint (grievance). See pages 37-38 for more information.

Transportation to dialysis facilities

Medicare covers ambulance services to and from your home to the nearest dialysis facility for treatment of End-stage Renal Disease (ESRD) **only** if other forms of transportation could endanger your health.

For non-emergency, scheduled, repetitive ambulance services, the ambulance supplier must get a written order from your doctor before you get the ambulance service. The doctor's written order must certify that ambulance transportation is medically necessary and must be dated no earlier than 60 days before you get the ambulance service.

If you're in a Medicare Advantage Plan (like an HMO or PPO), the plan may cover some non-ambulance transportation to dialysis centers and doctors. Read your plan materials, or call the plan for more information.

For more information about ambulance coverage, visit Medicare.gov/publications to read or print the booklet "Medicare Coverage of Ambulance Services." You can also call 1-800-MEDICARE.

If you need non-ambulance transportation help, talk to the social worker at your dialysis facility to find out what's available.

Dialysis in a hospital

If you're admitted to a hospital and get dialysis, your treatments will be covered by Medicare Part A as part of the costs of your covered inpatient hospital stay. See page 33 for information about inpatient and outpatient costs for dialysis.

Home dialysis

Medicare Part B covers training for home dialysis, but only by a facility certified for dialysis training. You may qualify for training if you think you would benefit from home dialysis treatments, and your doctor approves. Training sessions occur at the same time you get dialysis treatment and are limited to a maximum number of sessions.

Your dialysis facility will be responsible for providing all of your home dialysis related items and services including equipment and supplies (either directly or under arrangement). Home dialysis equipment and supplies provided directly from dialysis suppliers are no longer available. However, dialysis suppliers may provide equipment and supplies under arrangement with your dialysis facility. Medicare makes a single payment per dialysis treatment to the dialysis facility for all dialysis-related services, including equipment and suppliers. Third-party suppliers are paid by dialysis facilities from this single payment amount.

Monthly doctor visits for home dialysis

Medicare pays doctors (and certain non-doctors, like physician assistants and nurse practitioners), on a monthly basis, to help people with Medicare who perform home dialysis treatments manage their care.

This benefit includes a face-to-face visit between you and your doctor once a month. The face-to-face visit allows you and your doctor to review your lab work, discuss your care and the effectiveness of your dialysis, check for complications, and to give you a chance to ask questions about your home dialysis treatment.

Dialysis when you travel

You can still travel within the U.S. if you need dialysis. There are about 6,000 dialysis facilities around the country. Your facility can help you plan your treatment along the route of your trip before you travel.

While you're traveling, you may need to pay your co-pay when you get your dialysis. Check with the social worker at your dialysis facility to learn more.

Your dialysis facility will help you by checking to see if the facilities on your route:

- Are Medicare-certified to give dialysis
- Have the space and time to give care when you need it
- Have enough information about you to give you the right treatment

In general, Medicare will only pay for hospital or medical care that you get in the U.S.

Note: If you get your dialysis services from a Medicare Advantage Plan, your plan may be able to help you arrange to get dialysis while you travel. Contact your plan for more information.

Knowing how well your dialysis is working

With the right type and amount of dialysis, you'll probably feel better and less tired, have a better appetite and less nausea, have fewer hospital stays, and live longer.

You can tell how well the dialysis is working with blood tests that keep track of your URR or Kt/V (pronounced "kay tee over vee") number. These numbers tell your doctor or nurse how well dialysis is removing wastes from your body. Your doctor or nurse usually keeps track of one or both of these numbers, depending on which test your dialysis facility uses.

A URR of 65% and a Kt/V of 1.2 are the minimum numbers for adequate dialysis. Your health care provider or dialysis center may set a higher dialysis goal for your health and to make you feel better. Talk to your health care provider about your number.

Even if you feel fine, you should still check how well your dialysis is working. For a short period of time, you may feel okay without adequate dialysis. However, over time, not getting adequate dialysis can make you feel weak and tired, which can lead to a higher risk of infection, prolonged bleeding, and shorten your life.

Here are some steps you can take to make adequate dialysis more likely:

- Go to all of your scheduled treatments and arrive on time.
- Stay for the full treatment time.
- Follow your diet and fluid restrictions.
- Follow the advice of your dialysis staff on taking care of yourself.
- Check your URR or Kt/V adequacy number each month.
- Talk to your doctor about which hemodialysis vascular access is best for you. (Your vascular access uses your blood vessels and is created by a surgeon to use for cleaning your blood during dialysis.) During dialysis, your blood is removed and returned through your vascular access.
- Learn how to take care of your vascular access.

To learn more about how well your dialysis is working, talk with your doctor or other health team members at your dialysis facility. If you have a problem with the care that you're getting for your kidney disease, you have the right to file a complaint. See "Filing a complaint (grievance)" on pages 37–38 for more information.

Section 3: Kidney transplants

What's a kidney transplant?

A kidney transplant is a type of surgery that puts someone else's healthy kidney into your body. This donated kidney does the work that your own kidneys can no longer do. You may get a kidney from someone who has recently died, or from someone who's still living, like a family member. The blood and tissue of the person who gives you the kidney must be tested to see how well they match yours so that your body won't reject the new kidney.

To be covered by Medicare, your kidney transplant must be done in a hospital that's Medicare-certified to do kidney transplants.

If you have a problem with the care that you're getting for your transplant or with getting a referral for a transplant work-up, you have the right to file a complaint (grievance). See "Filing a complaint (grievance)" on pages 37–38 for more information.

Words in red are defined on pages 49–52.

Kidney transplant services covered by Medicare

Service or supply	Medicare Part A	Medicare Part B
Inpatient services in a Medicare-certified hospital.	✔	
Kidney registry fee.	✔	
Laboratory and other tests needed to evaluate your medical condition.*	✔	
Laboratory and other tests needed to evaluate the medical condition of potential kidney donors.*	✔	
The costs of finding the proper kidney for your transplant surgery (if there's no kidney donor).	✔	
The full cost of care for your kidney donor (including care before surgery, the actual surgery, and care after surgery).	✔	
Any additional inpatient hospital care for your donor in case of problems due to the surgery.	✔	
Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery).		✔
Doctors' services for your kidney donor during their hospital stay.		✔
Immunosuppressive drugs (for a limited time after you leave the hospital following a transplant). See pages 25–26. See pages 27–30 for information about Medicare prescription drug plans.		✔
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood). See page 36.	✔	✔

To find out what you pay for these services, see pages 34–35.

*These services are covered whether they're done by the Medicare-approved hospital where you'll get your transplant, or by another hospital that participates in Medicare.

Transplant drugs (also called immunosuppressive drugs)

What are transplant drugs?

Transplant drugs are immunosuppressive drugs used to reduce the risk of your body rejecting your new kidney after your transplant. You'll need to take these drugs for the rest of your life.

If you're only eligible for Medicare because of End-Stage Renal Disease (ESRD) (you're not 65 or older, or have a disability), Medicare Part B will only cover your transplant drugs if both of these conditions are met:

- You already had Medicare Part A at the time of your transplant.
- Your transplant surgery was performed at a Medicare-approved facility.

Part B will only cover your transplant drugs after you're enrolled in Part B. There won't be any retroactive coverage.

What if I stop taking my transplant drugs?

If you stop taking your transplant drugs, your body may reject your new kidney, and the kidney could stop working. Talk to your doctor before you stop taking your transplant drugs.

How long will Medicare pay for transplant drugs?

If you're eligible for Medicare only because of permanent kidney failure, **your Medicare coverage will end 36 months after the month of the transplant**.

Medicare will continue to pay for your transplant drugs **with no time limit if one of these conditions applies:**

- You were already eligible for Medicare because of age or disability before you got ESRD.
- You became eligible for Medicare because of age or disability after getting a transplant that was paid for by Medicare, or paid for by private insurance that paid primary to your Medicare Part A coverage, in a Medicare-certified facility.

> If you're entitled to Medicare only because of permanent kidney failure, your Medicare coverage will end when your 36-month period is over.

Transplant drugs (also called immunosuppressive drugs) (continued)

What if I can't pay for the transplant drugs?

If you're eligible for Medicare only because of permanent kidney failure, your transplant drugs are only covered for 36 months after the month of your transplant. If you're worried about paying for them after your Medicare coverage ends, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs. See pages 39–42 to learn more about other health coverage options.

Information about pancreas transplants

If you have ESRD and need a pancreas transplant, Medicare covers the transplant if it's done at the same time you get a kidney transplant or it's done after a kidney transplant.

Note: In some rare cases Medicare may cover a pancreas transplant, even if you don't need a kidney transplant.

If you're entitled to Medicare only because of permanent kidney failure, and you have the pancreas transplant after the kidney transplant, Medicare will only pay for your immunosuppressive drug therapy for 36 months after the month of the kidney transplant. This is because your Medicare coverage will end 36 months after a successful kidney transplant if you only have Medicare due to permanent kidney failure.

If you were already eligible for Medicare because of age or disability before you got ESRD, or if you became eligible for Medicare because of age or disability after getting a transplant, Medicare will continue to pay for your transplant drugs with no time limit.

Section 4: Prescription drug coverage

What Medicare covers

Medicare Part B covers transplant drugs after a covered transplant, and most of the drugs you get for dialysis. See pages 25–26. However, Part B doesn't cover prescription drugs for other health conditions you may have, like high blood pressure. Medicare offers prescription drug coverage (Part D) to help you with the costs of your drugs not covered by Part B.

> Medicare prescription drug coverage won't cover drugs you can get under Part B, like immunosuppressive drug therapy under the conditions discussed on pages 31–32. However, if you don't meet the conditions on pages 31-32, you may be able to get coverage of your immunosuppressive drug therapy by joining a Medicare Prescription Drug Plan.

Medicare prescription drug coverage is offered by private companies approved by Medicare. There are 2 types of Medicare plans that provide Medicare prescription drug coverage:

1. Medicare Prescription Drug Plans that add coverage to Original Medicare or certain types of Medicare health plans.
2. Medicare prescription drug coverage provided as part of Medicare Advantage Plans (like HMOs or PPOs). Most people with End-Stage Renal Disease (ESRD) can **only** get prescription drug coverage through a Medicare Advantage Plan if they already belong to a plan, or if they switch to a different plan offered by the same company.

Most Medicare drug plans charge a monthly premium that varies by plan. Your premium may be higher based on your income. You pay the Part D premium in addition to the Part B premium. Some plans have no premium at all. Your costs will vary depending on which drugs you use and which drug plan you choose.

Words in red are defined on pages 49–52.

If you have limited income and resources, you may be able to get Extra Help paying for your Part D prescription drug costs. See below. For more information, visit Medicare.gov/publications to read or print a copy of "Your Guide to Medicare Prescription Drug Coverage."

Extra Help

You can get Extra Help paying prescription drug costs if you meet specific income and resource limits. Resources include your savings and stocks, but not your home or car. If you qualify, you'll get help paying for your Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance.

To qualify for Extra Help, your yearly income in 2018 must be below $18,210 ($24,690 for a married couple), and your resources must be below $14,100 ($28,150 for a married couple). These amounts may change in 2019.

If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, your income limits are higher. Resources don't include your home, one car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

Note: If you live in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa you may be able to get help with Medicare drug costs. This help isn't the same as the Extra Help described here. For more information, visit Medicare.gov/contacts to get the contact information for your Medicaid office.

How can I apply?

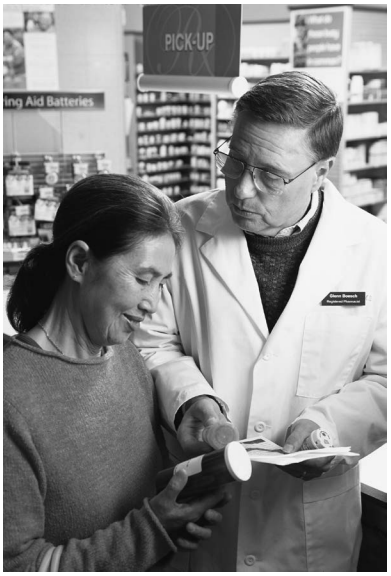
Some people with Medicare automatically qualify for Extra Help and will get a letter from Medicare.

If you don't get a letter stating that you automatically qualify, visit socialsecurity.gov or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. After you apply, you'll get a letter in the mail letting you know if you qualify and what to do next. Even if you don't qualify, you should still consider joining a Medicare Prescription Drug Plan.

If you qualify for Extra Help, and don't join a prescription drug plan, Medicare will enroll you in a plan. You can "opt out" of being automatically enrolled. Medicare will send you a letter letting you know what plan it will enroll you in and when your coverage begins. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. If not, you can change plans.

When can I join?

If you become eligible for Medicare based on ESRD, your first chance to join a Medicare drug plan will be during the 7-month period that begins 3 months before the month you're eligible for Medicare and ends 3 months after the first month you're eligible for Medicare.



Your prescription drug coverage will start the same time your Medicare coverage begins or the first month after you make your request, whichever is later. See pages 10–11.

When can I join? (continued)
If you don't join when you're first eligible, you can join between October 15–December 7 each year. Your coverage will begin on January 1 of the next year. If you join after your initial enrollment period is over, and there was a period of 63 continuous days or more during which you didn't have creditable prescription drug coverage, **you may have to pay a late enrollment penalty (which is added to your monthly premium)**.

This amount increases the longer you go without creditable coverage. You'll have to pay this penalty as long as you have Medicare prescription drug coverage. However, if you get Extra Help, you don't have to pay a late enrollment penalty.

For more information about Medicare prescription drug coverage, visit Medicare.gov/publications to read or print a copy of "Your Guide to Medicare Prescription Drug Coverage." You can also contact your local State Health Insurance Assistance Program (SHIP). See pages 46–47.

Section 5: Costs & payments

What Medicare costs

Medicare Part A costs

Most people don't have to pay a monthly premium for Part A because they (or a spouse) paid Medicare taxes while they were working.

Medicare Part B costs

Most people must pay a monthly premium for Part B. The standard Part B premium for 2018 is $134 per month, although it may be higher based on your income. Premium rates can change yearly.

You need Part B to get the full benefits, including regular dialysis, available under Medicare for people with End-Stage Renal Disease (ESRD), and you must pay the premium to get Part B. For more information about the Part B premium, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Paying for dialysis services

These Part B covered services and items are included in the ESRD payment system and must be provided by your dialysis facility:

- All equipment and supplies used in the treatment of ESRD and defined as dialysis services by Medicare
- Injectable and intravenous drugs and biologicals and their oral forms, including erythropoiesis stimulating agents used for ESRD dialysis treatment*
- Laboratory tests and other items and services provided for ESRD dialysis treatment
- Home dialysis training by a Medicare-certified home dialysis training facility (if you choose to get dialysis at home)

*Medications that are only available in oral form will continue to be covered under Medicare prescription drug coverage (Part D). Talk with your doctor or health care team about the use of any drugs, including over-the-counter products.

Words in red are defined on pages 49–52.

Important note for people taking Calcimimetics (Sensipar® or Parsabiv™):

Medicare Part B covers calcimimetic medications under the ESRD payment system. Calcimimetic medications include the intravenous medication, Parsabiv, and the oral medication, Sensipar.

Your ESRD facility is responsible for giving you these medications. They can give them to you at their facility, or through a pharmacy they work with. You'll have a 20% co-pay for these medications, like any other service you get through Part B. If you're in a Medicare Advantage Plan (like an HMO or PPO), your costs may be different.

You'll need to work with your ESRD facility and your doctor to find out where you'll get these medications, and how much you'll pay.

What will I pay for dialysis services in a dialysis facility?

If you have Original Medicare, you'll continue to pay a 20% coinsurance of the Medicare-approved amount for all covered dialysis related services. Medicare will pay the remaining 80%.

The dollar amount of your coinsurance may vary. If you're in a Medicare Advantage Plan or have a Medicare Supplement Insurance (Medigap) policy that covers all or part of your 20% coinsurance, then your costs may be different. Read your plan materials or call your benefits administrator to get your cost information. You must also continue to pay your monthly Medicare Part B and Part D (if applicable) premiums.

Note: Your 20% copayment covers all of the services and items listed on page 16. Since these services and items are included in the new bundled payment system, you **can't** be billed separately for them. You also don't need to get the drugs that are included in the bundle from your Medicare drug plan (if you have one).

What will I pay for dialysis in a hospital?

If you're admitted to a hospital and get dialysis, your treatments will be covered by Medicare Part A as part of the costs of your covered inpatient hospital stay.

- **Inpatient doctors' services**

  In Original Medicare, your kidney doctor bills separately for the Medicare-covered ESRD services you get as an inpatient. In this case, your kidney doctor's monthly payment will be based on the number of days you stay in the hospital.

- **Outpatient doctors' services**

  In Original Medicare, Medicare pays most kidney doctors a monthly amount. After you pay the Medicare Part B yearly deductible ($183 in 2018), Medicare pays 80% of the monthly amount. You pay the remaining 20% coinsurance. In some cases, your doctor may be paid per day if you get services for less than one month.

Example: Let's say the monthly amount that Medicare pays your doctor for each dialysis patient is $125. After you pay the Part B yearly deductible, here are the costs:

- Medicare pays 80% of the $125 (or $100).
- You pay the remaining 20% coinsurance (or $25).

Remember, what you pay may be different than what's shown.

What will I pay for home dialysis training services?

In Original Medicare, Medicare pays your dialysis facility a flat fee to supervise home dialysis training. After you pay the Part B yearly deductible ($183 in 2018), Medicare pays 80% of the flat fee and you pay the remaining 20%.

Example: Let's say the flat fee for the dialysis facility who's supervising the home dialysis training is $500. After you pay the Medicare Part B yearly deductible, here are the costs:

- Medicare pays 80% of the $500 (or $400).
- You pay the remaining 20% coinsurance (or $100).

Remember, what you pay may be different than what's shown.

What will I pay for my child who has ESRD?
If you have a child under 18 who has Medicare because of ESRD, the payment rules are the same as described above. However, the rates paid to the dialysis facilities are adjusted based on the child's age and the type of dialysis they get. These adjustments allow for the special care needs of children. Your 20% coinsurance will be based on these special rates.

For additional information on Medicare coverage for children with ESRD, see page 7.

What Medicare pays for transplant services

The amounts listed in this section are for transplant services covered in Original Medicare. If you're in a Medicare Advantage Plan (like an HMO or PPO), your costs may be different. Read your plan materials, or call your plan to get information about your costs.

Paying for transplant services

What do I have to pay for my kidney donor?

Medicare will pay the full cost of care for your kidney donor. You don't have to pay a deductible, coinsurance, or other costs for your donor's hospital stay. In addition, your kidney donor doesn't have to pay a deductible, coinsurance, or any other costs for their hospital stay.

What do I have to pay for hospital services?

If you have Original Medicare, in 2018, you pay:

- $1,340 deductible per benefit period
- Days 1–60: $0 coinsurance for each benefit period
- Days 61–90: $335 coinsurance per day of each benefit period
- *Days 91 and beyond: $670 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
- *Beyond lifetime reserve days: all costs

For Medicare-approved care in a skilled nursing facility (SNF), you pay:

- Days 1–20: $0 for each benefit period
- Days 21–100: $167.50 coinsurance per day of each benefit period
- Days 101 and beyond: all costs

To find out what you pay for other Medicare Part A and Medicare Part B services, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

*In Original Medicare, lifetime reserve days are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

What do I have to pay for doctors' services?

In Original Medicare, you must pay the Medicare Part B yearly deductible ($183 in 2018). After you pay the deductible, Medicare pays 80% of the Medicare-approved amount. You must pay the remaining 20% coinsurance.

Important: There's a limit on the amount your doctor can charge you, even if your doctor doesn't accept assignment. If your doctor doesn't accept assignment, you only have to pay the part of the bill that's up to 15% over the Medicare-approved amount.

What do I have to pay for clinical laboratory services?

You pay nothing for Medicare-approved laboratory tests.

What Medicare pays for blood services

In most cases, Medicare Part A and Medicare Part B help pay for:

- Whole blood units or packed red blood cells
- Blood components
- The cost of processing and giving you blood

Paying for blood services

Under both Part A and Part B, in most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital for the first 3 units of whole blood or equivalent units of packed red blood cells that you get in a calendar year (while you're staying in a hospital or skilled nursing facility (SNF)) or replace the blood.

You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.

Note: Once you've paid for or replaced the required units of blood, you don't have to do so again under either Part A or Part B for the remainder of the calendar year.

Having blood donated

You can replace the blood by donating it yourself or getting another person or organization to donate the blood for you. The blood that's donated doesn't have to match your blood type. If you decide to donate the blood yourself, check with your doctor first.

You can't be charged for blood that you've already donated. A hospital or SNF can't charge you for any of the first 3 pints of blood you've already donated or will donate in the future.

> Medicare doesn't pay for blood for home dialysis unless it's part of a doctor's service or is needed to prime the dialysis equipment.

Section 6: Filing a complaint (grievance) about dialysis or kidney transplant care

End-Stage Renal Disease (ESRD) Networks and State Survey Agencies work together to help you with complaints (grievances) about your dialysis or kidney transplant care.

ESRD Networks

ESRD Networks (or "Networks") monitor and improve the quality of care given to people with End-Stage Renal Disease (ESRD), and can help you with complaints about your dialysis facility or transplant center. To get the ESRD Network phone number for your state, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you have a complaint about your care:

- You can complain directly to your facility, but you don't have to.
- You can file it directly with your Network instead of with your facility.
- Your facility or Network must investigate it, work on your behalf to try to solve it, and help you understand your rights.
- Your Network can still investigate a complaint and represent you, even if you wish to remain anonymous.
- Your facility can't take any action against you for filing a complaint.

Examples of complaints you may contact your ESRD Network for include:

- The facility staff doesn't treat you with respect.
- The staff don't let you eat during dialysis, and you're always hungry.
- Your dialysis shifts conflict with your work hours, and the facility won't let you change your shift.
- You've made complaints to your facility, and they weren't resolved.

Words in red are defined on pages 49–52.

State Survey Agencies

State Survey Agencies also deal with complaints about Medicare and Medicaid participating dialysis facilities and transplant centers (as well as hospitals and other health care settings). Examples of complaints you may contact your State Survey Agency for include:

- Claims of abuse
- Mistakes in giving out or prescribing drugs
- Poor quality of care
- Unsafe conditions (like water damage or electrical or fire safety concerns)

Note: For questions about a specific service you got, look at your "Medicare Summary Notice" (MSN). Your MSN is a notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

You'll get this in the mail every 3 months. You can also visit MyMedicare.gov. If you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan, you can file an appeal.

Section 7: Other kinds of health coverage

There are other kinds of health coverage that may help pay for the services you need for the treatment of permanent kidney failure. They include:

- Employee or retiree coverage from an employer or union
- Medicare Supplement Insurance (Medigap) policies
- Medicaid
- Veteran Administration benefits

Employee or retiree coverage from an employer or union

If you have group health plan coverage based on your or your spouse's past or current employment, call your benefits administrator to find out what coverage they might provide for your permanent kidney failure. If you're eligible for coverage under the group health plan, but haven't yet signed up for it, call the benefits administrator to find out if you can still enroll.

Generally, employer plans have better rates than you can get if you buy a policy directly from an insurance company. Also, employers may pay part of the cost of the coverage.

See pages 12–13 for an explanation of when your employer will pay first, and when Medicare will pay first with your employer providing supplemental coverage.

If you lose your employer or union coverage, you may be able to continue your coverage temporarily through COBRA. This federal law allows you to temporarily keep your employer or union health coverage after your employment ends or after you lose coverage as a dependent of a covered employee. Talk to your benefits administrator for more information.

Words in red are defined on pages 49–52.

Medicare Supplement Insurance (Medigap) policies

A Medigap policy is health insurance sold by private insurance companies to help fill the "gaps" in Original Medicare coverage, like deductibles and coinsurance. Medigap policies help pay some of the health care costs that Original Medicare doesn't cover. Medigap insurance must follow federal and state laws that protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance" and provide standardized benefits, no matter which insurance company sells it.

Not all insurance companies will sell Medigap policies to people with Medicare under 65. If a company does sell Medigap policies voluntarily, or because state law requires it, these Medigap policies will probably cost you more than if you were 65 or older.

Medigap rules vary from state to state. Call your State Health Insurance Assistance Program (SHIP) (see pages 46–47) for information about buying a Medigap policy if you have a disablity or have End-Stage Renal Disease (ESRD). When you turn 65, you'll be guaranteed an opportunity to buy a Medigap policy.

For more information about Medigap policies:

- Visit Medicare.gov to get information about Medigap policies offered in your state. When you use this website, you'll get a personalized summary page with general information to help you compare plans. You can get detailed information about all the plans available in your area, or just the ones you're most interested in. Medicare.gov has information on:
    - Which Medigap policies are sold in your state
    - Comparing Medigap policies
    - What each policy covers
    - Your out-of-pocket costs
- Visit Medicare.gov/publications to read or print a copy of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Medicaid

This is a joint federal and state program that helps pay medical costs for some people who meet financial eligibility requirements. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid and see providers who accept both.

States also have Medicare Savings Programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a limited income. To qualify for these programs, generally you must have:

- Medicare Part A.
- A monthly income of less than $1,386 for an individual or $1,872 for a couple in 2018. These income limits are slightly higher in Hawaii and Alaska. Income limits can change each year.
- Savings of $7,560 or less for an individual, or $11,340 or less for a couple. Savings include money in a checking or savings account, stocks, and bonds.

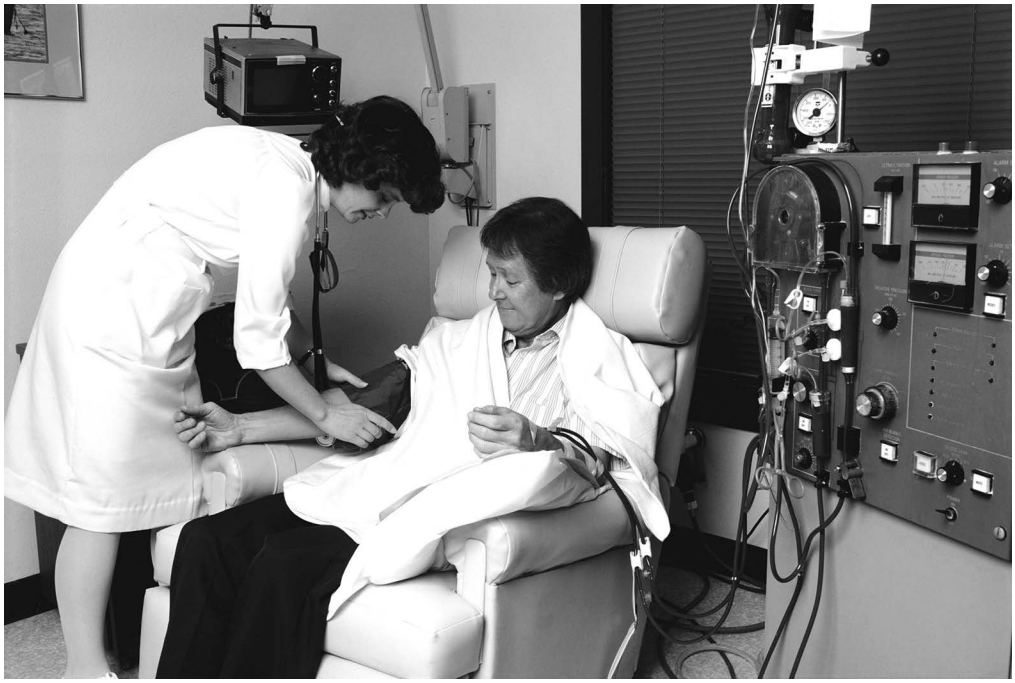
To get more information on these programs, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Veterans' benefits

If you're a veteran, the U.S. Department of Veterans Affairs can help pay for End-Stage Renal Disease (ESRD) treatment. For more information, visit va.gov or call the U.S. Department of Veterans Affairs at 1-800-827-1000. TTY users can call 1-800-829-4833.

Other ways to get help

In most states, there are agencies and state kidney programs that help with some of the health care costs that Medicare doesn't pay. Call your State Health Insurance Assistance Program (SHIP) if you have questions about health coverage. See pages 46–47.



Section 8: Where to get more information

You have many resources available to help you learn more about kidney dialysis, transplants, and your situation. In addition to talking with your health care team, you can also connect with other people who have End-Stage Renal Disease (ESRD) through a national Kidney organization, find information on Medicare.gov, or reach out to your local ESRD Network, State Health Insurance Assistance Program (SHIP), or State Survey Agency.

Kidney organizations

There are special organizations that can give you more information about kidney dialysis and kidney transplants. Some of these organizations have members who are on dialysis or have had kidney transplants and who can give you support.

American Association of Kidney Patients
14440 Bruce B. Downs Blvd.
Tampa, Florida 33613
1-800-749-2257
aakp.org

American Kidney Fund
11921 Rockville Pike, Suite 300
Rockville, Maryland 20852
1-800-638-8299
kidneyfund.org

Dialysis Patient Citizens
1012 14th Street, NW, Suite 1475
Washington, DC 20005
1-866-877-4242
dialysispatients.org

National Kidney Foundation
30 East 33rd Street
New York, New York 10016
1-800-622-9010
kidney.org

Words in red are defined on pages 49–52.

National Institute of Diabetes and Digestive and Kidney Diseases
9000 Rockville Pike
Bethesda, Maryland 20892
1-800-860-8747
kidney.niddk.nih.gov

End-Stage Renal Disease (ESRD) Networks

You can call your local ESRD Network Organization (see pages 46–47) to get information about:

- Dialysis treatments
- Kidney transplants
- How to get help from other kidney-related agencies
- Problems with your facility
- Location of dialysis facilities and transplant centers

Your Network makes sure that you're getting the best possible care and keeps your facility aware of important issues about kidney dialysis and transplants. To get the ESRD Network phone number for your state, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

State Health Insurance Assistance Programs (SHIPs)

Call your State Health Insurance Assistance Program (SHIP) (see pages 46–47) if you have questions about:

- Medigap policies
- Medicare health plan choices
- Filing an appeal
- Other general health insurance questions

Visit shiptacenter.org to get the phone number for your SHIP or call 1-800-MEDICARE (1-800-633-4227).

State Survey Agencies

The State Survey Agency inspects Medicare and Medicaid participating dialysis facilities and makes sure that Medicare standards are met. Your State Survey Agency can also help you if you have a complaint about your care. Visit Medicare.gov/contacts to get the phone number for your State Survey Agency. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. **Your calls and name will be kept private.**

Other Medicare products for kidney patients

To read or print a copy of the booklets listed below, visit Medicare.gov/publications. You can also call 1-800-MEDICARE to find out if a copy can be mailed to you.

- **"Medicare's Coverage of Dialysis and Kidney Transplant Benefits: Getting Started"**
  This brochure explains basic Medicare benefits for people with kidney disease.
- **"Medicare for Children with End-Stage Renal Disease"**
  This brochure gives information about Medicare coverage for children with permanent kidney failure.

Important phone numbers

ESRD Networks and State Health Insurance Assistance Program (SHIP) phone numbers are on pages 46–47. At the time of printing, these phone numbers were correct. Phone numbers sometimes change. To get the SHIP phone number for your state, visit shiptacenter.org, or call 1-800-MEDICARE. To get the ESRD Network phone number for your state, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Thank you.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Thank you.

Important phone numbers

Doctor _____

Social worker _____

Health insurance company _____

ESRD Network _____

State Survey Agency _____

Notes

Section 9: Definitions

Assignment—An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period—The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Creditable prescription drug coverage—Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

End-Stage Renal Disease (ESRD)—Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Extra Help—A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Grievance—A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Group health plan—In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Home health care—Health care services and supplies a doctor decides you may get in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

Long-term care—Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term services and supports at any age. Medicare and most health insurance plans don't pay for long-term care.

Medicaid—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)— A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan.
- Medicare services aren't paid for by Original Medicare.
- Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare prescription drug coverage (Part D)—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medigap policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare—Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Out-of-pocket costs—Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.

Penalty—An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Secondary payer—The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Skilled nursing facility (SNF)—A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Survey Agency—A state agency that oversees health care facilities that participate in the Medicare and/or Medicaid programs. The State Survey Agency inspects health care facilities and investigates complaints to ensure that health and safety standards are met.

Supplier—Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

TTY—A TTY (teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

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Notice of Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides auxiliary aids and services to help us better communicate with people with disabilities. Auxiliary aids include materials in Braille, audio/data CD or other accessible formats.

Note: You can get the "Medicare & You" handbook electronically in standard print, large print, or as an eBook.

For general Medicare inquiries and Medicare publications, call us at 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For all other CMS publications and documents in accessible formats, you can contact our Customer Accessibility Resource Staff:

- **Call** 1-844-ALT-FORM (1-844-258-3676). TTY: 1-844-716-3676.
- **Send a fax** to 1-844-530-3676.
- **Send an email** to altformatrequest@cms.hhs.gov.
- **Send a letter to:**

  Centers for Medicare & Medicaid Services
  Offices of Hearings and Inquiries (OHI)
  7500 Security Boulevard, Mail Stop S1-13-25
  Baltimore, MD 21244-1850
  Attn: Customer Accessibility Resource Staff

You can also contact the Customer Accessibility Resource staff:

- To inquire about a request for accessible formats.
- To submit concerns and issues about accessible communications, including the quality and timeliness of your request.

Note: Your request for a CMS publication or document should include:

- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

Note: If you're enrolled in a Medicare Advantage or Prescription Drug Plan, you can contact your plan to request their documents in an accessible format.

Nondiscrimination Notice

CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

How to File a Complaint

If you believe you've been subjected to discrimination in a CMS program or activity, there are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online:** www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. **Phone**: Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. **Writing:** Send information about your complaint to:
   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

Paid for by the Department of Health & Human Services.

Notes

Notes

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
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CMS Product No. 10128
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This booklet is available in Spanish.
To get your copy, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.