CENTERS for MEDICARE & MEDICAID SERVICES

Medicare & Home Health Care

This official government booklet tells you:

- Who's eligible
- What services are covered
- How to find and compare home health agencies
- Your Medicare rights

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 & Home Health Care" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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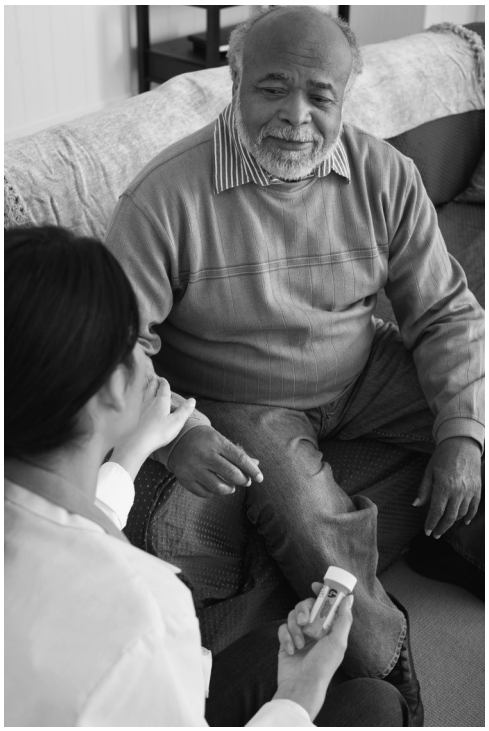

Home health care

Many health care treatments that were once offered only in a hospital or a doctor's office can now be done in your home. Home health care is usually less expensive, more convenient, and can be just as effective as care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury. Where possible, home health care helps you get better, regain your independence, and become as self-sufficient as possible. Home health care may also help you maintain your current condition or level of function, or to slow decline.

Medicare pays for you to get health care services in your home if you meet certain eligibility criteria and if the services are considered reasonable and necessary for the treatment of your illness or injury.

This booklet describes the home health care services that Medicare covers, and how to get those benefits through Medicare. If you get your Medicare benefits through a Medicare health plan (not Original Medicare) check your plan's membership materials, and contact the plan for details about how the plan provides your Medicare-covered home health benefits.

Section 1: Medicare Coverage of Home Health Care

Who's eligible?

If you have Medicare, you can use your home health benefits if:

1. You're under the care of a doctor, and you're getting services under a plan of care established and reviewed regularly by a doctor.
2. You need, and a doctor certifies that you need, one or more of these:
   - Intermittent skilled nursing care (other than drawing blood)
   - Physical therapy
   - Speech-language pathology services
   - Continued occupational therapy

   See pages 8–9 for more details on these services.
3. The home health agency caring for you is approved by Medicare (Medicare-certified).
4. You're homebound, and a doctor certifies that you're homebound. To be homebound means:
   - You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury, or leaving your home isn't recommended because of your condition.
   - You're normally unable to leave your home, but if you do it requires a major effort.

   You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like an occasional trip to the barber, a walk around the block or a drive, or attendance at a family reunion, funeral, graduation,

Words in red are defined on pages 27–28.

or other infrequent or unique event. You can still get home health care if you attend adult day care or religious services.

5. As part of your certification of eligibility, a doctor, or certain health care professionals who work with a doctor (like a nurse practitioner), must document that they've had a face-to-face encounter with you (like an appointment with your primary care doctor) within required timeframes and that the encounter was related to the reason you need home health care.

If you need more than "intermittent" skilled nursing care, you don't qualify for home health services. To determine if you're eligible for home health care, Medicare defines "intermittent" as skilled nursing care that's needed:

- Fewer than 7 days each week.
- Daily for less than 8 hours each day for up to 21 days. In some cases, Medicare may extend the three week limit if your doctor can predict when your need for daily skilled nursing care will end.

If you're expected to need full-time skilled nursing care over an extended period of time, you wouldn't usually qualify for home health benefits.

How Medicare pays for home health care

Medicare pays your Medicare-certified home health agency one payment for the covered services you get during a 30-day period of care. You can have more than one 30-day period of care. Payment for each 30-day period is based on your condition and care needs.

Getting treatment from a home health agency that's Medicare-certified can reduce your out-of-pocket costs. A Medicare-certified home health agency agrees to:

- Be paid by Medicare
- Accept only the amount Medicare approves for their services

Medicare's home health benefit only pays for services provided by the home health agency. Other medical services, like visits to your doctor or equipment, are generally still covered by your other Medicare benefits.

Look in your "Medicare & You" handbook for information on how these services are covered under Medicare. To view or print this booklet, visit Medicare.gov/publications. You can also call 1-800-MEDICARE (1-800-633-4227) if you have questions about your Medicare benefits. TTY users can call 1-877-486-2048.

What's covered?

If you're eligible for Medicare-covered home health care (see page 5), Medicare covers these services if they're reasonable and necessary for the treatment of your illness or injury. "Skilled nursing and therapy services are covered when your doctor determines that the care you need requires the specialized judgment, knowledge, and skills of a nurse or therapist to be safely and effectively provided.

- **Skilled nursing care:** Medicare covers skilled nursing care when the services you need require the skills of a nurse, are reasonable and necessary for the treatment of your illness or injury, and are given on a part-time or intermittent basis (visits only to draw your blood aren't covered by Medicare). "Part-time or intermittent" means you may be able to get home health aide and skilled nursing services (combined) any number of days per week as long as the services are provided:

- Fewer than 8 hours each day
- 28 or fewer hours each week (or up to 35 hours a week in some limited situations)

A registered nurse (RN) or a licensed practical nurse (LPN) can provide skilled nursing services. If you get services from an LPN, your care will be supervised by an RN. Home health nurses provide direct care and teach you and your caregivers about your care. They also manage, observe, and evaluate your care. Examples of skilled nursing care include: giving IV drugs, certain injections, or tube feedings; changing dressings; and teaching about prescription drugs or diabetes care. Any service that could be done safely and effectively by a non-medical person (or by yourself) without the supervision of a nurse **isn't** skilled nursing care.

- **Physical therapy, occupational therapy, and speech-language pathology services:** Your therapy services are considered reasonable and necessary in the home setting if:
    1. They're a specific, safe, and effective treatment for your condition
    2. They're complex such that your condition requires services that can only be safely and effectively performed by, or under the supervision of, qualified therapists
    3. Your condition requires one of these:
        - Therapy that's reasonable and necessary to restore or improve functions affected by your illness or injury
        - A skilled therapist or therapist assistant to safely and effectively perform therapy under a maintenance program to help you maintain your current condition or to prevent your condition from getting worse
    4. The amount, frequency, and duration of the services are reasonable

- **Home health aide services:** Medicare will pay for part-time or intermittent home health aide services (like personal care), if needed to maintain your health or treat your illness or injury. Medicare

doesn't cover home health aide services unless you're also getting skilled care. Skilled care includes:

- Skilled nursing care
- Physical therapy
- Speech-language pathology services
- Continuing occupational therapy, if you no longer need any of the above

"Part-time or intermittent" means you may be able to get home health aide and skilled nursing services (combined) any number of days per week, as long as the services are provided:

- Fewer than 8 hours each day
- 28 or fewer hours each week (or up to 35 hours a week in some limited situations)

- **Medical social services:** Medicare covers these services when a doctor orders them to help you with social and emotional concerns that may interfere with your treatment or how quickly you recover. This might include counseling or help finding resources in your community. However, Medicare doesn't cover medical social services unless you're also getting skilled care as mentioned above.
- **Medical supplies:** Medicare covers supplies, like wound dressings, when your doctor orders them as part of your care.

Medicare pays separately for durable medical equipment. The equipment must meet certain criteria and be ordered by a doctor. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, like a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

Note: Before your home health care begins, the home health agency should tell you how much of your bill Medicare will pay. The agency should also tell you if any items or services they give you aren't covered by Medicare, and how much you'll have to pay for them. This should be explained by both talking with you and in writing.

The home health agency is responsible for meeting **all** of your medical, nursing, rehabilitative, social, and discharge planning needs, as noted in your home health plan of care. See page 19 for more information. Home health agencies are required to perform a comprehensive assessment of each of your care needs when you're admitted to the home health agency, and communicate those needs to the doctor responsible for the plan of care. After that, home health agencies are required to routinely assess your needs.

What isn't covered?

Here are some examples of what Medicare doesn't pay for:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services, like shopping, cleaning, and laundry
- Custodial or personal care like bathing, dressing, and using the bathroom when this is the only care you need

Talk to your doctor or the home health agency if you have questions about whether certain services are covered. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: If you have a Medigap (Medicare Supplement Insurance) policy or other health coverage, be sure to tell your doctor or other health care provider so your bills get paid correctly.

What you pay

You may be billed for:

- Services and supplies that are never paid for by Medicare, like routine foot care.
- Services and supplies that are usually paid for by Medicare but won't be paid for in this instance, when you've agreed to pay for them. The home health agency must give you a notice called the "Advance Beneficiary Notice of Noncoverage" (ABN) in these situations. See the next page.

- 20% of the Medicare-approved amount for Medicare-covered medical equipment, like wheelchairs, walkers, and oxygen equipment.

"Advance Beneficiary Notice of Noncoverage" (ABN)

The home health agency must give you a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) before giving you a home health service or supply that Medicare probably won't pay for because of any of these:

- The care isn't medically reasonable and necessary.
- The care is only nonskilled, personal care, like help with bathing or dressing.
- You aren't homebound.
- You don't need skilled care on an intermittent basis.

When you get an ABN because Medicare isn't expected to pay for a medical service or supply, the notice should describe the service and/or supply, and explain why Medicare probably won't pay. The ABN gives clear directions for getting an official decision from Medicare about payment for home health services and supplies and for filing an appeal if Medicare won't pay.

In general, to get an official decision on payment, you should do these:

- Keep getting the home health services and/or supplies if you think you need them. The home health agency must tell you how much they'll cost. Talk to your doctor and family about this decision.
- Understand you may have to pay the home health agency for these services and/or supplies.
- Ask the home health agency to send your claim to Medicare so that Medicare will make a decision about payment. You have the right to have the home health agency bill Medicare for your care.

If Original Medicare pays for your care, you'll get back all of your payments, except for any applicable coinsurance or deductibles, including any coinsurance payments you made for durable medical equipment.

The home health agency must also give you a "Home Health Change of Care Notice" (HHCCN) before any reduction or stoppage to home health services or supplies that will result in a change to your plan of care.

Examples:

- The home health agency makes a business decision to reduce or stop giving you some or all of your home health services or supplies.
- Your doctor has changed or hasn't renewed your orders.

Your right to a fast appeal

When all of your covered home health services are ending, you may have the right to a fast appeal if you think these services are ending too soon. During a fast appeal, an independent reviewer called a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) looks at your case and decides if you need your home health services to continue.

Your home health agency will give you a written notice called the "Notice of Medicare Non-Coverage" (NOMNC) at least 2 days before all covered services end. If you don't get this notice, ask for it. Read the notice carefully. It contains important information about the termination of services, including:

- The date all your covered services will end
- How to ask for a fast appeal
- Your right to get a detailed notice about why your services are ending
- Any other information required by Medicare

If you ask for a fast appeal, the BFCC-QIO will ask why you think coverage of your home health services should continue. The BFCC-QIO will also look at your medical information and talk to your doctor. The BFCC-QIO will notify you of its decision as soon as possible, generally no later than 3 days after the effective date of the NOMNC.

If the BFCC-QIO decides your home health services should continue, Medicare may continue to cover your home health care services, except for any applicable coinsurance or deductibles.

If the BFCC-QIO decides that your coverage should end, you'll have to pay for any services you got after the date on the NOMNC that says when your covered services should end. Your home health agency must give you an ABN with an estimate of how much these services will cost.

You may stop getting services on or before the date given on the NOMNC and avoid paying for any further services. If you don't ask for a fast appeal and want to continue getting services after the date listed on the NOMNC, your home health agency must give you an ABN to let you know what you must pay.

For more information on your right to a fast appeal and other Medicare appeal rights, look at your "Medicare & You" handbook or visit Medicare.gov/appeals. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Section 2: Choosing a Home Health Agency

Finding a Medicare-certified home health agency

If your doctor decides you need home health care, you may choose an agency from the participating Medicare-certified home health agencies that serve your area. Home health agencies are certified to make sure they meet certain federal health and safety requirements. Your choice should be honored by your doctor, hospital discharge planner, or other referring agency. You have a say in which agency you use, but your choices may be limited by agency availability, or by your insurance coverage. If you have a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan, it may require that you get home health services from agencies they contract with. Call your plan for more information.

Words in red are defined on pages 27–28.

Home Health Agency Checklist

Use this checklist when choosing a home health agency.

Name of the home health agency: _____

Question	Yes	No	Comments
1. Medicare-certified?			
2. Medicaid-certified (if you have both Medicare and Medicaid)?			
3. Offers the specific health care services I need, like skilled nursing services or physical therapy?			
4. Meets my special needs, like language or cultural preferences?			
5. Offers the personal care services I need, like help bathing, dressing, and using the bathroom?			
6. Offers the support services I need, or can help me arrange for additional services, like a meal delivery service, that I may need? (NOTE: These types of services aren't generally covered by Medicare).			
7. Has staff that can give the type and hours of care my doctor ordered and start when I need them?			
8. Is recommended by my hospital discharge planner, doctor, or social worker?			
9. Has staff available at night and on weekends for emergencies?			
10. Explained what my insurance will cover and what I must pay out-of-pocket?			
11. Has letters from satisfied patients, family members, and doctors that testify to the home health agency providing good care?			

Special rules for home health care

In general, most Medicare-certified home health agencies will accept all people with Medicare. An agency isn't required to accept you if it can't meet your medical needs. An agency shouldn't refuse to take you because of your condition, unless the agency would also refuse to take other people with the same condition.

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

Find out more about home health agencies

Your State Survey Agency, the agency that inspects and certifies home health agencies for Medicare, also has information about home health agencies. Ask them for the state survey report on the home health agency of interest to you. Visit Medicare.gov/contacts to get your State Survey Agency's phone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In some cases, your local long-term care ombudsman may have information on the home health agencies in your area. Visit ltcombudsman.org, visit eldercare.gov, or call the eldercare locator at 1-800-677-1116.

To find out more about home health agencies, you can:

- Ask your doctor, hospital discharge planner, or social worker.
- Ask friends or family about their home health care experiences.
- Use a senior community referral service, or other community agencies that help you with your health care.

Section 3: Getting Home Health Care

Usually, once your doctor refers you for home health services, staff from the home health agency will come to your home to talk to you about your needs and ask you some questions about your health. The home health agency will also talk to your doctor about your care and keep your doctor updated about your progress. You need a doctor's order to start and continue care.

Your plan of care

Your home health agency will work with you and your doctor to develop your plan of care. A plan of care lists what kind of services and care you should get for your health condition. You have the right to be involved in any decisions about your plan of care. Your plan of care include:

- What services you need
- Which health care professionals should give these services
- How often you'll need the services
- Visit schedule
- The medical equipment you need
- What results your doctor expects from your treatment

Your home health agency must give you all of the home care listed in your plan of care, including services and medical supplies. The agency may do this through its own staff or through an arrangement with another agency. The agency could also hire nurses, therapists, home health aides, and medical social workers to meet your needs.

Words in red are defined on pages 27–28.

Your plan of care (continued)

Your doctor and home health team review your plan of care as often as necessary, but at least once every 60 days. If your health condition changes, the home health team should tell your doctor right away. Your health care team will review your plan of care and make any necessary changes with the approval of your doctor. Your home heath team will:

- Review your plan of care and make any necessary changes with your doctor
- Tell you about any changes in your plan of care. If you have a question about your care, or if you feel your needs aren't being met, talk to both your doctor and the home health team.
- Teach you (and your family or friends who are helping you) to continue any care you may need, including wound care, therapy, and disease management. You should learn to recognize problems like infection or shortness of breath, and know what to do or whom to contact if they happen.

Your rights getting home health care

In general, as a person with Medicare getting home health care from a Medicare-certified home health agency, you have the rights to:

- Get a written notice of your rights before your care starts
- Have your home and property treated with respect
- Be told, in advance, what care you'll be getting and when your plan of care is going to change
- Participate in your care planning and treatment
- Get written information about your privacy rights and your appeal rights
- Have your personal information kept private
- Get written and verbal information about how much Medicare is expected to pay and how much you'll have to pay for services
- Make complaints about your care and have the home health agency follow up on them
- Know the phone number of the home health hotline in your state where you can call with complaints or questions about your care

Visit Medicare.gov to learn more about your rights and protections. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Where to file a complaint about the quality of your home health care

If you have a complaint about the quality of care you're getting from a home health agency, you should call either of these organizations:

- Your state home health hotline. Your home health agency should give you this number when you start getting home health services.
- The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your state. To get the phone number for your BFCC-QIO, visit Medicare.gov/contacts. You can also call 1-800-MEDICARE.

Home Health Care Checklist

This checklist can help you (and your family or friends who are helping you) monitor your home health care. Use this checklist to help make sure that you're getting good quality home health care.

When I get my home health care	Yes	No	Comments
1. The staff is polite and treats me and my family with respect.			
2. The staff explains my plan of care to me and my family, lets us participate in creating the plan, and lets us know ahead of time of any changes.			
3. The staff is properly trained and licensed to perform the type of health care I need.			
4. The agency explains what to do if I have a problem with the staff or the care I'm getting.			
5. The agency responds quickly to my requests.			
6. The staff checks my physical and emotional condition at each visit.			
7. The staff responds quickly to changes in my health or behavior.			
8. The staff checks my home and suggests changes to meet my special needs and to ensure my safety.			
9. The staff has told me what to do if I have an emergency.			
10. The agency and its staff protect my privacy.			

Section 4: Getting the Help You Need

Help with questions about home health coverage

If you have questions about your Medicare home health care benefits or coverage and you have Original Medicare, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you get your Medicare benefits through a Medicare Advantage Plan (Part C) or other Medicare health plan, call your plan.

You may also call the State Health Insurance Assistance Program (SHIP). SHIP counselors answer questions about Medicare's home health benefits and what Medicare, Medicaid, and other types of insurance pay for.

To get the phone number for your SHIP, visit shiptacenter.org or call 1-800-MEDICARE.

Words in red are defined on pages 27–28.

What you need to know about fraud

In general, most home health agencies are honest and use correct billing information. Unfortunately, there may be some who commit fraud. Fraud wastes Medicare dollars and takes away money that could be used to pay claims. You play an important role in the fight to prevent Medicare fraud, waste, and abuse.

Look for these:

- Home health visits that your doctor ordered, but that you didn't get.
- Visits by home health staff that you didn't request and that you don't need.
- Bills for services and equipment you never got.
- Fake signatures (yours or your doctor's) on medical forms or equipment orders.
- Pressure to accept items and services that you don't need or that Medicare doesn't cover.
- Items listed on your "Medicare Summary Notice" (MSN) that you don't think you got or used.
- Home health services your doctor didn't order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free and they need your number for their records.

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

Reporting fraud

If you suspect fraud, you can:

- Contact your home health agency to be sure the bill is correct.
- Contact the Office of Inspector General:
  Phone: 1-800-HHS-TIPS (1-800-447-8477)
  Fax: 1-800-223-2164 (no more than 10 pages)
  E-mail: HHSTips@oig.hhs.gov
  Mail: Office of the Inspector General
  HHS TIPS Hotline
  P.O. Box 23489
  Washington, DC 20026

  Please note that it's current Hotline policy not to respond directly to written communications.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Important: If you're reporting a possible case of Medicare fraud, provide as much identifying information as possible. Include the person or company's name, address, and phone number. Details should include the basics of who, what, when, where, why, and how.

Important phone numbers

Doctor _____

Health insurance company _____

Notes

Definitions

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Durable medical equipment—Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

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.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all 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, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare

Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

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. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

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 2 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).

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.

CMS 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 free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. **Call us:** For Medicare: 1-800-MEDICARE (1-800-633-4227)
   TTY: 1-877-486-2048
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a fax:** 1-844-530-3676
4. **Send us a letter:**

   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

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare Prescription Drug Plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

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Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (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.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare Prescription Drug Plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online:** hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

2. **By phone:** Call 1-800-368-1019. TTY users can call 1-800-537-7697.

3. **In 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

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Blvd.
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