
Provider Regulations

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This section highlights state and federal statutes and regulations, including statutes and regulations contained in the *Welfare and Institutions Code* (W&I Code), *California Code of Regulations* (CCR), Patient Protection and Affordable Care Act (ACA) and Code of Federal Regulations (CFR). The following statutes and regulations are binding for Medi-Cal providers, their designated agents, all public and private agencies and/or individuals that are engaged in planning, providing or securing Medi-Cal services for or on behalf of recipients or applicants.

Nondiscrimination and Language Assistance

«Medi-Cal providers may not discriminate against beneficiaries and must provide language assistance services, as described below.

Nondiscrimination

Medi-Cal providers must allow full and equal access to the benefits of the Medi-Cal program and may not discriminate on the basis of:

- Race ∞
- Color ∞
- Sex ∞
- Age ∞
- National origin ∞
- Ancestry
- Ethnic group identification
- Religion
- Disability ∞
- Mental disability
- Physical disability
- Medical condition
- Genetic information
- Marital status
- Gender
- Gender identity
- Sexual orientation»

«Language Assistance Under Federal Law

Under the regulations implementing Section 1557, Medi-Cal providers must take reasonable steps to ensure limited English proficient (LEP) individuals have meaningful access to the health program or activity they provide. Language assistance services must be accurate, timely, and provided free of charge, and protect the privacy and independence of the LEP individual. These language assistance services may include interpretation (oral language assistance) and written translation of written content in paper or electronic form. (45 CFR Sec. 92.101.)

Language Assistance Under State Law for Managed Care Plans

In addition to federal requirements, under W&I Code Section 14029.91, a managed care plan contracted with DHCS to provide Medi-Cal services must provide language assistance services to LEP beneficiaries who are mandatorily enrolled in managed care as follows:

- Oral interpretation services must be provided in any language on a 24-hour basis at key points of contact.
- Translation services must be provided to the language groups identified by DHCS (See DHCS APL 20-015, 17-011, and any subsequent APLs).»

«A managed care plan must notify beneficiaries of the availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to health care programs or activities to LEP beneficiaries. (W&I Code Sections 14029.91, 14727.)

Requirement Resources

For more information about the application and requirements of W&I Code 14029.91 and the rule implementing Section 1557, providers should contact their representative professional organizations. They may also visit the HHS Section 1557 web page to find more information on Section 1557

(www.hhs.gov/civil-rights/for-individuals/section-1557/index.html).»

Contact Information for Claims of Discrimination

«In the event that a Medi-Cal recipient makes a claim that a health care provider has failed to provide covered Medi-Cal services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, the health care provider must refer the Medi-Cal recipient to its representative designated to coordinate compliance with nondiscrimination requirements, or to handle grievances generally, and to DHCS's Office of Civil Rights by phone, in writing or electronically:»

By phone: Call (916) 440-7370. If recipients cannot speak or hear well, please call 711 (Telecommunications Relay Service).

In writing: Fill out a complaint form or send a letter to:

Office of Civil Rights
Department of Health Care Services
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Email: CivilRights@dhcs.ca.gov

Complaint forms are available on the DHCS website at (www.dhcs.ca.gov/Pages/Language_Access.aspx).

Electronically: Send an email to *CivilRights@dhcs.ca.gov*.

In the event that a Medi-Cal recipient makes a claim that a health care provider unlawfully discriminated on the basis of race, color, national origin, age, disability or sex, the health care provider must also refer the Medi-Cal recipients to the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing or electronically:

By phone: Call 1-800-368-1019. If recipients cannot speak or hear well, please call TTY/TDD 1-800-537-7697.

In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201-0004

Complaint forms are available on the HHS website at (www.hhs.gov/ocr/office/file/index.html).

Electronically: Visit the Office for Civil Rights Complaint Portal on the HHS website at (ocrportal.hhs.gov/ocr/portal/lobby.jsf).

Confidentiality

W&I Code, Section 10850 provides that names, addresses and all other information concerning circumstances of any applicant or recipient of Medi-Cal services for whom or about whom information is obtained shall be considered confidential and shall be safeguarded. Both the release and possession of confidential information in violation of this statute are misdemeanors.

Recordkeeping Criteria

Providers should carefully review the full text of regulations regarding the keeping and availability of records in CCR, Title 22, Section 51476. A summary of the regulations is as follows:

- Providers must keep, maintain and have available records that fully disclose the type and extent of services provided to
- Medi-Cal recipients. The required records must be made at or near the time the service was rendered.

- Provider records must document the meeting of Code I restrictions for medical supplies listed in the W&I Code, Section 14105.47 and for drugs listed in CCR, Title 22, Section 59999.
- Records of services rendered by Non-Physician Medical Practitioners (NMPs) must include the signature of the NMP and the countersignature of the supervising physician.
- Every practitioner who issues prescriptions for Medi-Cal recipients must maintain, as part of the recipient's chart, records concerning each prescription and records concerning medical transportation.
- Records of psychiatric and psychological services must include recipient logs, appointment books or similar documents showing the date and time allotted for recipient appointments and the time actually spent with each recipient.
- Providers must make available all pertinent financial books and records concerning health care services provided to Medi-Cal recipients to any authorized Department of Health Care Services (DHCS) or Department of Justice representative. Failure to produce such records may result in sanctions, audit adjustments or recovery of overpayments in accordance with CCR, Title 22, Section 51458.1.

In addition, for recordkeeping purposes providers should carefully review the full text of W&I Code, Chapter 7 (commencing with Section 14000) and, in some cases, Chapter 8. Medi-Cal requires providers to:

- Agree to keep necessary records for a minimum of three years from the date of service to disclose fully the extent of services furnished to the recipient. The provider also must agree to furnish these records and any information regarding reimbursements claimed for providing the services, on request, to DHCS; Bureau of Medi-Cal Fraud, California Department of Justice; DHCS Audits and Investigations; Office of State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. In addition, providers must certify that all information included on the printed copy of the original document is true, accurate and complete.

DHCS may initiate one or more of the following administrative actions if a provider fails or refuses to produce required documents and if DHCS determines that claims for services were not substantiated or were unnecessary:

Administrative Actions

Action	CCR, Title 22
Authorization	51455
Suspension from the Program	51458
Recovery of Overpayments	51458.1
Special Claims Review	51460

Electronic Claims Submission and Recordkeeping

«Providers or their agents who electronically submit claims to Medi-Cal through ASC X12N 837 v.5010 claims submission must retain sufficient data to meet all recordkeeping requirements.»

Source Documentation

Providers may maintain source documentation on a range of electronic media including microfiche and tape according to CCR, Title 22, Section 51476. Source documents include every document, record and/or printed representation of information on which the provider relies to submit a claim.

«Electronic Claims Submission Violators»

DHCS will suspend electronic billing privileges of any provider or biller who violates the regulations for proper electronic claims submission.

DHCS has amended the CCR, Title 22, Section 51502.1, to include authorization for suspension of a provider or biller who violates the regulations for program participation.

The provider or biller will be notified of the suspension in writing and may appeal within 30 days of the date of notification. DHCS will review the appeal in accordance with CCR, Title 22, Section 51015(d).

«Providers may submit claims to the California MMIS Fiscal Intermediary on the Medi-Cal Provider Portal in the manner approved by the Director of Health Services and in accordance with W&I Code, Section 14040.» Regulations for participation are in CCR, Title 22, Section 51502.1.

Civil Money Penalties

The Director of DHCS may assess civil money penalties against a Medi-Cal provider who knowingly submits a false or improper claim. The Director may assess a penalty after determining that a provider knew that items or services:

- Were not provided as claimed
- Are not reimbursable under the Medi-Cal program or
- Were claimed in violation of an agreement with the State

The determination of liability will be based on facts obtained through the State's usual audit and investigation procedures. DHCS will notify a provider of a penalty assessment by letter. The assessment will be collected on the 61st calendar day from the date of the DHCS notice.

DHCS may assess penalties for up to three times the amount claimed by the provider for each improper item or service.

Providers may appeal decisions to assess civil money penalties during the 60-day period between notification of the decision and collection of the penalty. CCR, Title 22, Section 51017 describes procedures for requesting an administrative hearing. If a provider files an appeal, DHCS will defer the collection of the assessment pending the hearing's outcome.

W&I Code, Section 14123.2 provided the legal authority for civil money penalties and CCR, Title 22, Section 51485.1 established the regulations to implement the law.

Continuance Policy for Administrative Hearings on Provider Overpayments

CCR, Title 22, Section 51016, et. seq. (Hearings Regarding Overpayments) contains information concerning the following:

According to Justice Gardner in *San Bernardino v. Doris*, 72 Cal App 3d 776 at 781, continuances should be granted sparingly and “only on a proper and adequate showing of good cause.”

1. Who may grant a continuance?

- The Administrative Law Judge assigned to hear a case has the authority to grant continuances during any pre-hearing stage or at the formal hearing. When a continuance is requested, all representations made in support or opposition to continuance shall be in writing or made a part of the formal electronic record, if the hearing has already commenced.
- In the event of the unavailability of the assigned Administrative Law Judge, the Chief Administrative Law Judge may grant continuances.

2. When may a hearing be continued?

A hearing may be continued at any time provided good cause exists.

3. What is a “good cause” to continue a hearing?

Only the following events or conditions may be good cause to continue a hearing:

- Death of a party, representative or attorney of a party, or witness to an essential fact, or the parent, child or member of the household of such person, when it is not feasible to substitute another representative, attorney, or witness because of the proximity of the hearing date.
- Order of the Superior Court staying the date of the hearing, e.g., an order to compel discovery under Government Code, Section 11507.7.
- Incapacitating illness of a party, representative or attorney of a party, or witness to an essential fact, when it is not feasible to substitute another representative, attorney, or witness because of the proximity of the hearing date.
- Lack of notice of hearing as provided in CCR, Title 22, Section 51025.

- Material change in the status of the case where a change in the parties or pleadings requires postponement, or an executed settlement or stipulated findings of fact obviates the need for hearing. A partial amendment of the pleadings is not good cause for continuance to the extent that the unamended portion of the pleadings is ready to be heard. The probability of resolution of other litigation which may affect the outcome or the extent of the parties' participation in the hearing may constitute a material change warranting continuance.
- Substitution of the representative or attorney of a party upon showing that the substitution is required.
- Unavailability of a party, representative, attorney or witness to an essential fact on account of conflicting and required appearance in a judicial matter if:
 - When the hearing date was set, the person did not know and could neither anticipate nor at any time avoid the conflict.
 - The conflict with request for continuance is immediately communicated by written declaration under penalty of perjury or document from the court to the assigned Administrative Law Judge, no later than 15 working days before hearing, when same is feasible.
- The unavailability of a party, representative or attorney, or material witness due to an unavoidable emergency.

4. What is a "good cause" to continue a hearing?

- Evidence of the event or condition which constitutes good cause to continue the hearing shall be of the sort and to the degree that responsible persons would rely thereon in the conduct of serious affairs.
 - The following represents examples of what is not "good cause":
 - ❖ Pressure of business
 - ❖ Delay in counsel
 - ❖ Delay in consulting attorney
 - ❖ Delay in completing discovery
- In the case of illness of a party, representative, attorney or witness as set forth in III.C., the petitioner for continuance may be required to provide a written statement by an attending physician which shall recite the nature and probable duration of the illness and extent of incapacitation.
- In the case of unavailability on account of required and conflicting appearance in a judicial matter, the petitioner for continuance shall provide the assigned Administrative Law Judge, the identity of the court, the caption of the matter and the action or case number, no later than 15 working days before hearing, when same is feasible.

Medi-Cal Copayment Criteria

Services Subject to Copayment	Copayment Fee	Exceptions to Fee
<p>Non-Emergency Services Provided in an Emergency Room</p> <p>A nonemergency service is defined as “any service not required for alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.” Such services provided in an emergency room are subject to copayment.</p>	\$5	<ol style="list-style-type: none"> 1. Persons age 18 or younger 2. Any woman during pregnancy and the postpartum period (through the end of the month in which the 60-day period following termination of pregnancy ends) 3. Inpatients in a health facility (hospital, skilled nursing facility or intermediate care facility) 4. Any child in Aid to Families with Dependent Children-Foster care 5. Any service for which the program’s reimbursement is \$10 or less 6. Any hospice recipient 7. Family planning services and supplies

Medi-Cal Copayment Criteria

Services Subject to Copayment	Copayment Fee	Exceptions to Fee
Outpatient Services Physician, optometric, chiropractic, psychology, speech therapy, audiology, acupuncture, occupational therapy, podiatric, surgical center, hospital or outpatient clinic, physical therapy.	\$1	<ol style="list-style-type: none"> 1. Persons age 18 or younger 2. Any woman during pregnancy and the postpartum period (through the end of the month in which the 60-day period following termination of pregnancy ends) 3. Inpatients in a health facility (hospital, skilled nursing facility or intermediate care facility) 4. Any child in Aid to Families with Dependent Children-Foster care 5. Any service for which the program's reimbursement is \$10 or less 6. Any hospice recipient 7. Family planning services and supplies

Third Party Liability and Copayments

This policy does not change the basic copayment requirements, and all previously-stated exceptions/exemptions are still in place. The only changes occur when third party reimbursements are involved.

The Consolidated Omnibus Reconciliation Act (COBRA) of 1985 contains several provisions relating to the circumstances under which providers may not collect cost-sharing (copayment) from recipients. This statute, among other things, specifies that:

- When a Medi-Cal recipient has third party insurance which pays an amount equal to or exceeding the amount payable under Medi-Cal, the provider cannot seek to collect from the recipient any additional amounts, including Medi-Cal copayments.
- Cost-sharing may not exceed the lesser of the amounts the recipient would be required to pay in the absence of Third Party Liability (TPL) (\$1 or \$5 under California's Copayment Program) or the difference between such TPL and the Medicaid reimbursement amount. COBRA further states that violation of this provision could result in provider reimbursement sanctions of up to three times the amount being sought. Also, COBRA 1985 prohibits a provider from refusing to furnish services to a Medicaid eligible recipient who has third party insurance.

The following four examples illustrate how these provisions are applied:

Example 1

For the non-emergency use of an emergency room, the copayment is \$5. The hospital's bill is \$100 and TPL pays \$75. The Medi-Cal scheduled reimbursement is \$75 and the Medi-Cal balance due is \$0.

No copayment may be collected because the \$75 TPL reimbursement equals the Medi-Cal scheduled reimbursement.

Example 2

For a physician office visit, the copayment is \$1. The physician's bill is \$50 and TPL pays \$25. The Medi-Cal scheduled reimbursement is \$40 and the Medi-Cal balance due after TPL is \$15. The recipient pays \$1.

The copayment may be collected because the copayment amount does not exceed what the recipient would be required to pay in the absence of TPL and because Medi-Cal's reimbursement is more than \$10.*

Example 3

For a physician office visit, the copayment is \$1. The physician's bill is \$50 and TPL pays \$40. The Medi-Cal scheduled reimbursement is \$45 and the Medi-Cal balance due is \$5.

No copayment may be collected because Medi-Cal's reimbursement is not more than \$10.

Example 4

For the non-emergency use of an emergency room, the copayment is \$5. The hospital's bill is \$100 and TPL pays \$80. The Medi-Cal scheduled reimbursement is \$95 and the Medi-Cal balance due is \$15. The recipient pays \$5.

Copayment (\$5) may be collected because it is the lesser of:

- The amount the recipient would be required to pay in the absence of TPL and
- The difference between the TPL amount (\$80) and the Medi-Cal reimbursement amount (\$95), or \$15.

Copayment Refunds to the Recipient

The affected recipient can be identified by the response from the Medi-Cal eligibility verification system to an eligibility verification transaction. The transaction identifies whether Other Health Coverage (OHC) exists. Any copayment collected from the recipient should be refunded if:

- The provider bills the other insurance carrier and chooses not to bill Medi-Cal because he or she knows Medi-Cal will pay no more on the claim
- The provider bills the other insurance, then bills Medi-Cal, and then receives notice from Medi-Cal that no additional reimbursement is due
- The provider bills Medi-Cal and receives a refund check after Medi-Cal has billed and collected from the other insurance carrier

Crossover Recipients

Providers who accept Medicare assignment are reminded that Medicare assignment rules preclude providers from collecting any amount from enrollees, or anyone else, which would exceed the "reasonable charge" determination when added to the benefit reimbursement.

Collection of copayment from crossover (dually eligible) recipients could result in violation of the assignment agreement. If collection of the \$1 copayment would result in total reimbursement to the provider of more than Medicare's reasonable charge determination, Medicare rules prohibit copayment collection from the crossover recipient.

Providers must not treat recipients eligible for both Medicare and Medi-Cal as if they were eligible only for Medicare and then collect Medicare deductibles and coinsurance.

Discriminatory Billing for Third Party Liability

Pursuant to federal law and regulation, providers must not refuse to furnish Medi-Cal covered services to eligible recipients because of a third party's potential liability. If recipients are eligible for Medi-Cal, they are entitled to the full range of benefits authorized by Medi-Cal regardless of a third party's liability.

Liens

The filing of provider liens in third party actions is no longer allowed once the provider has billed and been paid by Medi-Cal.

State and federal statutes provide for Medi-Cal to be the payer of last resort. Generally, the provider must bill a recipient's OHC before billing Medi-Cal when OHC is known to exist. When other entitlements are discovered after billing Medi-Cal, the provider is prohibited from billing the third party because Medi-Cal reimbursement (regardless of the percent of the provider's billed amount) constitutes reimbursement in full.

DHCS Notification Requirements

To notify DHCS of any possible Third Party Liability action, the provider should send a copy of the claim documents to:

Department of Health Care Services
Recovery Section
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

Recipient Liability

Providers may receive a *Medi-Cal Information Notice to Providers – Clarification of Liability* (MC 174) from the County Welfare Department whenever a Medi-Cal recipient pays medical expenses, or encumbers or liens excess property as a way of bringing property within the appropriate Medi-Cal property limits to establish or maintain Medi-Cal eligibility for the month. Providers are prohibited from billing Medi-Cal and reimbursing recipients for services paid for or obligated by a recipient to establish eligibility (W&I Code, Section 14019.3 [d]).

Form MC 174 is simply a notification not to bill Medi-Cal and does not require information from the provider. However, it must be retained for the required audit retention period. The recipient will also receive a copy of the notice.

Note: Medi-Cal expenses paid or obligated by the recipient to reduce excess property and establish eligibility for Medi-Cal cannot be used to meet the recipient's Share of Cost (SOC). Therefore, providers do not perform a Share of Cost clearance transaction for any services listed on the MC 174.

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL NOTICE TO PROVIDERS CLARIFICATION OF LIABILITY

NOTE: If you are not a Medi-Cal provider
please disregard this notice.

(Provider's Name)

(Address)

(City, State, ZIP code)

Dear _____
(Provider's Name)

This is to provide you with notification that the Medi-Cal Program is not liable for services provided:
La presente es para notificarle que el programa de Medi-Cal no es responsable de los servicios proporcionados:

To: _____
A: _____
(Name of Beneficiary) (Nombre del Beneficiario)

On: _____, totaling \$ _____
En: _____, con un total de _____
(Date) (Fecha)
_____, totaling \$ _____
(Date) (Fecha)
_____, totaling \$ _____
(Date) (Fecha)
_____, con un total de _____
(Date) (Fecha)

The expenses indicated above were used by the beneficiary to reduce the value of excess property to establish or maintain Medi-Cal eligibility for the month of 20_____. Under Section 14019.3(d), Welfare and Institutions Code, the beneficiary is not entitled to a refund or release of his/her liability for these expenses. (Medi-Cal is not liable for these medical expenses.) None of these expenses used by the beneficiary to reduce the value of his/her excess property, may be used to meet his/her share of cost.

Los gastos que se indican arriba fueron usados por el beneficiario para reducir el valor de bienes en exceso, para establecer o continuar reuniendo los requisitos para Medi-Cal para el mes de 20_____. En conformidad con la sección 14019.3(d) del Código de Bienestar e Instituciones, el beneficiario no tiene derecho a reembolso o liberación de su responsabilidad con relación a estos gastos. (Medi-Cal no es responsable de estos gastos médicos.) Ninguno de estos gastos que usó el beneficiario para reducir el valor de sus bienes en exceso, puede ser usado para cumplir con su parte del costo.

(Eligibility Worker) (Trabajador(a) de Elegibilidad) _____
(Phone Number) (Número de Teléfono) _____
(Date) (Fecha) _____

Permission to release information: I give my permission to the County Welfare Department to release this information to _____
(Provider's name)

Permiso para revelar información: Doy mi permiso al departamento de bienestar del condado para que revel información a _____
(Nombre del Proveedor)

(Applicant's signature) (Firma del solicitante)

MC 174 English/Spanish (05/07)

Figure 1: Medi-Cal Information Notice to Providers (MC 174)

Retroactive Eligibility Provider Obligations

Medi-Cal providers are obligated to bill Medi-Cal and accept reimbursement for services covered by the Medi-Cal program when a recipient is found to be retroactively eligible. For example, a recipient applies for Medi-Cal, but eligibility has not been determined prior to the delivery of services or a recipient does not apply for Medi-Cal until after services are rendered.

W&I Code, Section 14019, states that presenting a Medi-Cal card is authorization for the provider to bill Medi-Cal for covered services. If all eligibility conditions are met, eligibility may be retroactively established up to three months prior to the actual month of application.

W&I Code, Section 14019.3, states that a recipient, or any person on behalf of a recipient, who has paid for health services otherwise covered by Medi-Cal and received by the recipient is entitled to a return of any part of the reimbursement from the provider that meets all the following conditions:

- Was paid during any period prior to determining Medi-Cal eligibility
- Was reimbursed to the provider by the Medi-Cal program following all audits and appeals to which the provider is entitled
- Is not payable by a third party under contractual or other legal obligation
- Was not used to satisfy a paid or obligated liability (Share of Cost) for health care services or to establish eligibility

In addition, if a recipient is subsequently determined eligible for a decreased Share of Cost or no Share of Cost, the recipient is entitled to the return of that part of a reimbursement.

When the recipient presents a Benefits Identification Card and the response from the Medi-Cal eligibility confirmation system indicates that the recipient is eligible for the retroactive date of service, the provider must bill Medi-Cal for reimbursement of any services rendered during the month indicated in the eligibility verification system response.

If the retroactive claim is denied by the FI, the provider must resubmit a corrected claim and, if necessary, exhaust all administrative remedies in seeking reimbursement. The only exception is if the service is not a Medi-Cal benefit. The provider must promptly return any and all reimbursements made by the recipient for such services, or by other persons on his/her behalf (other than third parties obligated to pay because of contractual or legal entitlements), upon receipt of Medi-Cal reimbursement for the covered services. If the claim for covered services continues to be denied because the billing error cannot be corrected (for example, TAR not approved), the provider is still obligated to return all reimbursements made by or on behalf of the recipient.

Recipient Self Determination of Medical Treatment: OBRA 1990

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires all hospitals, nursing facilities, home health agencies, hospices and health maintenance organizations (HMOs) that receive Medi-Cal or Medicare funds to provide all their adult recipients/enrollees with information that helps them make decisions regarding their medical treatment and execute advance directives such as living wills and Durable Powers of Attorney for Health Care.

Requirements of Federal Legislation

This federal legislation requires facilities to:

- Provide written information to all adults about their right to make decisions concerning their medical care. This includes the right to accept or refuse medical or surgical treatment, the right to formulate an advance directive such as a living will, a “Declaration” under the California Natural Death Act and the right to a Durable Power of Attorney for Health Care.
- Maintain and give to recipients/enrollees written information about the facilities’ policies regarding the implementation of recipients’/enrollees’ self-determination rights.
- Document in the recipient/enrollee’s medical record whether or not he/she has executed an advance directive.
- Not condition the provision of care or otherwise discriminate based on whether or not he/she has executed an advance directive.
- Ensure compliance with state law regarding medical treatment decision-making and advance directives and
- Provide education to their staffs and the community about the issues involved with advance directives by releasing newsletters, articles in local newspapers, local news reports or commercials.

When Information is Given to Recipients

The following explains when information about medical decision-making and advance directives must be provided:

- Hospitals must give information to adults at the time of admission as an inpatient
- Nursing facilities must give information to adults at the time of admission as a resident
- Home health care or personal care services providers must give information before individuals come under the provider's care
- Hospice programs must give information at the time recipients receive their initial hospice care
- HMOs must give information to enrollees at the time of enrollment with the organization, both initial and re-enrollment

Implementation and Brochure

The California Consortium on Patient Self-Determination was formed to assist in the implementation of this federal statute. The Consortium was composed of health care providers, professionals, consumers, the Commission on Aging and DHCS. This Consortium developed a brochure entitled "Your Right to Make Decisions about Medical Treatment," which describes the rights of recipients to make medical treatment decisions and advance directives.

This brochure **must** be used to provide recipients, residents and HMO enrollees with basic information about their rights. Providers must use the exact language of this brochure that describes California law, as required by federal law. Providers may copy this brochure or create their own and may add their organization's policies and procedures to their brochure.

Copies of the recipient brochure in English as well as translations into other languages may be obtained from the Pacific Center for Health Policy and Ethics by telephone at (213) 740-2541.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Pursuant to state law (W&I Code, Section 14134), no copayment may be collected when Medi-Cal's reimbursement is \$10 or less.
∞	Section 1557 of ACA prohibits discrimination on these categories. Discrimination on the basis of the other categories is prohibited by Government Code section 11135.