

130.3 - State Law Primary

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* program's advance directive requirements, which Fee-For-Service providers have been following for some years, are guidelines, which refer to state law, whether statutory or recognized by the courts of the State. Therefore, *Medicare cost plans* must comply with the advance directive requirements of the states in which they provide services. The CMS cannot give detailed guidelines as to what constitutes best efforts in each state. Medicare regulations give *Medicare cost plans* and states a great deal of flexibility, and CMS is prepared to work with the HMO and CMP (and the state, if needed) to ensure that advance directive requirements conform to Federal law.

Changes in State law must be reflected in the information HMOs and CMPs provide their enrollees as soon as possible, but no later than 90 days after the effective date of the state law or the date of the court order.