
Provider Responsibilities

Page updated: August 2020

This section outlines the requirements of enrollment as a Family Planning, Access, Care and Treatment (Family PACT) Program provider, including onsite client eligibility and certification, administrative responsibilities, ensuring access to care, referring clients to Medi-Cal providers and other programs, compliance reviews and record keeping. The following statutes and regulations are binding for all Family PACT providers, their designated agents, all public and private agencies and/or individuals that are engaged in planning, providing or securing Family PACT services for or on behalf of eligible Family PACT clients.

Nondiscrimination and Language Assistance

Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities. Section 1557 builds on long-standing federal civil rights laws: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

The Health and Human Services (HHS) Office for Civil Rights issued its final rule implementing Section 1557 at Title 45 Code of Federal Regulations (CFR) Part 92. The rule applies to any health program or activity, any part of which receives federal financial assistance, an entity established under Title I of the ACA that administers a health program or activity, and HHS. In addition to other requirements, Title 45 CFR Part 92.201 requires:

- *Language assistance services requirements:* Language assistance services required under paragraph (a) of Part 92.201 must be accurate, timely and provided free of charge, and protect the privacy and independence of the individual with limited English proficiency.
- *Specific requirements for interpreter and translation services:* Subject to paragraph (a) of Part 92.201:
 - A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency.
 - A covered entity shall use a qualified translator when translating written content in paper or electronic form.

- *Grievance procedures and notice requirements:*
 - A covered entity that employs 15 or more persons must designate at least one employee to coordinate its compliance with Section 1557, including the investigation of grievances, and must adopt procedures providing for the prompt and equitable resolution of grievances, as required by paragraphs (a) and (b) of Part 92.7.
 - A covered entity must notify beneficiaries of its compliance with section 1557, as required by Part 92.8, including the availability of the grievance procedure and how to file a grievance. Significant publications and communications must contain the notice required by Part 92.8 as well as taglines offering language assistance in at least the top 15 languages spoken by individuals with limited English proficiency.

For more information about the application and requirements of the final rule implementing Section 1557, providers should contact their representative professional organizations. They may also visit the HHS Office of Civil Rights Section 1557 web page to find sample materials and other resources

(<https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>).

Senate Bill 223 (Atkins, Chapter 771, Statutes of 2017) codified certain requirements of the HHS Office of Civil Rights Section 1557 of the ACA and expanded the list of protected characteristics for purposes of the Department of Health Care Services (DHCS) nondiscrimination notices to include race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. DHCS Medi-Cal/Family PACT providers are also prohibited from discriminating unlawfully on any protected ground identified in Government Code Section 11135.

In the event that a Family PACT client makes a claim that a health care provider has failed to provide covered Family PACT 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 Family PACT client to its Section 1557 grievance coordinator, if applicable, and to DHCS' Office of Civil Rights by phone, in writing or electronically:

By phone: Call (916) 440-7370. If clients cannot speak or hear well, 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 (www.dhcs.ca.gov).

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

In the event that a Family PACT client 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 Family PACT client to the U.S. Department of Health and Human Services, Office of Civil Rights by phone, in writing or electronically:

By phone: Call 1-800-368-1019. If clients cannot speak or hear well, call TTY/TDD at 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 (www.hhs.gov).

Electronically: Visit the Office for Civil Rights Complaint Portal on the HHS website.

Responsibility for Client Eligibility Determination and Certification

The Family PACT Program requires a formal onsite client application, eligibility determination and enrollment process before a client receives services. The Family PACT provider must:

- Be responsible for determining the initial and continuing eligibility of each family planning client, based on the client's completion of the *Health Access Programs Family PACT Program Client Eligibility Certification* (CEC) form (DHCS 4461 or DHCS 4461 SP), which includes the client's self-declaration of family size, income and health care coverage. Providers must not ask clients for proof of family size, income or California residency.
- Eligible clients are women and men with a medical necessity for family planning services and must be residents of California with incomes at or below 200 percent of the federal poverty guidelines, with no other source of family planning health care coverage, except as specified in "Eligible Clients with Other Health Coverage (OHC)" in the *Client Eligibility* section in this manual.

- The CEC forms are available on the DHCS website on the Office of Family Planning Forms web page or the Family PACT website on the Forms web page under the Resources tab.
- Clients must independently complete the CEC form (DHCS 4461) and *Retroactive Eligibility Certification* (REC) form (DHCS 4001), if applicable. Providers may not complete the forms on behalf of the client. The CEC form (DHCS 4461) or REC form (DHCS 4001) must not be prepopulated by the provider. Clients may ask questions for clarifications purpose only. The provider should assess if the client understands the form and that all questions have been answered appropriately. Clients must complete all fields of the CEC form (DHCS 4461) and REC form (DHCS 4001). If the client does not have an income, it should be noted as a “zero” or a “0” on the CEC form (DHCS 4461) and REC form (DHCS 4001).
- Request the client’s Social Security Number (SSN). The client’s SSN is a required field on the CEC form (DHCS 4461). If the client does not have or provide the SSN, the client’s stated reason that it is not available must be noted on the CEC form (DHCS 4461) in the “Social security number” box. The inability of the client to provide the SSN shall not deny client access to family planning services if all other eligibility criteria are met.
- Per *Welfare and Institutions Code* (W&I Code), Section 24005(u), providers or the enrolling entity shall make available to all applicants, prior to or concurrent with enrollment, information on the manner in which to apply for insurance affordability programs. This includes, but is not limited to, the Family PACT provider providing a paper copy of the single application for Covered California or Medi-Cal coverage upon the client’s request. Family PACT providers are not required to provide applicants with assistance in completing the single form application. If the applicant requests assistance, providers may direct them to:
 - Online: (www.coveredca.com)
 - Phone: 1-800-300-1506 (TTY 1-888-889-4500)
 - Covered California Customer Service Center
 - In person: A listing of trained Certified Enrollment Counselors, Certified Insurance Agents and local county social services offices can be found at www.coveredca.com or by calling 1-800-300-1506

- Be accountable for eligibility determination, according to the administrative practices defined by the program and within this manual.
- Issue a Health Access Programs (HAP) card to the client, upon determination of client eligibility. Failure to comply may jeopardize provider participation in the program.
- Confirm eligibility status at each subsequent visit. For more information, refer to the *Client Eligibility* section in this manual.
- Comply with the fair hearing decisions of the Office of Family Planning (OFP) or the director of DHCS. If an applicant is ineligible for any of the above reasons, the provider must give the applicant a copy of the *Fair Hearing Rights* located on the backside of the CEC form (DHCS 4461).
- Inform the client of the limited scope of services available under the program.
- Not request a donation or other amounts in conjunction with the provision of family planning services. If a non-profit agency customarily asks for donations, it must be done in such a way that it is made to all clients in the same manner and is not associated in any way with the client eligibility and activation process, or with the delivery of services to Family PACT clients.
- Agree not to charge clients for enrollment in the Family PACT Program, or for rendering services that are benefits of the program, including laboratory and pharmaceutical services.
- Agree not to charge clients for the exchange or transfer of medical record information.

In accordance with *Family PACT Standards*, all services must be provided to eligible clients without regard to gender, sexual orientation, age (excluding sterilization), race, marital status, parity or disability. Services must be rendered at the enrolled location only. For more information, refer to the *Program Standards* section in this manual.

Administrative Responsibilities

The Family PACT Program provider must:

- Be responsible for the training of eligibility determination personnel with regard to the administrative practices and procedures outlined in this manual and for providing continuing training and updates as needed.

- At a minimum, recertify every three years or as directed by DHCS. Family PACT enrolled providers will have 90 days from the date of DHCS request to submit a fully completed application for recertification. Failure to timely submit a completed application will result in the provider being disenrolled as a Family PACT provider.
- Complete required training(s) as determined by DHCS to remain in compliance with program policies.
- Furnish information or copies of records and documentation requested by DHCS.

A Family PACT provider is prohibited from exchanging and/or offering to exchange, anything of value, in an effort to induce (or reward) the referral of, or application to, the Family PACT Program. Failure to adhere to this policy will result in disenrollment from Family PACT.

Scope of Services

Only licensed personnel with family planning skills, knowledge and competency may provide the full range of family planning medical services covered under Family PACT per W&I Code, Section 24005(b). Clinical providers electing to participate in the Family PACT Program shall provide the full scope of family planning, education, counseling and medical services specified by Family PACT, either directly or by referral, consistent with the *Family PACT Standards* issued by the Department per W&I Code, Section 24005(c). At a minimum, long-acting reversible contraception (LARC) shall be provided onsite.

Consent of Parents or Others Not Required

The provision of family planning services does not require the consent of anyone other than the person who is to receive services. Minors may apply for family planning services on the basis of their need for services, without parental consent (*California Family Code*, Section 6925. subd. [a]; W&I Code, Section 24003 subd. [b], except as otherwise provided by law). In determining eligibility for minors, the state will exclude parental income.

HIPAA Requirements and Notice of Privacy Practices

All Family PACT providers are required to comply with the Health Insurance Portability and Accountability Act (HIPAA) with regards to client confidentiality and providing clients with a *Notice of Privacy Practices* annually at the time of service. The notice may be downloaded from the "Privacy Office" web page of the DHCS website (www.dhcs.ca.gov).

Providers are required to provide the notice upon completion of a CEC form (DHCS 4461) and upon annual recertification. Providers must document in the client's medical record, with the date, that the client either received a copy of the *Notice of Privacy Practices* or was offered a copy and declined. It must be posted in a clear and prominent location where it is reasonable to expect individuals seeking services from the health provider will be able to read it. To ensure confidentiality, do not mail the notice to Family PACT clients, but give it to them in person when they are present for services. General information about HIPAA Privacy Protection may be found at the Privacy Office website (<http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx>).

Access to Care

The Family PACT provider is responsible for client access to Family PACT Program services in accordance with the requirements of the *Family PACT Standards*. Enrolled Family PACT providers agree to make available to eligible clients the scope of comprehensive family planning and family planning-related services, consistent with the *Family PACT Standards*, either directly or by referral. Clients must only be referred to enrolled Family PACT providers or Medi-Cal providers.

Collaboration Encouraged

Enrolled Family PACT providers have the responsibility to ensure client access to services and are encouraged to collaborate with other providers, such as laboratory, pharmacy and primary care providers. Ensuring that other providers participating in client care have information about the Family PACT Program will facilitate clients' access and care.

Family Pact Referrals

Family Pact Referrals

Medi-Cal providers who are not enrolled in the Family PACT Program may render Family PACT services only when the client is referred by an enrolled Family PACT provider. Family PACT providers may refer clients to Medi-Cal laboratory, pharmacy, radiology and anesthesiology providers for covered services. Referrals may be made to Medi-Cal consulting clinicians when a covered procedure is outside the technical skill of the Family PACT provider or when there is insufficient volume to ensure and maintain a high skill level of the Family PACT provider.

Referring Providers

The referring Family PACT provider is responsible for informing all rendering providers (including clinicians, laboratories, anesthesiologists, radiologists and facilities) of Family PACT Program policies and scope of services, so that clients do not receive services that are not program benefits, and are not charged for services. A Medi-Cal provider who is not enrolled in the Family PACT Program must know the following information to bill for services – client name; HAP ID number; family planning ICD-10-CM code and any additional ICD-10-CM code(s) needed and reimbursed by Family PACT; and the referring enrolled Family PACT provider's name and National Provider Identifier (NPI).

Client Records Transfer

Family PACT clients must not be charged for exchange or transfer of medical record information.

Primary Care and Local Resource Referrals

Family PACT Standards include a provision that providers shall make referrals to appropriate resources for needed medical, psychosocial and more intensive counseling services that are not covered by this program, including primary care not offered in enrolled provider practices. Information about other sources of funding for these services and options for a sliding-fee-scale is particularly helpful for clients who have no other health care or mental health care coverage.

Other Programs by Referral

Family PACT providers may refer clients to other programs, such as Every Woman Counts (EWC), Breast and Cervical Cancer Treatment Program (BCCTP) and Presumptive Eligibility for Pregnant Women (PE4PW).

Every Woman Counts (EWC)

Clients who meet the EWC eligibility requirements, with a finding such as a positive mammogram, breast nodule or bloody nipple discharge, who need diagnostic testing to evaluate the possibility of breast cancer diagnosis may be referred to EWC at 1-800-511-2300. For eligibility requirements, refer to the *Every Woman Counts* section in the appropriate Part 2 Medi-Cal manual. After a cancer diagnosis is confirmed, either the Family PACT provider or the EWC primary care provider may enroll the client into BCCTP for treatment.

Breast and Cervical Cancer Treatment Program (BCCTP)

Family PACT providers have the opportunity to enroll clients directly into BCCTP for services beyond the scope of Family PACT. The BCCTP provides Medi-Cal benefits for the treatment of breast and cervical cancer. Family PACT providers may enroll clients with a breast or cervical cancer diagnosis (including CIN 2 and CIN 3) into BCCTP with an internet-based application available on the Transactions web page of the Medi-Cal website (www.medi-cal.ca.gov). Clients must meet the Family PACT income guidelines in order to be referred to, or enrolled in, BCCTP. For more information about BCCTP, call 1-800-824-0088. To find out how to participate as a referring provider, call the Telephone Service Center (TSC) at 1-800-541-5555.

Presumptive Eligibility for Pregnant Women (PE4PW)

Presumptive Eligibility for Pregnant Women is a Medi-Cal program designed to provide immediate, temporary coverage for prenatal care to low-income pregnant women pending a formal Medi-Cal application. Any woman who thinks she is pregnant and whose family income is under a certain amount is eligible for PE. However, she must seek this care through a participating provider to determine if she is eligible for this program. For more information, and to find out how to become a PE4PW provider, refer to the *Presumptive Eligibility for Pregnant Women Provider Enrollment Instructions* section in the appropriate Part 2 Medi-Cal manual.

Non-Medi-Cal Clinics

As defined in the *California Code of Regulations* (CCR), Title 22, Section 51115(b), community clinics, free clinics, county operated organized outpatient clinics, Rural Health Clinics (RHCs) and other clinics that are not enrolled in the Medi-Cal program as an “organized outpatient clinic with surgical facilities” may not bill Family PACT for emergency, examining and treatment rooms. This includes HCPCS codes Z7500, Z7506, Z7508, Z7510 and Z7512, as defined by CCR, Title 22, Section 51509.1. A Family PACT provider must have the appropriate provider type on file with Medi-Cal Provider Enrollment Division to bill for facility use.

Compliance Review

Compliance Review

Adherence to the Family PACT Standards is a requirement for all enrolled Family PACT providers and associated practitioners. The Family PACT Standards define the scope, type and quality of care required under the Family PACT program, and the terms and conditions under which the providers will be reimbursed.

The Department may conduct or arrange for compliance reviews and/or audits to be conducted to ensure compliance with *Family PACT Standards*, regulations and laws and program policies and administrative practices. In addition, site reviews may be performed. Follow-up compliance reviews, audits or site reviews may occur as deemed necessary. Failure to comply with *Family PACT Standards*, regulations and laws and program policies and administrative practices will result in suspension and/or disenrollment from the Family PACT Program.

Recordkeeping

Recordkeeping

The Family PACT Program defers to Medi-Cal regulations for keeping and maintaining medical records. For a summary of Medi-Cal regulations, refer to the *Provider Regulations* section in the Part 1 Medi-Cal manual. The Family PACT Program has additional guidelines for recordkeeping that include, but are not limited to, the CEC form (DHCS 4461), sterilization *Consent Form* (PM 330), signature requirement for drugs and devices and a log of devices and implants.

Medical Record Documentation

The *Family PACT Standards* require medical documentation to support services billed for reimbursement. Also, the clinical rationale for providing, ordering or deferring services for client assessment, diagnosis, treatment and follow-up is required. Documentation must reflect the scope of education and counseling services, including individual client assessment. All medical record entries must be legible and the clinician must be clearly identifiable. In accordance with W&I Code, Section 24005(p), each provider of health care services rendered to any program beneficiary shall keep and maintain records of each service rendered, the beneficiary to whom the service was rendered, the date and any additional information that the department may by regulation require

Client Eligibility Certification (CEC) Form

The provider must maintain the CEC form (DHCS 4461) in the medical record for each applicant/client, including those found ineligible, for at least three years. The CEC form may be maintained electronically, in compliance with all aspects of *Health and Safety Code* (H&S Code), Section 123149.

Sterilization Consent Form

The provider must maintain the completed and signed sterilization *Consent Form* (PM 330) in the client's chart as a permanent part of the medical record. The Family PACT provider must make the *Consent Form* available to any providers and facilities to which the client is being referred. A copy must be attached to claims for sterilization services. For information about completing a *Consent Form* (PM 330), refer to the *Sterilization* section in the appropriate Part 2 Medi-Cal manual.

Ordering Sterilization Consent Forms

Sterilization Consent Forms (in English and Spanish) can be downloaded from the Forms web page of the Medi-Cal website located at www.medi-cal.ca.gov or can be ordered by calling the Telephone Service Center (TSC) at 1-800-541-5555. Providers must supply their NPI number when ordering the form(s). The following information also may be requested:

- Date
- Name of document (sterilization *Consent Form*, PM 330)
- Name of provider/facility (registered provider name associated with the NPI)
- Complete shipping address: Street, city, state, ZIP code (P.O. Box not accepted)
- Quantity of forms requested
- Contact person and telephone number
- Relationship of the client to the person receiving a prescription, if the client is not picking up the medication

Signature for Drugs or Devices Billed to Family PACT

W&I Code, Section 14043.341 requires providers to obtain and keep a record of Family PACT client signatures, acknowledging the dispensing of a drug, device or supplies, or when obtaining a laboratory specimen. Providers who dispense a drug, device or supplies requiring a written order or prescription to be covered under the program, and providers who obtain a specimen for performance of a clinical laboratory test or examination, must maintain the following items in their files to qualify for Family PACT reimbursement:

- Signature of the person receiving the drug or device, or from whom a specimen was obtained
- Client's printed name
- Date signed
- Prescription number or item description for drugs or devices
- Relationship of the client to the person receiving a prescription, if the client is not picking up the medication

As an alternative, a provider obtaining a specimen for a clinical laboratory test or examination may satisfy this requirement by doing both of the following:

- Keep the requisition document provided to the clinical laboratory on file, and
- Obtain the signature and printed name of the client on the requisition document

Several exceptions apply to the signature requirement. A provider does not need to obtain a signature and related information when:

- A biological specimen is obtained for the purpose of anatomical pathology examinations performed during inpatient or outpatient surgery, if a notation of the performance of the anatomical pathology examination appears in the medical record.
- Dispensing a complimentary sample of a dangerous drug, provided no charge is made to the patient and an appropriate record is entered in the client's chart.
- Dispensing a drug or device occurs on a periodic basis within an established provider/patient relationship. The signature shall only be required with the initial dispensing or furnishing of the drug, so long as an appropriate record of each dispensing or furnishing is entered in the patient's chart.
- Obtaining a biological specimen is required in order that a test or examination occurs on a periodic basis within an established provider/patient relationship. The signature shall only be required upon obtaining the biological specimen necessary for the initial test or examination, so long as an appropriate record of each test or examination is entered in the patient's chart.

- The provider is a licensed pharmacy or clinical laboratory, owned and operated by a non-profit health care service plan with at least 3,500,000 enrollees, or is owned and operated by a non-profit hospital corporation that has a mutually exclusive contract with a non-profit health care service plan with at least 3,500,000 enrollees. The provider is a licensed provider who practices within a physician organization that meets either of the requirements set forth in paragraph (2) of subdivision (g) of H&S Code, Section 1375.4; that is, a risk-bearing organization such as a professional medical corporation, medical partnership, medical foundation or other lawfully organized group of physicians that deliver, furnish, arrange for or provide health care services.

Providers who bill Family PACT but do not comply with the requirements, and do not qualify for an exception, will be subject to civil money penalties.

Log of Intrauterine Contraceptive (IUC) Devices and Contraceptive Implants

For at least three years from the date of insertion, providers should keep a written log or electronic record of all intrauterine contraceptive (IUC) devices and contraceptive implants provided, including the following:

- Client's name
- Medical record and HAP card numbers
- Date of insertion
- Type of IUC or implant
- Lot number of the device or product

All IUCs and implants inserted through the Family PACT Program must be FDA-approved devices, labeled for use in the United States, and obtained from FDA-approved distributors. Providers must maintain invoices for insertion kits billed to Family PACT for at least three years from the date of the invoice (W&I Code, Section 24005 [7][p]).

<<Legend>>

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

Symbol	Description
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