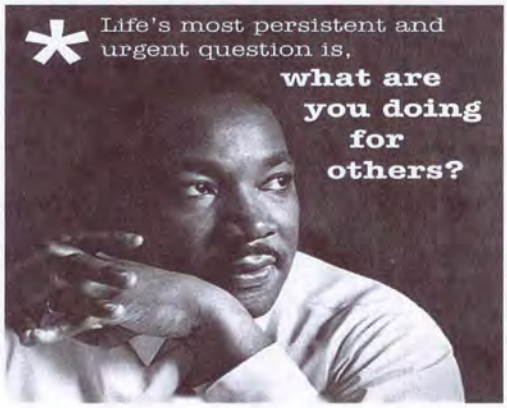
Maternal and Child Health Access – Monthly Meeting

January 24, 2013

AGENDA



1. Introductions
2. Materials distributed and newsletter e-mailed
3. Updates:
    a. Healthy Kids Closure to 6-18 year olds March 1 – Liz Ramirez
    b. Welcome Baby and Select Home Visitation models expansion – Luz Chacon
    c. HF-MC transition – WIC for kids in Medi-Cal to 250% poverty
4. Special Guest Speaker – Lucy Quacinella, JD – Multiforum Advocacy Solutions
   Relief & Challenges: Proposed State Budget 2013-14
5. Announcements

Next meeting: Thursday, February 21, 2013

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: JANUARY 23, 2013

All Plan Letter 13-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROCESSING ERRORS RELATED TO DENIED MEDICAL EXEMPTION REQUESTS REGARDING MANDATORY ENROLLMENT INTO A MEDI-CAL MANAGED CARE PLAN

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of recently identified Medical Exemption Request (MER) processing errors and associated remedies for impacted beneficiaries.

BACKGROUND:
State regulations allow certain beneficiaries to request a medical exemption from MCP enrollment for up to 12 months to complete necessary treatment with their current Medi-Cal fee-for-service (FFS) provider(s).[1] This treatment must be for a complex medical condition and must be provided by a physician, certified nurse midwife, or licensed midwife who is participating in FFS Medi-Cal but is not contracting with any of the MCPs available in an eligible beneficiary's county of residence.

A beneficiary who is granted a medical exemption from MCP enrollment may remain with the FFS Medi-Cal provider until his or her medical condition is stabilized to a level that enables him/her to change to a MCP physician without deleterious medical effects, as determined by the beneficiary's FFS Medi-Cal provider. At any time, the Department of Health Care Services (DHCS) may verify the complexity, validity, and status of the medical condition and treatment plan and verify that the provider is not contracting or otherwise affiliated with a MCP in the beneficiary's county of residence. DHCS may deny a request for exemption from MCP enrollment or revoke an approved MER if a provider fails to fully cooperate with DHCS's verification process.

[1] Exemptions from enrollment in Two-Plan Model health plans are set forth in Title 22 of the California Code of Regulations (CCR), Section 53887. Exemptions from enrollment in Geographic Managed Care health plans are set forth in Title 22 CCR 53923.5.

DISCUSSION:
DHCS identified two errors related to MER processing:

1. Incomplete MERs:

   Between March 1, 2011 and October 15, 2012, MERs that DHCS clinical staff identified as incomplete were often denied automatically upon receipt by DHCS's enrollment broker. These MERs should have been placed on hold for 30 days while the enrollment broker requested additional medical documentation from the submitting provider, as described in the corrected process below. As a result, beneficiaries and their providers were not given the opportunity to provide additional information in support of their MERs. This error impacted beneficiaries whose MERs were denied during this time period because DHCS clinical staff determined them to be incomplete.

   Corrected Process
   DHCS established a process to verify the complexity, validity, and status of the medical condition and treatment plan of the beneficiary requesting exemption from Medi-Cal managed care. If DHCS clinical staff do not have enough information to complete the verification process, the submitting provider will be contacted in two ways to obtain the necessary additional information: first, by facsimile notice; and second, by telephone up to five separate times on five consecutive business days. If the provider submits the requested medical documentation, DHCS will process the complete MER. If DHCS does not receive the requested information within 30 days from the date of the request, the MER will be denied.

2. Denial Notices:

   Between March 1, 2011 and October 15, 2012, the DHCS enrollment broker did not mail MER denial notices to some beneficiaries who should have received them. This error; however, did not occur 100 percent of the time. As a result, some beneficiaries did not have the opportunity to appeal DHCS's decision and apply for a state fair hearing (SFH).

Corrected Process
If a beneficiary's MER is denied, DHCS will mail a denial notice.

DHCS is deeply concerned about the impact to beneficiaries as a result of these errors. DHCS takes these findings very seriously and views remediation of them to be the highest priority. DHCS is, or has taken, the following steps to remedy these errors:

1. On October 15, 2012, DHCS and its enrollment broker implemented stopgap measures to ensure no additional beneficiaries are negatively impacted.
2. DHCS and its enrollment broker developed a corrective action plan to implement both temporary and permanent operational corrections to address all errors in an expedited manner.
3. DHCS developed beneficiary remedies and is communicating them to all impacted beneficiaries through notices that were mailed in January 2013.
4. DHCS retained an external auditor to immediately validate the stopgap measures and audit the entire MER process. The first deliverable, validating the stopgap measures, is scheduled to be released in January 2013.

BENEFICIARY REMEDY:
DHCS is offering a remedy to the affected beneficiaries. DHCS will offer a separate remedy for each error. For beneficiaries impacted by both errors, DHCS will offer the remedy developed for "incomplete MERs" because it addresses both processing errors.

DHCS will communicate these remedies and options to beneficiaries in January 2013 both by mail and by telephone. The following table includes information about each error, the corresponding beneficiary remedy, and the corresponding notice number for reference.

Table 1: Remedy Overview			
Processing Error	**Description**	**Beneficiary Remedy**	**Notice Identification**
Incomplete MER	DHCS's enrollment broker denied incomplete MERs upon receipt, rather than placing them on hold for 30 days pending receipt of additional medical documentation that had been requested.	The beneficiary can file a new MER either while enrolled in the MCP or after requesting to return to FFS.	Footer: Notice # MU_MER3856 in the right hand corner and the letter **B** in the left hand corner.
Denial Notice	DHCS's enrollment broker did not mail a MER denial notice.	The beneficiary can file a request for a SFH either while enrolled in the MCP or after requesting to return to FFS.	Footer: Notice # MU_MER3857 in the right hand corner and the letter **X** in the left hand corner.

Beneficiaries are not required to pursue a beneficiary remedy and may choose to do nothing and remain with their MCP. In addition, this APL does not impact a Medi-Cal beneficiary's existing right to change MCPs or providers upon request.

1. Incomplete MER Remedy:

   This population was impacted because DHCS's enrollment broker issued denial notices for MERs that DHCS's clinical staff determined as incomplete. DHCS intended for the enrollment broker to request additional medical documentation from the FFS Medi-Cal provider and place the MERs on hold for 30 days. Because the enrollment broker did not request additional medical documentation, a medical review of the MER was never completed.

   DHCS is offering these beneficiaries the option to file a new MER. DHCS will notify these beneficiaries by mail in January 2013. An impacted beneficiary may file a MER while the beneficiary is enrolled in an MCP, or the beneficiary may return to FFS Medi-Cal while the MER is being processed. An impacted beneficiary must submit a request to return to FFS Medi-Cal within 30 days from the date of the letter.

   Beneficiaries requesting to return to FFS Medi-Cal and filing a new MER must submit the MER within six months from the date of the letter notifying them of their options. If a beneficiary does not file the new MER within the specified timeframe, or if DHCS denies the new MER, the beneficiary will automatically be enrolled into the same MCP he/she was enrolled in prior to requesting to return to FFS Medi-Cal.

The MCP must take steps to ensure that the beneficiary will be able to utilize the same MCP providers they were utilizing prior to the beneficiary returning to FFS Medi-Cal, unless the beneficiary indicates a desire to change providers. If the new MER is denied, the beneficiary must also be extended continuity of care in accordance with APL 11-019; Medi-Cal Managed Care Division Policy Letter 12-004; Welfare and Institutions Code Sections 14005.27 and 14182(b); Health and Safety Code Sections 1373.95 and 1373.96; Title 22 CCR Sections 53286, 53810, and 53887; Title 28 CCR Section 1300.67, et seq.; and any other applicable state and federal statutes and regulations.

Each beneficiary who completes a new MER while remaining in the MCP must submit the MER within 45 days of the date of the letter. The MCP provider must complete the MER if requested by the beneficiary.

Each beneficiary should have his or her provider complete the new MER according to the process noted above and submit it to Health Care Options by fax at 916-364-0278.

Instructions to complete the MER form can be found by accessing the link below:

http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/Provider_Bulletin_July2012.pdf

A copy of the MER form can be found at:

http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx

MCP providers should note that although the MER instructions and MER form are written to apply to FFS providers, in this instance only, they also apply to MCP providers. MCPs will receive a data file that identifies their members that are impacted by this policy.

2. Denial Notices Remedy:

This population was impacted because DHCS's enrollment broker did not mail a MER denial notice to these beneficiaries even though DHCS's clinical staff had denied their MERs. As a result, the impacted beneficiaries were not informed of their right to request a SFH.

DHCS is offering these affected beneficiaries the option to request a SFH. The SFH request can be filed while the beneficiary is enrolled in an MCP, or the beneficiary can return to FFS Medi-Cal while the SFH request is being processed. Requests to return to FFS Medi-Cal must be submitted within 30 days from the date of the letter.

If the request for a SFH is not filed within 45 days from the date of the letter, or the SFH is denied, the beneficiary will automatically be enrolled back into the same MCP they were enrolled in prior to requesting to return to FFS Medi-Cal. For additional information on the SFH process, beneficiaries may contact the Department of Social Services at 1-800-952-5253; TTY: 1-800-952-8349; Monday through Friday, from 8 a.m. to 5 p.m.

MCPs will receive a data file that identifies members impacted by this policy.

If you have any questions regarding this APL, please contact your Contract Manager.

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Healthy Kids 6-18 Program - March 1, 2013 Discontinuation
Frequently Asked Questions

Q: When will coverage end in the Healthy Kids 6-18 Program?

A: L.A. Care has not formally announced the ending of the program. However, the Healthy Kids 6-18 Program will end March 1, 2013. Healthy Kids 6-18 members should see their doctor before March 1st.

Q: Will children 0-5 be affected?

A: No. Thanks to First 5 LA, there is sufficient funding to cover all eligible 0-5 year-olds through June 2015. But, Healthy Kids coverage will end when the child turns six.

Q: What will happen to my child aging out of Healthy Kids 0-5?

A: They will no longer have coverage. But, you may contact your local CAA agency who can assist you in finding other coverage options for your child(ren).

Q: What other coverage options are available for my child(ren)?

A: You may contact your local CAA agency to discuss finding other coverage options for your child(ren). You can also visit www.chigla.org/apply for a list of CAA agencies in your neighborhood. Additionally, L.A. Care will send you information regarding these health coverage options that are offered in L.A. County.

Q: How can I enroll into the Kaiser Child Health Plan (KPCHP) if my child(ren) is already in the Healthy Kids 6-18 Program?

A: Your local CAA can help you enroll into Kaiser's program. However, families can submit KPCHP applications with a HK termination date (at least 45 days from the day of submission to allow for processing). Additionally, you may also attach a copy of your Healthy Kids 6-18 termination letter to the KPCHP application for further proof of disenrollment date.

Q: Will I still have to submit my monthly premium payment?

A: Yes, premium payments will still be due by the 20th of the month.

Q: I have premium credit, will I get a refund?

A: Yes, you will be refunded after the Healthy Kids 6-18 Program ends.

Q: My child(ren) is in the middle of treatment, will he/she still be able to continue?

A: We will work with you to ensure that your child(ren) receives the care that he/she need (case-by-case issues).

Q: How can I get a copy of my child(ren)'s medical records?

A: You may get a copy of your child(ren)'s medical record by going to your doctor. We can also assist you in making a request for your medical records. In some cases your doctor may charge you a fee.

Maternal and Child Health Access

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Health Care Alternatives for Kids

LA Care has announced the end of Healthy Kids coverage for enrolled children 6-18 at the end of February 2013.

- **Kaiser Permanente Child Health Plan is open for new enrollment:** This program provides comprehensive health and dental services to children from birth thru age 18 who are not eligible for other public/private, such as Medi-Cal or Healthy Families. You can request an enrollment kit at: http://info.kaiserpermanente.org/html/child_health_plan/index.html or call Kaiser Member services toll free at 1-800-4000.
- **Is the child under five years of age?** Enrollment is still open in the Healthy Kids program for children who are 5 1/2 and younger and meet existing Healthy Kids eligibility requirements. Call LA Care at 1-888-452-2273 for more info.
- **California Kids is currently closed for new enrollment but may re-open on February 1, 2013**: Cal Kids provides preventive and primary health care benefits to children ages 2 – 18; inpatient/ hospitalization services are not covered. There is no income limit and immigration status does not matter. Monthly premiums are $75 per child and co-payments range from $5 to $110, depending on the service. You can call to check on program status or an application at (818) 755-9700 or download an application at: http://www.californiakids.org/
- **Is the child over five years of age?** Refer to a Community Partner clinic (Healthy Way LA "unmatched"), that provides preventive and primary care, or to an L. A. County Department of Health Services (LAC-DHS) clinic for primary, preventive, specialty, and urgent health care (Outpatient Reduced Simplified Application "ORSA"). If the family income is under 133% of poverty and the child does not qualify for full scope Medi-Cal due to immigration status, the child may be eligible for free coverage under HWLA "unmatched" or ORSA. If the child is over-income for HWLA s/he may use the County Pre-Pay Program, as long as s/he doesn't have an open Medi-Cal Share of Cost case. Applicants must live in L.A. County. For information call (877) 333-4952 or to locate a HWLA provider http://www.ladhs.org/wps/portal/HWLA, **click on Provider Directory.**
- **Is the child within the Child Health and Disability Prevention Program (CHDP) schedule of visits or is a problem suspected or a visit needed outside the schedule for sports physical or foster care exam?** If so, the child can get up to two months full Medi-Cal if s/he does not already have Restricted (sometimes called "Emergency") Medi-Cal. During that time, it is possible to receive care for even longer by applying for ongoing coverage. Call MCH Access or attend one of our trainings if you need assistance helping families in this way. To find a CHDP provider you can call toll-free (800) 993-CHDP or online http://publichealth.lacounty.gov/cms/provider_finder.htm

CHDP Periodicity (schedule of visits):

Less than 1 month of age	9 months of age	2 years of age	9-12 years of age
2 months of age	12 months of age	3 years of age	13-16 years of age
4 months of age	15 months of age	4-5 years of age	17-20 years of age
6 months of age	18 months of age	6-8 years of age	

- **If the child is undocumented, is it possible the child is Permanently Residing Under Color of Law (PRUCOL, a Medi-Cal category) and thus eligible for full-scope Medi-Cal?**
  The most likely reason is that his/her immigration status is being adjusted, the family has applied for Legal Permanent Residency (LPR or "green card") or in some other way is adjusting status.

- **Does the child have an urgent need that may be considered an emergency?** That is:
  "A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  (a) placing the patient's health in serious jeopardy;
  (b) serious impairment to bodily functions; or
  (c) serious dysfunction of any bodily organ or part."

  If so, s/he may be able to use Restricted or Emergency Medi-Cal, regardless of immigration status. The treatment does NOT have to be in an emergency room! Having Restricted Medi-Cal will eliminate the ability to get temporary full-scope Medi-Cal from the CHDP Gateway, but will not eliminate the ability to get a CHDP exam and immunizations.

- **Is the child or teen in need of confidential services for family planning, pregnancy, rape treatment, exam or treatment for a possible Sexually Transmitted Infection, outpatient mental health care, or alcohol or drug abuse services?** S/he may be eligible for Minor Consent Medi-Cal if living in the parents' home or temporarily away at school. The parents' income will not count.

- **Is the child or teen in need of confidential health education, reproductive health services such as family planning, emergency contraception, or a gynecological exam, HIV and other STI screening, available from the Family PACT program?** Call (800) 942-1054 to locate a provider in your area or see http://www.familypact.org/

- **Does the child have a serious or chronic medical condition?** Immigrants ineligible for regular Medi-Cal and Healthy Families are still eligible for health care for serious and/or chronic medical conditions from California Children's Services (CCS), services from Regional Centers, mental health care, etc., in addition to Medi-Cal emergency services, Minor Consent Medi-Cal, and FamPACT. See the Health Consumer Center's brochure at http://www.healthconsumer.org/publications.htm. To make a referral to CCS, or for more information on the program, call (800) 288-4584.

If you would like more information or an in-service/training please contact Liz Ramirez at (213) 749-4261, lizr@mchaccess.org. See our training calendar at: www.mchaccess.org

BROWSE BY TOPIC

- Health Reform
- Medicaid/CHIP
- Medicare
- Costs/Insurance
- Uninsured/Coverage
- State Policy
- HIV/AIDS
- U.S. Global Health Policy
- Minority Health
- Women's Health Policy
- Media & Health

BROWSE BY REPORT TYPE

Fact Sheets GO

SPECIAL FEATURES

- Pulling It Together, From Drew Altman
- Kaiser Commission on Medicaid & the Uninsured
- Kaiser Polls
- Media Fellowships
- Barbara Jordan Health Policy Scholars Program
- News Media Partnerships
- Health Communication & Media Partnerships
- South Africa
- Fast Facts

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Getting into Gear for 2014: Briefing, Survey Examine 2013 Data From 50-State Survey of Medicaid and CHIP Eligibility and Enrollment Policies

Following the Supreme Court ruling upholding the Affordable Care Act (ACA) and as 2014 approaches, many states are moving into high gear to prepare for implementation of the major provisions of the law, including a new streamlined Medicaid enrollment system and, at states' option, the expansion of Medicaid. Nearly all states are pressing forward with information technology and process improvements to develop faster, streamlined Medicaid enrollment systems as required under the ACA, whether or not the state elects to expand Medicaid coverage under the law.

These and other findings appear in the Kaiser Commission on Medicaid and the Uninsured report, "Getting into Gear for 2014:Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," the product of a comprehensive annual survey conducted with the Georgetown University Center for Children and Families. A second report released at the briefing highlights the experiences of some previously uninsured people who obtained Medicaid coverage in
states that opted to serve the newly eligible population before 2014.

The Foundation released the reports and convened an expert panel discussion at a public briefing Jan. 23, 2013, at its Washington, D.C., office.

Getting into Gear for 2014: Findings From a 50-State Survey of Eligibility, Enrollment,Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013

Faces of the Medicaid Expansion: How Obtaining Medicaid Coverage Impacts Low-Income Adults

Materials from the January 23, 2013 briefing:

Full Video — Speakers' Slides Synced to the Video of the Briefing

NOTE:

* You must view the archived webcast with slide sync in Internet Explorer. Download it here (http://www.microsoft.com/windows/Internet-explorer/default.aspx)

* To see the presentation by individual speaker, click on "Slide Index" in the lower left and scroll to the title slide of that speaker.

Full Video — All Other Browsers

Podcast

Agenda (.pdf)

Speaker Bios (.pdf)

Information provided by the Kaiser Commission on Medicaid and the Uninsured
Publish Date: 2013-01-23

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RELATED RESOURCES:

- Previous Annual Surveys on Eligibility Rules, Enrollment and Renewal Procedures and Cost-Sharing Practices

Relief & Challenges: Proposed State Budget 2013-14

MCH Access,
January 24, 2013

Relief. . .

- No major cuts to health & human services
- 5% increase to budget overall– to $97.7 billion
- $4 billion to K-12 ($2.7) & higher ed ($ 1.3)
- $1 billion for reserve
- Not adding to $27.8 billion debt from previous years
- $4.2 billion to start to pay down that debt

Bit of a closer look at HHS. . .

- $142.8 million for welfare-to-work services (but grants still at only 40% of poverty)
- Tiny– 1%-- increase to child care services, $22 million. Stakeholder "streamlining".
- Child support services increase to L.A.: $6.7 million
- CAPI COLA ($10/$20 for couples)
- Federal SSI COLA
- $78.8 million for L.A. LEADER Replacement System
- Health Care Reform implementation– see below

How? Why?

- Prop 30 from last Nov.-- $6.8 to $8.8 billion
- Improving economy
- Dem 2/3, so fees on plans and hospitals for $527.3 million for Medi-Cal now seem possible to reinstate
- **Main reason: Massive cuts in past 5 years-- $5.3 billion**
  - CalWORKs grants
  - Childcare services
  - Adult dental and other Medi-Cal benefits
  - Medi-Cal provider rates
  - Low-income housing
- No restorations. . .

Keep your eyes on. . .

- Limit Medi-Cal managed care changes to once a year
  - Saves only $1 million– so why limit consumer choices?
- $135 million cut to Medi-Cal for managed care "efficiencies"
- $3 million cut for child care Resource and Referral and other agencies
- May Revise

Health and Human Services Network of California, January 23, 2013

". . .[T]he Governor's new budget lacks a vision for helping the millions of Californians who are unemployed or living in poverty despite working. We must work for a budget that will restore, rebuild and reinvest so that families, children, seniors, and people with disabilities are a part of our economic recovery moving forward - not left behind in poverty."

Medi-Cal & Health Care Reform

- New household and income-counting rules in 2014
- Two proposed options for expanding Medi-Cal to adults with income up to 138% of poverty
- A proposal for affordable coverage for adults with income 139% to 200% of poverty
- Special eligibility and scope of benefits issues for pregnant women

Rule Changes

- Changes in who is included in the "household" and how income is to be counted for Medi-Cal (MAGI conversion)

Medi-Cal Expansion for Adults

- To 138% of poverty
- No assest test
- Affects 1.4 million adults
- Feds pay 100% for first few years
  - Tapers to 90% by 2020
  - States wants more federal guidance on claiming methodology
- $350 million "placeholder" for cost of the expansion
- Excludes pregnant women (see below)

How will Medi-Cal's adult expansion be implemented?

- With Medi-Cal's scope of benefits?
- Or Essential Health Benefits (EHBs)?
- No decision yet
  - State wants more guidance from feds
- Special Session of the Legislature on health care reform implementation to start in late January

Two options for 138% adult expansion– preliminary considerations:

- How would each option affect county hospitals and health systems?
- County health care funding for residual uninsured, including immigrants excluded from federal health care reform?
- Other county funding for social services, like child care?

Option One, County-Based Approach for the 138% Adult Expansion Program

- Continue the Low-Income Health Programs (LIHP)
  - Now in 17 counties, serving 500,000 adults
  - Under the "bridge to reform" Medi-Cal waiver
  - Would need new waiver approval
- Require statewide eligibility requirements
- EHBs at a minimum. No LTC.
- Counties would run their own programs, assemble provider networks, set rates, etc.
- Counties to put up local funds
  - Nothing in 2014 and for a few years, but gradually going to 10% of the cost
- Why would counties agree to this?

Option Two: State-Based Approach for the 138% Adult Expansion

- State expands Medi-Cal to 138%, except for LTC
- State re-directs to Sacramento what counties save by Medi-Cal covering these adults
- Details not clear, but 1991 County Realignment funds, now used for health and public health, and/or childcare funds, are the likely state targets
  - Realignment funds $1.2 billion statewide, of which $395 million in L.A.

Medi-Cal "Bridge" Proposal for Adults 139% to 200% of Poverty

- Private insurance purchased through the Exchange is not likely to be affordable for families at or below 200% of poverty
- "Basic Health Option" in federal law might help, but no federal guidance yet
- "Bridge" would allow Exchange Board to negotiate contracts with Medi-Cal for this population, using the federal subsidies and Medi-Cal market leverage to promote affordability
  - Emphasis on plans with "safety net" providers, for continuity of care as adults move over/under 139%

Special Issues Affecting Pregnant Women: 138% Adult Expansion Program

- Federal law excludes pregnant women from the 138% expansion and the Exchange, to the extent that "pregnancy-only" Medi-Cal covers them
- CA covers pregnant women to 200% of poverty– but only for "pregnancy-related" care
- **MCHA advocates defining "pregnancy-related" services to include all medically necessary care during pregnancy**
  - New federal regulations say the default for pregnant women is full-scope
  - State must now seek permission to exclude benefits
  - What will CA do?

Special Issues Affecting Pregnant Women, 138% Program, cont'd.

If "limited scope" for pregnant women retained, what then?

If pregnant at application, to pregnancy-only Medi-Cal (required by federal law).

- CPSP + dental
- Women should also be **simultaneously enrolled in 138% program** for coverage excluded from the "limited scope" program for pregnancy-related care. **With one card, seamless to the woman.**
  - Similar to current Medi-Cal policy on dual enrollment in "share of cost" for anything Medi-Cal covers that is excluded from the 200% program for pregnant women.

Special Issues Affecting Pregnant Women, 138% Program, cont'd.

If become **pregnant after enrollment** into 138% program, women need **choice** to:

- Remain in that program (CE for pregnancy); OR
- Change to Medi-Cal, if Medi-Cal scope, providers, fee-for-service access better meet a woman's needs.
- **Clear, timely information to women for informed choices**

Special Issues Affecting Pregnant Women, 139% to 200% "Bridge" Program

If "limited scope" for pregnant women retained, what then?

- As MCHA proposes for the 138% program (see above)

Healthy Families Transition

- Started January. No new enrollments.
- Children enrolled in HF before January 1 being transitioned to Medi-Cal in phases throughout 2013
- Some Los Angeles Healthy Families children – 11,504-- are in Phase 1B
  - They transition to LA Care's Medi-Cal managed care plan on **March 1**
- The remaining Los Angeles children– 57,282– are in Phase 1C
  - They are going to Health Net's Medi-Cal managed care plan **April 1.**

prepared by Multiforum Advocacy Solutions - MAS

Dental and the HF Transition in L.A.

- Same transition schedule as medical
- Children will keep their Healthy Families dental provider if the provider is in a Denti-Cal managed care plan
  - If not, child's dental will be in fee-for-service, unless the family opts for managed care with another provider.
- Families can disenroll their children from dental managed care and instead use Denti-Cal in fee-for-service for any reason.

prepared by Multiforum Advocacy Solutions - MAS

Continuity of Care and the HF Transition

- What to do if a transitioning child loses access to her current doctors or specialists?
  - Contact the following for help regaining access
    - The provider
    - The Healthy Families and Medi-Cal plans
    - The State Department of Managed Health Care
    - The Medi-Cal managed care Ombudsman
    - Health Consumer Center or other Legal Aid

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HF Children with Annual Eligibility Review (AER) dates before their transition dates

- Healthy Families children with AER dates before their transition dates will return to Healthy Families if otherwise eligible
  - Eligibility for such children includes family income being within the usual Healthy Families limits for the child's age.
  - This is because children may not move from Healthy Families to Medi-Cal before their scheduled transition dates.
  - Note: Kids 6-18 must now be screened with Medi-Cal's more generous "Section 1931(b)" income disregards (see *MCHA v. DHCS & MRMIB*). So more of them will be going to Medi-Cal before their transition dates.

prepared by Multiforum Advocacy Solutions - MAS

Thank you.

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WHAT WOULD YOU DO IF YOU HAD MORE MONEY?

Get a tune-up? Stock up on groceries? Pay down the bills? Well, money could be waiting for you at the IRS. Some working people will get hundreds, even thousands back when they file their taxes and claim the Earned Income Tax Credit.

GOING FOR TAX HELP OR RETURN PREPARATION? GO PREPARED WITH:

- Valid driver's license or photo identification (self & spouse, if applicable)
- Social Security cards for all persons listed on the return
- Dates of birth for all persons listed on the return
- All income statements: Forms W-2 and 1099, Social Security, unemployment, other statements, such as, pensions, stocks, interest and any documents showing taxes withheld. If self-employed or you own a business, bring records of all your income
- All records of expenses, such as, tuition, mortgage interest or real estate taxes. If self-employed or you own a business, bring records of all your expenses
- Dependent child care information: payee's name, address and SSN or tax ID number
- Proof of account at financial institution for direct debit or deposit (voided check with ABA routing number)
- Prior year tax return (if available)
- Any other pertinent tax documents or papers

Will you be paying a tax professional to prepare your return? Be sure to choose one who uses a Preparer Tax Identification Number (PTIN) and signs your return. It is against IRS regulations for preparers to omit either from your return. See irs.gov for additional information on how to choose a tax return preparer.

Life's a little easier with **www.irs.gov/eitc**

eitc earned income tax credit

¿QUÉ HARÍA SI TUVIERA MÁS DINERO?

¿Afinaría el coche? ¿Llenaría el carrito del supermercado? ¿Pagaría algunas cuentas? Pues, quizás algún dinero le espera a usted en el IRS. Algunas personas que trabajan recibirán un reembolso de cientos o hasta miles de dólares cuando presenten sus impuestos y reclamen el Crédito Tributario por Ingreso del Trabajo, o EITC.

¿VA A OBTENER AYUDA PARA SUS IMPUESTOS O PARA PREPARAR SU DECLARACIÓN? VAYA PREPARADO CON:

- Licencia de conducir válida u otra identificación válida con foto (propia y de su cónyuge, si corresponde)
- Tarjeta de Seguro Social de todas las personas que figuran en la declaración
- Fecha de nacimiento de todas las personas que figuran en la declaración
- Todos los informes de ingresos: Formularios W-2 y 1099, Seguro Social, desempleo, otros informes o estados de ingresos, p.ej., pensiones, acciones, intereses y cualquier documento que indique impuestos retenidos. Si trabaja por cuenta propia o es propietario de un negocio, lleve los registros de todos sus ingresos.
- Todos los registros de gastos, p.ej., por matrículas, intereses hipotecarios o impuestos sobre bienes raíces. Si trabaja por cuenta propia o es propietario de un negocio, lleve los registros de todos sus gastos.
- Información de los gastos de cuidado de hijos dependientes: nombre, dirección y número de Seguro Social o de identificación tributaria del beneficiario de los gastos
- Prueba de cuenta en una institución financiera para débito o depósito directo (cheque anulado con número de ruta)
- Declaración de impuestos del año anterior (si está disponible)
- Cualquier otro documento tributario pertinente

¿Va a pagar a un profesional de impuestos para que prepare su declaración? Asegúrese de elegir un profesional que tenga un Número de Identificación de Preparador de Impuestos (PTIN, por sus siglas en inglés) y que firme su declaración. Si el preparador omite cualquiera de los dos de su declaración, va en contra de las normas del IRS. Visite irs.gov para obtener más información sobre cómo elegir un preparador de declaraciones de impuestos.

La vida es mejor con el **irs.gov/espanol**

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crédito tributario por ingreso del trabajo

Birth Parents' Bill of Rights

Every birth parent has the right to:

- Be treated like any other new mother or father.
- Be informed of agency policies on adoption.
- Be provided with unbiased, non-judgmental counseling.
- Choose and meet the adoptive parents for their child.
- Have the right to request written information about the adoptive family.
- Receive information about their baby (sex, size, birth weight, etc.).
- Be offered the opportunity of holding and feeding their baby at the hospital.
- Name the baby for the original birth certificate and to request a copy.
- Know what is happening to the child (legal proceedings, foster care, etc.).
- When foster care is part of the plan, to meet the foster family and visit with the baby while it is in foster care.
- If desired, to receive photographs of the child as a newborn and on an on-going basis.
- Have access to updated information about the child.
- If post-placement contact is desired (letters, visits, phone calls, photographs, etc.), to reach an agreement with the adoptive family on an plan that meets everyone's needs.

Holy Family Services
adoption & foster care
When you care enough to consider adoption

800-464-2367

License No. 197805291 & 197805292

LOS ANGELES COUNTY	ORANGE COUNTY	VENTURA COUNTY	INLAND EMPIRE
840 Echo Park Avenue	P.O. Box 9	80 E. Hillcrest, #201	1407 N. Arrowhead Ave.
Los Angeles 90026	Placentia, 92871	Thousand Oaks 91360	San Bernardino 92405
(213) 202-3900	(714) 528-6300	(800) 464-2367	(909) 885-4882

www.holyfamilyservices.org

Derechos de los Padres Biológicos

Todos los padres bidógicos tienen el derecho de:

- Ser tratados igual que cualquier padre o madre.
- Obtener asesoría imparcial, sin ser juzgados.
- Ser informados de las pólizas de adopción de la agencia.
- Elegir y conocer a la familia adoptiva de su niño.
- Poder alimentar al bebé y tenerlo en sus brazos durante su estancia en el hospital.
- Recibir información sobre el bebé (sexo, tamaño, peso al nacer, etc).
- Otorgar un nombre al bebé en el certificado original de nacimiento y solicitor una copia.
- Estar al tanto de lo que pasa con el niño (procedimiento legdes, padres de crianza, etc.)
- Cococer los padres de crianza y visitar al bebé mientras que este con ellos si cuidado provisiond es parte del plan.
- Recibir fotografías del bebé de recién nacido y después con regularidad.
- Poder pedir información por escrito sobre la familia adoptiva.
- Tener acceso a la más reciente información del niño.
- Ponerse de acuerdo para tener contacto después de la adopción (cartas, visitas, fotografías)
- Tener visitas con todos presentes incluyendo el niño si todas las partes están de acuerdo.

Una agencia sin denominación, con licencia, no-lucrativa, que provee asesoría, servicios de adopción, cuidado de padres de crianza, y servicios relacionados para la familia.

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(213) 202-3942 fax	(714) 528-6305 fax		

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