Hello,

The Bluegrass Aging and Disability Resource Center works with many of the programs that the Department for Community Based Services (DCBS) manages. We often refer many of our clients to apply for DCBS services including traditional Medicaid, SNAP, or Medicaid Waivers. Here are thoughts and proposals for changes to the 1915c Medicaid waiver programs.

- **DCBS staff needs to have updated training on the waiver application process**

  The Department of Community Based Services can offer many benefits when it is utilized correctly, however, because clients are denied the ability to easily access services, we are denying them the opportunity to improve their lives. Small problems can become larger problems. The lack of knowledge, information, and training amongst the DCBS workers regarding the Waiver programs needs to be addressed. Many clients are given incorrect information when dealing with DCBS. Often, we have had DCBS staff tell people after completing Medicaid application that the agency needs to upload the Level of Care (LOC). The agencies no longer do this and have not done so for several years- this is completed by nurse assessors. When DCBS workers do not know about the programs that are offered through their offices nor where to direct these questions this can be detrimental to the community. Clients become frustrated when they are given conflicting information and spend hours trying to reach the correct person. Oftentimes clients have been told that they won't qualify for certain programs—when they do indeed meet level of care and any financial restrictions. Clients have also been told by DCBS workers that the Medicaid Home and Community program has lost funding, doesn't exist, or that if they do utilize Waiver services, they will lose insurance coverage. Due to the lack of knowledge regarding the Waiver program, clients are being turned away and denied services. Even when clients ask for Medicaid for the Home and Community Based Waiver by name, oftentimes they are signed up for the wrong type of Medicaid, causing further delays.

- **Applications should be reviewed for services that are immediately available first.**

The application review process is out of order. Rather than being reviewed by HCB first, it is reviewed for HCB last. If they are applying for multiple waivers, the application must be

reviewed and then the person can be placed on a waiting list for MPW, ABI, or SCL before they can finally be reviewed for HCB which has no waiting list. Client loses valuable time they could have been receiving services waiting to be placed on a waiting list.

- **Waiver Program, Applications, Website, and Materials Need to be More Accessible**

  Oftentimes clients are unable to access services via phone, in person, or via the web. When contacting DCBS via phone, there is only one phone number for all the various programs and services. There needs to be a separate phone numbers or extensions for the various programs. DCBS phone number 1-855-306-8959 often becomes overwhelmed and tells callers that they are experiencing a high call volume before disconnecting. Additionally, the website is not easy to navigate or user intuitive. As professionals we have difficulty accessing the needed information through Benefind and Kynect. When someone calls our Aging and Disability Resource Center and is not sure of their case manager, we cannot access that information unless they are associated with our agency. Benefind and chfs.ky.gov often do not have up to date information and often have non-working links. While DCBS often encourages people to save time by applying online, this is not an option for most of the population.

  When the websites are functioning, applying for Medicaid for the Home and Community Waiver is a difficult process for individuals. There is not enough information explaining what is needed to complete the application and there are no clear deadlines for when they need to return documents i.e. MAP-10. Because the Waiver application has several timeline restrictions, which can cause an application to be timed out, individuals are losing services and having to begin again.

  Much of the documentation sent to applicants is confusing. The MAP- 10 states that "I certify that if waiver services were not available, institutional placement in a Nursing Facility(NF) or Intermediate Care Facility for Individuals with an Intellectual Disability shall be appropriate for this member." Many people interpret this to mean that if they get denied for waiver services, they will be forced to go to a nursing facility. We have many, many

upset individuals thinking this is the case. While we can explain it if we get that question, we have also had doctors interpret the statement as such.

- **Automatic case management assignment-**

If a person does not choose a case management agency within 30-60 days then they should automatically be assigned to a case management agency so that they do not lose services and have to start the application process again. Clients who are approved for the Waiver program, but have gone 60 days without any services, will lose their Waiver eligibility. This doesn't consider clients that are unable to find a case management agency—many are at capacity- Or the clients that are unable to find a case management provider due to age (i.e children). Because Traditional Services must be in place before they are able to choose the PDS option, families are losing their services and are having their children's lives put at risk. Clients who are enrolled for Waiver services but haven't chosen a case manager, due either to memory issues or lack of comprehension, have multiple timed out applications. There needs to be an option to have **certain** clients automatically enrolled with a case management and care provider agencies following their approval into the Waiver program and a follow up by DMS if they haven't chosen a case manager by x amount of days. "Would this client like to be automatically assigned a case manager upon approval for the Medicaid Waiver Program, select option if so." Giving clients the option to opt out of having a preselected case manager.

- **Application initiators should be able to close out old applications for individuals who never received services**

Clients who are enrolled for Waiver and haven't chosen a case manager nor received services, where the original application is more than 60 days old--but less than 6 months old—are in a limbo where they are unable to be reenrolled—due to being "enrolled" but not discharged from their original application. Because they never chose a case manager, there is no way for application initiators to close the original application.

We currently are emailing Madison Cline to close out applications that are in limbo, however, there aren't specific parameters for closure; resulting in some

applications being closed and others remaining open indefinitely. In order to close out the original application, the clients must sign a statement that they are declining services and would like to start again. This is very confusing to an already frustrated client who just wants to receive services. Given that the process for Waiver services is a lengthy one and doesn't consider emergency situations, many clients rapidly decline in health before they are able to receive services.

- **Child participants should have tailored Home and Community Based waiver program services**

Clients who are under the age of 18 need to have a separate Home and Community Based Program due in part, to their needs being different. While no program will ever cover around the clock, nursing home level care, it is important to address the differing abilities across multiple age groups. Similarly, clients who are in emergency situations that require immediate care need to have a program that addresses their dire needs.

Many children receive Waiver services while they are on the waiting list for the Michelle P. Waiver, given that the Michelle P. Waiver waiting list is several years long. Many parents of these medically fragile children do not feel comfortable or safe, hiring an outside care provider to provide Traditional Services. The Participant Directed Services requires that additional step of hiring a non-immediate family member, however in many cases these families do not have such a person that they trust.

Additionally, psychological evaluations are near impossible to get and they are often a required document. While we have been able to upload a document by their primary care doctor saying that the child doesn't qualify for a psychological evaluation at this time; long term they are required by both Michelle P and SCL, and with their rarity and expense (not covered by Medicaid) makes this another hurdle for the family.

- **Pending Medicaid Eligibility needs to be resolved quicker**

Individuals who do not income qualify for Medicaid are stuck in limbo at the end of the application process. At this point, they have been approved for Level of Care and submitted all

their required documentation to Medicaid. But they must wait 30+ days to get their Medicaid changed to long term Medicaid that is compatible with Medicaid waivers. Have a section that says “Client should be approved for Medicaid Eligibilty by _______date would be much easier to see if there is an issue with their Medicaid eligibility or if they are just in the limbo period. The limbo period doesn’t make sense and oftentimes people are in a weird gap in service from being discharged and not having any sort of assistance in the home, we have heard of countless stories where this lack of help led to deconditioning.

Thank You,

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