Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight

June 18, 2024

Chairperson Landwehr, Vice-Chairperson Gossage, and members of the Committee

Thank you for the opportunity to provide this written testimony regarding the "user experience" from the perspective of an HCBS applicant sharing their overall experience with the program. I learned of this Committee from an Assistant of the KanCare Ombudsman's Office while sharing my issues and concerns with the application process, encounters with customer service representatives and letters of denial/correspondence. The purpose of this testimony is in effort to improve the overall process by bringing areas of deficiency to your attention, thus preventing future applicants the angst.

I completed the application on behalf of my elderly uncle, a US Navy Veteran and retiree of the Osawatomie State Hospital (OSH) - KDADS. He had experienced significant health and age-related issues and was in desperate need of assistance. Although after 5 months, 24 days and two (2) applications later he was approved for and is currently receiving HCBS Medical Assistance under the Frail/Elderly Waiver, I feel my work is not complete without trying to bring about changes through awareness. The following information/testimony is a summary of some my experiences and areas/items to address in the future.

Background:

I submitted an appeal (OAH No. 24M0481 MA) on February 7, 2024 with the Kansas Office of Administrative Hearings and the hearing was held on April 15, 2024. As the Presiding Officer has not reached or informed the Interested Parties of his decision, I am limited in what details I am comfortable sharing, however, did not want to delay presenting to this Committee for another three (3) months when you meet again.

Observations, Impressions and Experiences: Key Areas to Address

- Meeting the financial resource eligibility limits and obtaining the necessary health assistance as a private pay individual during the application process almost guarantees that tens of thousands in debt will be accrued without any resources or way to ever repay. Simply put, the timeline requirements are impossible to meet and even successful applicants have no financial support or recourse, if needed.
- The approval process and staff's actions are driven and managed by "metrics" instead of by managing the process. This drives the wrong behavior as actions can result in better metrics but delays benefit to otherwise qualified applicants. From my experience, employing this mindset will never result in knowing the true application cycle time or approval/rejection rate or lead to the necessary improvements. As improvements and changes are implemented, the metrics will certainly follow.
- Delayed action on behalf of the CSR or Case Workers cost the applicant money. I provided information to contest a wait period for eligibility and three days elapsed before it was acknowledged, verified and updated. This is even after calling and informing that the information was uploaded. The practice of "Not Back-Dating" should be eliminated when it is the Agencies inability or failure to act or their mistake.

- The overall process lacks adequate checks and balances or issues such as these would be made evident this Committee.
- The process lacks dialogue between case workers and applicants leading to unnecessary delays and denials. An automated system is not a substitute to conversation in real time between both parties.
- The system and process are very difficult to navigate.
- There is an overall "Frustration" of the process, shared equally with staff and applicants.
- This is not an account of "isolated incidents" and I am not alone in my experience. I hear testimony of similar accounts from other applicants, health care providers and State Agencies.
- There are certain "workflow statuses" whereas the system will not allow supporting documents to be uploaded to the application.
- Faxes sent to the agency cannot be readily located by CSR's even with the date and time of the transmittal provided. In one instance it took 26+ minutes to find one while we were on the phone.
- Correspondence sent from this agency was postmarked 11 days after the date marked on the document and not received by the applicant via USPS for another 4 days leaving no grace period to challenge the decision. This correspondence is still in not available for viewing in Medical Consumer Self-Service Portal however all other correspondence is.
- When on a call checking status of the second application, I was told by the CSR that since I had filed an Appeal for a State Fair Hearing, that I needed to contact that Office for status. The Office of Administrative Hearings is not involved nor responsible for this based on my research. A day later, on my call with a different CSR, the application status was reported.
- Specific information requested by a case worker was provided and not acted upon. There is a reasonable expectation that key information critical to determining eligibility be reviewed and followed up on.
- Representatives speak so "Matter of Factly" even though they are not the final decision maker or correctly following, applying or citing policy.
- My pleas to authorized staff for continuance of the initial application by overturning the erroneous denial were not acted on thus creating an additional delay of approximately 45 days to receiving benefit.

Thank you again for this opportunity. It is submitted truly in effort to improve and assist those obtain the assistance they need in a timely manner. If I can answer any questions and/or provide more information now or in the future, please don't hesitate to contact me.

Sincerely,

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