



Council on Mental Retardation
Leadership Institute
101 Witherspoon Street
Louisville, KY 40202

Phone 502 587 6500
Fax 502 587 6570
www.councilonmr.org

Health and Wellness

Part Two: Managed Care

Accessing Medical Services and Navigating Kentucky's Medicaid Managed Care System

Medicaid – What is it anyway?

Medicaid is a federal-state matching entitlement program that provides medical assistance for certain individuals and families with low incomes and limited resources. Medicaid is the largest program providing medical care to eligible needy persons. You may qualify for Medicaid services based upon your disability and/or income.

You may have heard the word **Medicare**, which is a federal health insurance program and is associated with Social Security benefits. Medicare is, for the majority of persons with disabilities, an inferior health insurance program compared to Medicaid. Note: For the purpose of this manual we will only focus on Medicaid.

Basis of eligibility and maintenance assistance status

Medicaid does not provide medical assistance for all low-income persons. States generally have broad discretion in determining which groups their Medicaid programs will serve and the financial criteria for Medicaid eligibility. You may qualify for Medicaid in one of three different ways:

- 1) If you receive SSI, you will be automatically eligible for Medicaid.
- 2) If your income exceeds the qualification for SSI because you receive SSDI, you are eligible for Medicaid. You will probably have to pay a

predetermined amount toward your medical bills based on your income. This is called a spend down.

- 3) If you are denied SSI due to excess earnings, but not due to your medical disability, and your income does not cover your medical expenses, you may still be eligible for Medicaid. People whose primary disability is mental retardation are frequently eligible for Medicaid under this qualification. If you are denied SSI based on having too many resources, you are not eligible for Medicaid.

As stated above you must meet the “income and resource” test

Income is defined as anything received in cash or in kind that can be used to meet needs for food, clothing or shelter.

Resources is defined as cash or other liquid assets or real or personal property that an individual owns and could convert to cash which can be used to provide for food, clothing or shelter.

Be prepared to provide the Department of Community Based Services (DCBS) with the information they will need to determine eligibility.

How Can I Apply?

You may apply at the **DCBS** office in the county where you live. To make an appointment in Jefferson County, Kentucky you will call **502-594-4238** or visit their office at **908 W. Broadway**. For other counties look in your telephone directory in the blue pages under State Government for the Cabinet for Families and Children-Department for Community Services.

You can pick up an application for Medicaid. At that time, you should arrange an interview to discuss your application. If you have any questions, please call your DCBS office and ask to be referred to the worker of the day. This office is busy. You are more likely to reach the worker if you call after 11:00 a.m.

What Benefits Are Available?

- ✓ Physician Services *
- ✓ Hospital Services *
- ✓ Renal Dialysis Services
- ✓ Ambulatory Surgical Center Services
- ✓ Pharmacy Services
- ✓ Dental Services (coverage limited)

- ✓ Podiatry Services
- ✓ Primary Care Center Services
- ✓ Rural Health Clinic Services *
- ✓ Independent Laboratory Services *
- ✓ Vision Services (coverage limited)
- ✓ Hearing Services (coverage limited)
- ✓ Screening Services (under age 21) *
- ✓ Family Planning Services *
- ✓ Advanced Registered Nurse Practitioner
- ✓ Birthing Center Services *
- ✓ Mental Health Services (coverage limited)
- ✓ Home Health Services *
- ✓ Nursing Facility Services *
- ✓ Psychiatric Residential Treatment Facility (ages 6-21)
- ✓ Intermediate Care Facility Services for the Mentally Retarded and Developmentally Disabled (ICF/MR/DD)
- ✓ Medical Transportation
- ✓ Hospice Services
- ✓ Durable Medical Equipment (DMR)
- ✓ Waiver Services

Remember, not all services will be available to you. Please check with the local Department of Community Based Services office to determine what services are available to you.

Keep in mind that many of these services (see the above *) are federally mandated services. *All other services provided for under the Medicaid State Plans are **optional** services under the Federal requirements and may be eliminated during periods of the State's fiscal shortfall.*

Why is Medicaid Important to you and your Family?

Medicaid is typically the only primary health insurance plan for persons with disabilities who have limited income. The lack of adequate health insurance is often cited as a primary barrier to both the ability to live in the community and the ability to succeed in employment. Therefore, an increasing number of individuals with disabilities are looking to Medicaid as their primary health insurance plan, notwithstanding higher levels of income. Medicaid may be available to those individuals through state specific Medicaid waivers (*see the financial assistance section of this manual to learn more about Kentucky's waivers*).

Kentucky Waivers (Optional Service)

Before we proceed and discuss waivers, you might want to know what a waiver is. A waiver is when a state is exempted from certain regulations in order to use Medicaid funds to pay for services outside of a long-term care facility.

Community Waivers that are typically used by people with developmental disabilities in Kentucky are the:

- Home and Community Based Waiver
- Supports for Community Living

Home and Community Based Waiver

The Home and Community Based (HCB) Waiver program provides necessary medical services to Medicaid eligible persons, who are aged or disabled, who would otherwise require a nursing facility level of care.

Services include but are not limited to the following:

- Assessment and reassessment
- Case management
- Homemaker services
- Personal care services
- Respite
- Minor home adaptations
- Attendant care
- Adult day health care

A Home Health Care Agency, selected by you, conducts an assessment. (For a list of Home Health Agencies, see the Financial Assistance section). From that assessment an individual written plan of care is developed that includes: 1) all your service needs; 2) amount and duration of services(s) to be provided, and; 3) choice of service provider(s). **Be sure that all of your service needs are written in the plan before you sign it. The federal government will not reimburse for waiver services that are not included in this plan of care.** Your plan will then be reviewed and authorized by a Medical Review Board in Frankfort before it can be carried out.

At the time of this writing there is no waiting list for this program.

To be eligible you must be a Medicaid recipient; require services in order to avoid institutionalization; and verify through a physician that without these services, the physician would order placement in a nursing facility.

Home health care providers who have been approved by Kentucky's Department of Medicaid Services (DMS) provide services. A current list of providers is available through the DMS @ 502-654-5707 or Seven Counties, your local Comprehensive Care Center @ 502-459-5292.

How to Apply

The Home and Community Based waiver may be applied for by contacting the **Department of Medicaid Services @ 502-654-5707 or TTY @ 800-372-2973.**

Supports for Community Living waiver

The Supports for Community Living (SCL) waiver is a home and community based waiver under the Kentucky Medicaid program and was developed for Kentucky residents as an alternative to institutional care for an individual with mental retardation or developmental disabilities.

Services include:

- Support coordination
- Residential supports
- Community habilitation
- Supported employment
- Community living support
- Behavioral supports
- Psychological services
- Occupational therapy
- Physical therapy
- Speech therapy
- Respite

The SCL waiver has a waiting list. Please see the financial assistance section of this manual to learn more about Kentucky waivers.

Eligibility

To be eligible for the SCL waiver you must have mental retardation or a developmental disability and meet the requirements for residence in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR), and meet other Medicaid requirements.

SCL providers must be certified by the Department of Mental Retardation. Contact 502-564-7702 to receive a complete list of certified providers or go to the provider link at <http://mhmr.chs.ky.gov>.

How to Apply

To apply for the SCL waiver you must complete a MAP – 620 application for SCL waiver and ICF/MR service. You can call the SCL Area Administration at 502-361-2301 Ext. 2261 or call the Kentucky Department for Mental Health and Mental Retardation Services at 502-564-7702 for the complete application.

Waivers must grant recipient freedom of choice

Under the Federal Medicaid law (Section 1902 (a) (23) of the Social Security Act) you are guaranteed the right to select who will provide supports to you from among all qualified providers. The fact that a state operates a “waiver” program does not mean that it can ignore this law.

Kentucky assures that each individual eligible for the waiver will be given **freedom of choice** in selecting qualified providers for each service written in the plan. If you want a variety of providers to serve you, as indicated by your support plan that is your right. **If you are denied freedom of choice in provider(s) or services, be sure to get the denial in writing. You can appeal the denial. See appeals under this section.**

Payer of Last Resort

Medicaid funds may not be used to satisfy a financial commitment for services that may be paid for from another public or private source.

Kentucky's Medicaid Health Care Coverage Programs

The most important Medicaid –funded services to people with disabilities and their families are those that are both the most expensive and not usually covered through employer-funded health insurance programs. Unfortunately, more and more people are asking for services, and there is not enough money to pay for services for everybody who wants them.

In order to provide you with the same preventive and curative health services as people without disabilities receive and control the health care spending of people who receive the most expensive services, the Department of Medicaid Services developed two managed care programs.

Kentucky's two Medicaid managed care programs are the Kentucky Patient Access and Care (**Ken PAC**) and the Health Care Partnership Plan, (**Passport**), which operates in Louisville and its 15 surrounding counties. The State Medicaid Program regulates both KenPAC and Passport.

Note: Kentucky also operates the regular fee – for - service Medicaid.

First and Foremost...You must be eligible for Medicaid in order to receive either Ken PAC or Passport

As stated above you must be approved for Medicaid (See Medicaid-What is it Anyway section above) before you receive health care coverage paid for through Medicaid. Once approved you will receive a beneficiary information card called a **Medical Assistance Identification Card** which you receive the first part of every month. Keep this card! You need this card to assist you in accessing services. In addition, your health plan, such as **Passport** or **Ken PAC**, will provide you with an ID card that is different from your medical card. Be sure to check all the information on your card. If there is an error, contact Medicaid Member Services phone number provided by your health care plan and/or contact your local **Department of Community Based Services (DCBS) at 502-594-4238 if you live in Jefferson County, or contact your local county DCBS office** worker.

The determination of whether you are enrolled in a managed care plan or the fee-for service plan is determined by:

- Category of aid,
- Geographic location and/or,
- If you are in a long term care facility or receive a waiver.

Your local DCBS worker will determine what plan serves you best based on the health plans eligibility requirements. **All recipients in Region 3, which includes Louisville and the surrounding sixteen counties, are automatically enrolled in Passport, unless you are in a nursing facility or are in a waiver program.**

Kentucky Patient Access and Care (Ken PAC):

Ken PAC acts as a gatekeeper to oversee care. Most Kentucky recipients outside of Jefferson County region are enrolled in Ken PAC. Ken PAC allows Medicaid beneficiaries to select a primary care case manager (PCCM) who is a physician responsible for managing your health care by pre-authorizing, locating, coordinating and referring visits to other Medicaid providers. The assigned primary care physician is responsible for guaranteeing 24 hours a day, 7 days a week access to medical care.

How will you receive Medicaid services through Ken PAC?

Your primary care provider (PCP) is the provider you will see first when you need medical care. Your primary care provider will see you for routine care and refer you to a specialist when you need one. A primary care provider can be a pediatrician, an internist, a family doctor, a general doctor or an OB/GYN, a nurse practitioner or a physician assistant who works in a primary care center or a rural health center. **(Note: If you receive a Ken PAC covered service that requires authorization by your assigned Ken PAC physician or clinic, or is not a direct access benefit and service, and you did not seek such authorization, the cost of those services will not be reimbursable by Medicaid).**

You will choose your primary care provider either through the DCBS office at application or through the **KenPAC** HELP DESK @1-877-639-0010. If you use a telecommunications device for the deaf (TDD/TTY) you may call 1-877-0066 if you receive SSI. *(Note: SSI recipients are notified by letter to contact Department of Medicaid Services for assistance in choosing a PCP).*

Eligibility

The Department for Medicaid Services' information systems will identify if you are eligible for Ken PAC. You will receive a letter notifying you of your

eligibility. If you fit one of the below guidelines you will receive Medicaid services through KenPAC. They are:

- a) AFDC- related
- b) Family- related
- c) Poverty-related women and children
- d) Kentucky Children's Health Insurance Program (KCHIP)
- e) Supplemental security income (SSI) recipients age (19) and above
- f) SSI-related
- g) Receiving state supplementation

You will not qualify for Ken PAC If you are:

- ✓ An individual receiving Medicare benefits;
- ✓ An American Indian who is registered member of a federally-recognized tribe;
- ✓ A child under nineteen (19) years of age who is eligible for SSI under 42 U.S.C. 1382(e), in foster care or subsidized adoption;
- ✓ Receiving comprehensive case management services through a family-centered, community based, coordinated care system receiving grant funds;
- ✓ In the custody of the Department of Juvenile Justice and is placed outside the home; A recipient who participates in the Kentucky Health Insurance Premium Payment Program (KHIPP);
- ✓ A recipient who is: A resident of a nursing facility;
- ✓ A resident of an intermediate care facility for the mentally retarded or home and community based waiver;
- ✓ A recipient who resides in a county in which Medicaid services are provided through a managed care partnership operating under the authority of Section 1115 waiver;
- ✓ A recipient who is an alien with time-limited Medicaid eligibility;
- ✓ A recipient who has a Medicaid eligibility period that is only retroactive;
- ✓ A recipient who is Medicaid eligible through spend-down status;
- ✓ A recipient who is deceased on the date of eligibility approval; A resident of a psychiatric hospital or psychiatric residential treatment facility;
- ✓ A recipient who is receiving hospice services; A recipient whose care is coordinated through the Hemophilia Treatment Program of the Kentucky Commission for Children with Special Health Care Needs;
- ✓ A recipient for whom the primary payer is a third-party payer other than Medicaid and whose health care is coordinated by a primary care provider;
- ✓ And a recipient eligible in accordance with 907 KAR 1:800, (Breast and cervical cancer eligibility for Medicaid).

What if you want to change your primary care provider?

Medicaid grants you 90 days of enrollment into **KenPAC** to change your primary care provider if you find it not to be a good fit. Thereafter, **you can change your provider once a year, in your birth month, or at any time for a good reason**, with permission from the Department for Medicaid

Services. An example of a “good reason” would be moving to a different county.

What are your benefits with Ken PAC?

You medical benefits are the same as with regular fee-for –service Medicaid, and include:

- ✓ Physician services, including office visits
- ✓ Maternity and newborn care
- ✓ Prescription drugs
- ✓ Hospital care, inpatient and outpatient
- ✓ Home health and hospital services
- ✓ Laboratory and x-ray services
- ✓ Durable medical equipment
- ✓ Chiropractic services
- ✓ Podiatry
- ✓ Ambulatory surgery
- ✓ Transportation; and
- ✓ Basic dental, vision, and hearing services
- ✓ Physical, occupational and speech therapy

Direct Access Benefits and Services

Services that do not require a referral from your primary care provider are:

- ✓ Mental health services
- ✓ Maternity and newborn care
- ✓ Family planning services
- ✓ Transportation
- ✓ Basic dental, vision, and hearing care
- ✓ Chiropractic care
- ✓ Podiatry
- ✓ Screenings and treatment for sexually transmitted or communicable diseases.
- ✓ (Note: You may get many of the services listed above by calling your local health department or Medicaid provider).

Who should you contact if you have questions and concerns?

For information regarding Ken PAC, you should first call your local Department for Community Based Services. In Jefferson County, the number is 502-594-4238. If the problem cannot be resolved locally, then call:

Medicaid Member Services

1-800-635-2570

If you use a Telecommunications Device for the Deaf (TDD/TTY) may call

1-800-775-0296

What if you are unhappy with a decision made by Ken PAC?

If you are not happy with a decision made by Ken PAC, you have the right to request a hearing. If you wish to request a hearing, you may do so by filing a request at your local Department for Community Based Services Office or by mailing the request for a hearing to:

**Department for Medicaid Services,
Program Integrity/Appeals
275 E, Main Street, 6E-B
Frankfort, Kentucky 40601**

PLEASE NOTE: See 907 KAR 1:560, 907 KAR 1:075, and 907 KAR 1:563 at the end of this section for the complete process for hearing and appeals and grievances.

You may also contact Kentucky's office of the Ombudsman who is an independent government consultant designated to receive and investigate complaints made by individuals against alleged abuses or questionable acts of a government agency or provider. You can reach the Ombudsman at:

**Office of the Ombudsman
Toll Free Line: 877-807-4027
TTY: 800-648-6056
Voice Relay Service: 800-648-6057**

Passport Health Plan (Passport)

Passport is known as a Health Care Partnership network. Established as a "capitated" managed care program (which means doctors and other health care providers are paid a fixed monthly fee for each Passport member under their care, rather than for each service or treatment they perform), **Passport** is comprised of a wide range of public and private providers, with a focus on providers who have historically served large numbers of Medicaid recipients. As noted above, the plan serves members in the Commonwealth of Kentucky Medicaid Region 3, which is

comprised of the following 16 counties: Jefferson, Oldham, Trimble, Carroll, Henry, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Larue, Hardin, Grayson, Meade, and Breckinridge.

The AmeriHealth Mercy, a multi-state Medicaid managed care organization headquartered in Philadelphia, Pennsylvania, administers Passport Health Plan. **Passport** Health Plan's offices are located at 305 West Broadway, Louisville, Kentucky.

Eligibility

All recipients in Region 3, **Passport** Health Plan area (sixteen counties including the Louisville metro area) are automatically enrolled in **Passport**, unless you are a resident of a nursing facility or are in a Home and Community Based waiver program. There are no other exclusions. *(Note: The Partnership operates under an 1115 waiver, which grants the state the authority to enroll all recipients in that area).*

How will you get Medicaid Services through Passport?

Just like all recipients enrolled in a managed care plan, you will receive Medicaid covered services just as you would if you remained fee-for-service. All services whether provided through a managed care plan or fee-for-service, are only covered to the extent that they are medically necessary. There are different rules regarding authorization for coverage, based on the authority under which the managed care plan operates. **Passport** uses a primary care provider (PCP) model. You will have a choice of a PCP. You will be given a list of network providers from which to choose.

What if you want to change your primary care provider?

If you do not choose a provider after a certain period of time, one will be assigned to you. You can change your PCP at any time. The change will become effective the first day of the next month. Call the **Membership Services Department at 1-800-578-0603 or TDD/TTY 1-800-691-5566 between the hours of 8 a.m. and 4:30 p.m. eastern time.** (Note: Call the Membership Service Department and give them the name of your new PCP. They will send you a new identification card that lists your new PCP).

What are your benefits with Passport?

The following are some, but not all, of the Plan's benefits

- ✓ Routine, urgent, emergency, and immediate care
- ✓ Medical care during pregnancy
- ✓ Hospital services when you don't stay overnight
- ✓ Hospital stays including a semiprivate room, medical services, surgery, anesthesiology and drugs
- ✓ Basic vision exams
- ✓ Family planning (birth control)
- ✓ Dental care
- ✓ Chiropractic care
- ✓ X-rays and laboratory services
- ✓ Prescription drugs
- ✓ Over-the-counter drugs prescribed by a health care provider
- ✓ Physical, occupational, and speech therapy
- ✓ Durable medical equipment (such as wheelchairs or crutches)
- ✓ Non-emergency transportation to medical care
- ✓ Hospice care
- ✓ Home health services
- ✓ Disease screenings and treatment for sexually transmitted diseases, tuberculosis, HIV and AIDS
- ✓ Ambulance services for emergencies
- ✓ Specialty care referred by your PCP, for example a cancer specialist

Note: Children and adolescents are eligible for the Plan's regular benefits listed above. They are also eligible for a special program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). For more information on the EPSDT program see the Transition section of this manual.

Direct Access Benefits and Services

There are some services that you may get without the approval of your PCP. These services are called Direct Access Services. Members may go to other Passport Health Plan providers like dentist or obstetricians for these services, or they may go to the local health department or clinic, or their own PCP. Services included are:

- ✓ Chiropractic (after 12 visits you will need approval)
- ✓ Dental – Primary care including the following dental specialist: pediatric dentist, prosthodontics, orthodontics, periodontics and oral surgery
- ✓ Diabetes eye test
- ✓ Family planning
- ✓ Female care (one well-woman visit per year)
- ✓ Immunizations for children under 21

- ✓ Mammography
- ✓ Maternity care
- ✓ Screenings and treatment from any Passport Health Plan provider for diseases passed on by sexual activity, HIV, or tuberculosis, basic vision care

Who do I contact if I have a question or concern?

When you have a question or concern you will want to call the Member Services Department at 1-800-5778-0603 or TDD/TTY 1-800-69105566. They are available between 8:00 a.m. and 8:00 p.m., Monday through Friday. You can also go to their office or write:

**Passport Health Plan
Member Services Department
Fincastle Building
305 W. Broadway, 3rd Floor
Louisville, Kentucky 40202**

What if you are unhappy with a decision made by Passport Health Plan?

If you are not happy with a decision made by Passport Health Plan, you may file an appeal with them. You may also request a State Fair Hearing or contact Kentucky's Medicaid Ombudsman toll free line-877-807-4027.

To file an appeal with Passport Health Plan:

- ✓ You may file your appeal or you may have someone file it for you.
- ✓ You can file your appeal in person, in writing, or over the phone.

If you file your appeal over the phone, call Members Services at 1-800-578-0603 or TDD/TTY 1-800-691-5566.

A written appeal should be sent to:

**Appeals Coordinator
Passport Health Plan
305 W. Broadway, 3rd Floor
Louisville, KY 40202**

Passport will send you a letter within three days after receiving your appeal. This letter will tell you that they received your appeal and what will happen next.

There are two kinds of appeals, medical and non-medical.

State Fair Hearing

You may request a State Fair Hearing at any time. The State Fair Hearing is not connected in any way with Passport Health Plan. Passport Health Plan must follow the State Fair Hearing decision.

To request a State Fair Hearing- Please call or write:

**Kentucky Department for Medicaid Services
Program Integrity Branch, 6th floor
275 East Main Street
Frankfort, KY 40621**

**1-800-635-2570 or if you are a person with hearing impairments, call the TDD/TTY number
at 1-800-775-0296**

You can also contact Kentucky's Medicaid Ombudsman at the following address:

**Kentucky Department for Medicaid Services
Office of the Ombudsman, 5th floor
275 East Main Street
Frankfort, KY 40621**

**1-877-807-4027 or if you are a person with hearing impairments, call the TDD/TTY number
at 1-800-648-6056**

Building Successful Partnerships with Health Care Professionals

People with disabilities and their families are equal partners with providers in making health care decisions. In today's complex health care system, you play an important role in planning and organizing your health care. If you want good health care for you or your family, become an active partner with your health care providers and get the services you need.

Working with Health Care Professionals

The HRSA Maternal and Child Health in Bright Futures for Families – Partnering for Your Child's Good Health did a great job of outlining specific ways that you can work with your primary care provider and other health care professionals. Although it was written for families with

younger children the information is relevant at any age! We have paraphrased these good ideas for your use:

- **You Know Yourself Best:** Believe it or not, you're the number one expert on you. The knowledge you have is crucial to making good decisions. Build it into the planning you do with your health care providers.
- **Share Important Family Information:** Your family is both the same and different from other families. You have personal, social, religious or other family information that you will want to share. This will make a big difference when visiting your health care provider(s). So let them know what's on your mind.
- **Ask Questions:** When you have an appointment with a health care provider, it's a great idea to ask a lot of questions so you understand what's going on. Make a list before you go. Or take someone with you that can help you ask those questions. If you don't understand what's being said, keep asking questions. Remember, communication is a two-way street. So you do your part and ask questions!
- **Make Your Preferences Known:** Your values and concerns are important and need to be understood and incorporated into the planning process. Make sure that your point-of-view is known and appreciated by your health care providers. Take time to discuss treatment options so you can make good choices about how to proceed.
- **Learn About New Approaches in Health Care:** The more you know about health care trends and current practice, the better you can participate with your partners. Sometimes, parents or other family members read or hear about new health care ideas and options. Pay attention to the issues that make a difference to you. Health care providers must be knowledgeable about a wide range of treatments, so share any new information you have with them.
- **Plan for Your Long Term Health Needs:** Think out your health care needs as you grow and change. Your health care providers can be good source of information about the next stages of growth. Talk to your health care providers about your future.
- **Address Health and Well-Being in Lots of Settings:** Look at the broad picture of your health, in a number of different settings. Talk to your health care professionals about your needs and ask for support with appropriate referrals.

How To Be A Partner

Choose Your Health Care Provider: Questions To Ask When You Are Assigned To A Health Plan (Questions taken from The Road to Wellness: Accessing Medical Services and Navigating the Managed Care System, available from the Department of Developmental Services, Sacramento, California. For more information, call 1-877-337-4325.)

- Can I keep my current doctor?
- Are the doctors experienced in caring for individuals with disabilities?
- Do the doctors have staff with experience in special needs that can facilitate access to services?
- Do the doctors have facilities that can accommodate people with disabilities?
- Are the doctors available when you need them?
- What are the office hours?
- How much time is allowed for an office visit?
- Are the doctors on the plan's list close to me?
- Is the doctor accepting new patients?
- Does the plan have staff, doctors and nurses who speak my language?
- Does the plan use pharmacies that are close to me?
- Does the plan assist me in getting transportation to medical appointments?
- Is there someone at the plan who can explain how the plan works and what services are covered by the plan?
- Can I get a second opinion from another doctor in the plan?
- Does the plan cover psychiatric and mental health care?
- Does the plan cover alcohol and substance abuse treatment programs?
- Does the plan promote preventative strategies?
- Can I access a specialist when I need one?

Communicate Openly: Being an effective partner means being able to talk to your health care providers in an open and honest manner. Partnering works well when you're confident that they care about and listen to your concerns.

- Make a list of questions you want to ask and ask them.
- Take a friend or family member with you if you need help asking questions.

- Make sure you can talk with them easily.
- Do your health care providers respect your views? Do you respect theirs?
- Do you think you can trust them as partners over time?
- Do you understand everything they say?
- Do they check with you to make sure you understand?

Make sure you can share your values. Let your health care providers know what you really think.

Know What You Need, And When: Find out from your health provider team when you need immunizations or should be seen for regular checkups. Ask them for referrals to other provider partners, e.g. orthopedic. At the same time, find out who to call in an emergency, and exactly how.

Follow Through: Following through, or doing what you need to do after seeing the doctor, is important, even though it's time consuming and takes an extra effort on your part. It's worth it! When you and your health care provider agree on a plan of action, make sure you follow through with the activities that need to be done at home. Let your provider know if for any reason you can't carry out home treatment or activities, so you can explore alternatives.

Preparing For A Health Care Visit

Use this checklist to prepare

- Make sure you understand the purpose of your visit (e.g. regular check-up, immunizations, sickness, etc.)
- Bring any health records that you think are important to the visit.
- Think about your progress and what has changed since the last visit to the doctor (changes in health or behavior, etc.)
- Make a list of questions or concerns you want to discuss. Are there any concerns raised by other caregivers or family members that you should also discuss with your health care professionals?

Finally...Tips For Building a Successful Partnerships

- Develop a good working relationship with everybody who is important to you in your life.

- Enlist them! Tell them how important they are to your health and wellbeing. Let them know what you want and need.
- Respect the knowledge, skills, and experience that each partner brings.
- Build trust over time.
- Talk openly, respectfully, comfortably, and constructively. Be willing to hear and listen to what others have to say.
- Ensure that your goals and values, as well as your background, culture, and interests, are known.
- Do your best to work out differences and problems. Expect some ups and downs in life and relationships.
- Commit yourself to working for excellent outcomes.
- Be there as a partner for other people with disabilities!

What to do when it's not working for you.....

Tell your health care professional what isn't working for you.
 Try to work out a solution in a cooperative manner.
 Request a second opinion.
 Allow time for everyone to make adjustments.

If it's still not working:

Request a different health care provider or other insurance program.
 Locate other good health care providers.
 Follow through and make the changes.

Advocacy

According to the National Governors Association (NGA), states are facing the “most dire fiscal situation since World War II.” Budget shortfalls are increasing at an alarming rate. As written on the Advancing Independence: Modernizing Medicare and Medicaid website <http://www.aimmm.org>, the federal government provides between 50% and 83% of the funds it takes to provide Medicaid services in a state. The amount of federal matching funds a state receives is largely based on its number of low-income residents. But, generally speaking, most states now spend 30 percent or more of their own annual budgets on Medicaid, and these costs are rising rapidly. Hence, to deal with the overall budget crisis in Kentucky, the state is making deep cuts, reducing services funded by Medicaid, limiting Medicaid eligibility, delaying needed expansions of community living services, and reducing payments to providers.

Many actions will be debated and taken to revamp Medicaid at the federal and state levels. Some may be beneficial to people with disabilities and their families. However, given the cuts in services that already have been made, many of these changes may undermine the rights and abilities of people with disabilities of all ages to live in their own homes and communities.

As advised by The National Center for Family Support, advocates need to keep in mind a central fact: states have considerable latitude concerning eligibility and coverage. Federal policy permits states to operate very broad Medicaid programs at this time. To realize many of the opportunities afforded by federal policy, a state must elect to include an “option” or change its current policies.

Medicaid policy change at the state level means convincing policy makers (governors and legislators) to take advantage of key options, if they have not done so already. This is why it is important for individuals, families, and other stakeholders to be “at the table” when Medicaid policy is discussed. Find a coalition with like-minded people or go it alone, but get your message out!

One such group is the Coalition for Quality and Choice, which represents a broad-based effort by families, advocates, human service agencies, religious and interested community organizations committed to supporting one another and people with mental retardation. If you are interested in finding out more information on the Coalition for Quality and Choice and the work that they do, call 502-584-1239.

A great resource to polish up your advocacy skills and strategies is The Health Advocacy ToolBox that can be found on <http://www.cthealthpolicy.org/toolbox/decision/index.htm>.

