Briefing - Medicaid Enrollment and Redeterminations
Senate Finance Committee
26 January 2016

The ***Maryland Women's Coalition for Health Care Reform*** (Coalition) is a nonpartisan, statewide alliance working to promote health equity through high-quality, comprehensive and affordable health care for all. I am here today representing our membership of thousands of individuals and 100 organizations that include many of the 46 that sent a letter to Governor Hogan on January 13th. In that, we highlighted the devastating impact that the loss of Medicaid coverage has had on tens of thousands of Marylanders. We also provided an Issue Brief with substantive recommendations. These reflect the experiences of a diversity of individuals and organizations who deal with the affected populations and it builds on the advocacy efforts we have been engaged in with the Department of Health and Mental Hygiene and the Maryland Health Benefit Exchange starting in September 2014.

Let me set the stage for our recommendations with one example of the real world impact of the current redetermination process. Lelia Brogdon is a resident of Baltimore City and the mother of a 3 year old girl named Peyton, who is a patient with Greenspring Pediatric Associates. She suffers from severe epilepsy and relies upon two different and expensive medications to stay out of the emergency room. Just after Thanksgiving Lelia went to the pharmacy to fill her daughter's prescription and found that their family had lost Medicaid coverage. She had received no notice - and while she had moved in August she immediately notified Medicaid of the address change so the system should have been updated in time to get her the required notice. The first thing Lelia did was to contact her MCO and they told her to go to the DSS office, which she did in the week before Christmas. There she was told that DSS couldn't help her with Medical Assistance and redirected her to the Connector Entity in downtown Baltimore. She went to HealthCare Access Maryland and there she was told that since her account showed as being "active" they couldn't help her and she would have to go to DHMH - now the third stop of on her path to getting back onto Medicaid. The system at DHMH did show her as "inactive" - hence no coverage. This was several weeks ago and she still does not have coverage. In the early stage of this odyssey the clinic was covering her meds but she just paid $42 she cannot afford and she is "stretching" the meds and hoping Peyton won't have another seizure.

I do want to acknowledge that these issues began coming to light in the summer of 2014 - before the current leadership was in place. But, Lelia's story highlights the challenges that individuals face today despite the steps that DHMH, the Exchange and the Department of Human Resources have taken. We applaud those efforts, but we believe there is an opportunity to do more and that the recommendations we have presented to DHMH in June and which were expanded for our Issue Brief would substantially improve the situation for Lelia and the tens of thousands of others in her situation. For example:

- Communications must be improved across all agencies and organizations and at every level. We have heard this raised for years and from all corners including Local Health Departments, the Connector Entities and their partners.
- Training must also be improved - the areas we have heard most concern about are with the Call Center and at DSS offices and Local Health Departments where they have had insufficient training on the IT systems.
- Notices must be simplified so that they can be understood by the recipients - 10 page notices that lack a clear message are just one problem. But, of course, a greater effort should be made to ensure that

they get to the enrollees and, if Spanish or other languages are requested then those must be sent - not English as has happened.

- While some improvements have been made to the website more could and should be done to make it consumer-friendly.
- Redetermination dates should be included in the Electronic Verification System so that health care providers can alert their patients to pending terminations and link them to enrollment resources before a coverage gap occurs;

Most importantly, strategies need to be developed to more effectively address the immediate health needs of those who have been dropped from coverage through no fault of their own. While Lelia is one example of this another is Tekiah Allen. She was in her 7th month of pregnancy when she was unexpectedly dropped last November. First, she spent six hours on the computer and phone, but with no success so she then went to the DSS office. There she sat from 7:30 am to 4:30 pm. After nine hours she was finally able to hand in her paper application to a case worker. Then, on January 10, 2016 - just two weeks ago - she gave birth, but still her coverage issue had not be reconciled.

Tekiah's situation and that of tens of thousands of other is untenable. We strongly urge that our recommendations be seriously considered and that, to implement them, a multi-disciplinary and diverse Task Force be created. We have recommended that it be comprised of decision makers at DHMH, DHR, and MHBE and we would include the Health Education and Advocacy Unit which receives Medicaid calls. Also included should be representatives from: (1) two Connector Entities (one rural and one urban/suburban); (2) front-line work force from Local Health and Social Service offices; (3) MCOs; (4) a diversity of stakeholder organizations; and (5) consumer advocate representation including the Maryland Medicaid Advisory Committee. We do not believe that the MMAC in its current configuration and with its current agenda is positioned to tackle the complexity of the issues.

I would also point out that even with the more successful auto-renewal process the Medicaid population will continue to need in-person assistance, particularly in households with complex eligibility factors, like pregnancy or fluctuating income or household size. For that reason we believe that not only must steps be taken immediately to address the current crisis, but financial and other resources must be made available to the Connector Entities and others who provide in-person assistance - even as the technological challenges are addressed.

We very much appreciate the opportunity to provide our perspective and we look forward to working with you and others to remedy the situation and to ensure that all those eligible for Medicaid do, in fact, have the coverage and care they need and deserve.