Testimony Before Human Services And Appropriations Committees In Opposition To Demonstration Waiver For Medicaid LIA Program

July 24, 2012

My name is Denise Dean, and I have been a Medical Case Manager at The Fair Haven Community Health Center for 10 years. I was hired to work part-time under the Ryan White C grant to assist those living with HIV/AIDS, but also work with the entire population of The Clinic.

I am testifying to today to encourage you not to pursue this misguided Medicaid proposal. On several levels, this will negatively impact the people that we, at all community health centers, try to reach and engage in medical care. It's a struggle enough as it is, without having to deal with the issues of medical insurance.

For those still eligible for LIA/Husky D, earning less than $512 per month, those in favor of the waiver proposed apparently are feeling that further cuts needs to be made, even though LIA is one of the few success stories in our state's efforts to address the problem of the uninsured. This is illogical and will be harmful on many levels to all CT residents in need of healthcare.

First, I am not clear how one can logically deduce that with such meager income, any individual can save enough money to tip over a $10,000 asset limit. I am also not clear why that matters, as it does not in Husky A or B eligibility. Of all of my clients on Husky D, I can safely say that they have been able to save nothing, and the only asset a few proudly have is a battered up car they use to get to our clinic, or to their extremely random part-time jobs.

Layered into that is the issue of counting parents' income and assets for the subset of grantees from 19-26 still living at home. Of course they would be living at home if they have little or no income. What other option would they have? Even at earnings of $500 per month, they would not be able to maintain an apartment. Counting their parents' income when their parents are no longer legally responsible for them is unfair, and will likely kick all of them off of insurance. Also I would love to see the raw data to support the statement made by DSS that the majority of this age group is in college paid for by wealthy parents and therefore able to get health care there.

From a different level, as they are "healthy" and think of important screenings and routine care as unnecessary, this group can be especially difficult to engage in care. Add termination from or ineligibility for insurance into that equation, and the barriers solidify. If the goal is to provide health care for more individuals, this notion is counterproductive. Worse, this policy, if adopted, could force young people to make a dangerous choice: becoming homeless in order to continue their health insurance.

Second, with all respect due to the New Haven DSS office, they are already weeks behind in processing pending applications in the pipeline. My colleagues have patients that have waited 2 months for a decision on their cases, thus costing them appointments with dentists, eye doctors and mental health services. In addition, timely completed redeterminations from existing clients sit unopened in piles. Therefore, our patients get shut off, often without any notification from DSS. They are left unable to fill

their prescriptions , and disallowed to keep necessary specialty care appointments, at times for almost a month, despite doing everything they were asked. When I get involved as an advocate, the response I get, if I am ever able to actually get to speak with a worker, is that I need to understand that they are behind, overwhelmed and understaffed.

If we ask an overwhelmed, understaffed branch office that cannot keep up with their current workload to perform another series of mailings, and process another series of responses, based on an entirely new set of criteria for 78,000 people, how can we expect anything but chaos for all New Haven office clients?

And then, I ask you to ask yourselves what the true cost would be: This practice would only be in place until the federal Medicaid expansion takes over in 2014, at which point the eligibility guidelines would revert to what would be required by federal law. In the interim, thousands of patients of CHC's would suffer. Also consider the cost to the CHC's that take care of them without timely payment, then to the entire healthcare system that now struggles to reschedule appointments, and lastly to DSS workers already failing to meet program guidelines...

I am proud of my employer, and prouder still to live in CT, the first state to expand Medicaid reform ahead of the deadline. This proposal flies in the face of that success, and completely does not make sense.

Please don't let this happen. You can keep CT in the forefront of change, ahead of the curve. Decent, affordable healthcare should be a right for all.

I would welcome any questions you might have at this time.