Thank you for this opportunity to share my concerns and thoughts with you about the so-called "modernization" of Medicaid.

I am a 72 year old woman providing assistance for my sister who is 68. She has lived in a nursing home for 3 years, has numerous mental and physical health problems of long standing, and has Medicare and Medicaid coverage. For many years she has had numerous specialists to assist with her care.

We are told that Iowa Medicaid recipients will be transitioned to a managed care organization (MCO) beginning January 1, 2016. We have been assured that there will be no decrease in services. The four companies who have been selected by the state to provide this care are for-profit companies. Somehow, Governor Branstad seems to believe that a for-profit company will continue to provide the same services for less cost to almost 600,000 Iowans and the State of Iowa will save millions of dollars. How is this possible? If the Iowa Medicaid program can't save $51 million dollars in so short a time, how can for-profit companies get the job done? The answer? They can't unless they cut services and coverage.

Other questions: what happens when providers (some 30,000) of them can't or won't apply to be providers under the new plan? What happens when a specialist is no longer a Medicaid provider under the new program? Where will our loved ones receive care from a neurologist or psychiatrist when that specialist has opted out of the plans? What happens if the nursing homes choose to participate in only one or two of the four plans, but our loved ones have coverage under a third or fourth? Who does one contact for denial of care?

These companies are supposed to provide exactly the same services. Why choose one over the other? At a recent town meeting it was explained that some will have additional benefits, such as gym memberships. Frankly, I don't care about gym memberships or other "freebies" that the companies might use to lure new clients, particularly if there is no way for us to determine which providers might be available under which plan. It is an impossible situation for patients and their families.

We are told that the costs of providing Medicaid services to the most vulnerable population has increased dramatically since 2003. I wish the Governor would tell us what hasn't increased since then? What other costs have stayed the same? We have a budget surplus (granted, it can't be used to provide services to our residents, but it is there, none-the-less). Changing to these MCOs for health care for our vulnerable citizens will do nothing to benefit them...it will only line the pockets of the MCOs.

Think about this: if Iowa has 560,000 people on Medicaid and the population of our state is roughly 3,000,000 or slightly more, then nearly 20% of our population are Medicaid recipients. Do we truly want to turn over the care of such a significant number of vulnerable Iowans to for-profit MCOs, who want only one thing...a profit?

The program wasn't broken and didn't need to be fixed. "Modernizing" Medicaid on the backs of our 560,000 citizens who don't have a voice needs to be stopped, or at the very least, done with more thought and planning before irreparable harm has been done.

Sincerely,

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