Hi Patty,

My name is Sharon Davis. I'm 'Chris Davis' on FB, just joined the FB group, and signed the petition when it first appeared in my email.

In my life, I've had health care coverage, at various points, through: employer plans, on base as a military wife, TriCare, IowaCare, Medicare, and Medicaid.

During my working life, I've worked in or with HR, with various data bases, at Cigna, State Farm, NAIU (an underwriter company), and have interfaced on other employees' behalfs with insurance companies. In 1998, when hired by an attorney in Texas who had just, for the first time, provided a health care plan for his employees in three offices, I undertook the task of finding a more cost-effective, higher coverage plan for all employees in those three offices. This project took months. The old, 70/30 coverage was replaced with 80/20 and lower premiums for the boss.

When I first received the petition email, I called Iowa's Medicaid system. This 'plan' the Governor wants to implement unilaterally was not written in stone - yet. I asked the specific question: Is this MCO configuration the same, or roughly the same as an HMO? The answer was 'yes'.

This is troubling. In the past, HMOs were known for paying incentives to doctors NOT to refer patients for further treatment or limiting access to treament. In light of the goal of PPACA, this is not the direction our health care is supposed to be taking.

People are receiving sign-up packets from the state re: choosing an MCO. I received one last week, and called the number provided in the info packet. I have scanned and attached the info pages for each of the four choices.

Here's what was discussed:

1. I was told that our coverage, access, and current benefits will be exactly the same under this change.

>>>>>I was also told this state plan is now finalized. I didn't argue or talk about the circulating petition.

2. We have to pick a provider by December 17. If we don't pick one ourselves, we will be designated to the provider already chosen and listed in the info packet. I was assigned to AmeriGroup in the event I don't make my own choice.

3. There was a recent news article stating UnitedHealthCare, one of the choices, is strongly considering pulling out of the Exchange - the PPACA Exchange.

4. Two groups offer various extra incentives. See the attached scanned documents for details. Two do not - UHC and WellMark.

5. Unity Point is my health care provider organization. My doctor informed me last week that Unity Point has not yet signed up to accept any of the MCOs. It is one of the main health care provider organizations in Iowa.

6. If Unity Point doesn't sign up, all Medicaid users will have to find new doctors who accept Medicaid, or pay out of pocket to see their current doctor. The customer service rep I talked to was not only aware of this development with UP, she would be in the same boat trying to find a provider until her alternative health care coverage (whatever that will be) takes effect.

7. We can see our doctors until January 31, 2016, if they aren't on the upcoming network, and after that, we would have to pick up costs. This is some function of Medicaid, and I'm not sure how it works exactly.

8. Each MCO will have its own provider list. This is not currently available, so we're essentially stumbling in the dark with our choices.

9. It's not only our regular doctors we have to worry about. If we are referred to any specialists or outside providers (i.e., labs), we have to check to see if the provider we're referred to also accepts Medicaid, AND if the referral doctor is on our particular MCO's approved list. At times, this is not an easy task for those who know how to do it, much less those who don't - or can't.

My questions on this (not posed in the phone call) are: Why would UHC participate in the Iowa Medicaid change while considering pulling out of the Exchange? How does this benefit UHC? What are the arrangements between Iowa and UHC that would entice UHC to be a provider for the federal Medicaid program but pull out of the federal exchange? This question is very important. Goes to needs of the business and raises the question of why UHC would participate in providing health coverage for the poor and disabled populations over the general health population.

I cannot make it to the Dec. 7 hearing, but in following links and researching, I found out you are the contact for providing information we may have to date. I came across the following through the FB page and am contacting you as the result: http://www.senate.iowa.gov/democrats/take-action-what-you-can-do-about-the-branstad-reynolds-medicaid-mess/

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One article raises the dismissive speculation on the administration's part that people are simply afraid of change. That speculation is not accurate.

It's not that we're afraid of change, per se. We are concerned when someone unilaterally makes changes without notifying us in a reasonable amount of time in which to respond - or even asked to respond - during the planning process, especially concerning a federal program like Medicaid. Too many of us have experienced unfavorable results in the past, when something like this is 'sprung' on us rather than involving us in the process. The governor forgets that many of us have worked most of our lifetimes, paid taxes, and those taxes support the programs we now need to access - the programs we were told our taxes would support in case we needed them.

We are stakeholders and we were not consulted. In honest policy making process, ALL stakeholders are supposed to be equally considered, consulted, and our input evaluated in terms of the big picture. I took a grad course on policy making. There's a very thick book out there somewhere explaining how policy is supposed to be made.

This governor did not follow the format. He didn't involved the legislature. This, in and of itself, should raise concerns for everyone involved. We are not being represented in this process, nor was our input

sought. We need to know why. We need to know what the deals are for each MCO entity. The public needs to know exactly what the costs savings are supposed to be, what we can expect in terms of coverage and provider avaailability, and expected outcomes. We need to know more about the organizations the governor single-handedly chose. Why? Who benefits? In what ways? What are the ramification of these changes? Are state employees going to lose THEIR jobs? Why? The governor has already cut one government agency's staff from 125 to 80, and the results are that it doesn't run as efficiently as it used to. There simply aren't enough hands available to process paperwork for starters. The pressure on the remaining employees is very high, and overtime has been incurred at times. So how did those cuts save money and provide adequate services? Who oversees the MCOs, the process, the outcomes? What ARE the expected outcomes? Is this going to end up more like IowaCare or is it going to function as Medicaid is supposed to? What has been done to anticipate 'unintended consequences'? Why is such a change even necessary?

We have not been provided answers to any of those questions. We do not know how thoroughly this plan was developed, nor how well the implementation process has been laid out. We have to wonder how well it was even laid out, given the suddenness of this last minute proposal.

I called Unity Point the day after seeing my doctor and the day I called re: the info packet. I was told to call back about Dec. 10 to find out if Unity Point is going to sign up. If this provider chooses not to sign up, and given it is one of the largest providers in the state, we may be looking at tens of thousands of Medicaid patients being left with no easily accessible alternatives, given that many doctors don't accept Medicaid at all.

If that outcome is the anticipated result, then the change to the MCOs is a cynical political move to de facto limitation of access to the state's Medicaid - and its 'expansion' - and using it as the means to limit health care to the poor, children, elderly, and disabled without facing consequences for what is, essentially, breaking the rules. This would preserve the federal dollars, but severely limit people's health care. Personally, I think there should be serious consequences if this scenario ends up being the result of the change to MCOs.

Please contact me if you want to discuss this further. Please be judicious with forwarding the phone number below. :)

Sharon Davis