As a recipient of Medicaid benefits, I'm concerned about the rush to privatize the program. I'm not opposed to change when it is clearly presented, carefully and thoughtfully enacted, and the outcomes are known. That's not what is happening. Here are some things I see that either confuse me or cause me great concern.

1. I'm sure there are many of us who receive both Medicaid and Medicare benefits. It's not clear to me how the two programs will work together under privatization. On November 28 I received the twenty page members booklet and it does not make any reference to Medicare. We need to know if the state will continue to pay our Medicare premiums. If not, that's a significant change in benefits. Only one of the companies mentioned serving people eligible for both programs in its advertising literature provided with the booklet. What's that tell me about the other companies? They just left it out or they don't coordinate their Medicaid services with Medicare?
Currently, the state selects my Medicare prescription drug plan. Is this still the case? That's confusing because all of the companies advertise that they have prescription plans. Would they all honor my Medicare plan and it's formulary? I need to know that this has been addressed and what the answers are.
2. How do I find out what provider is on which plan? There is not a master list provided by the state. I checked three companies and one had technical difficulties, one said a provider search option was coming soon, and the other was extremely difficult to use. It also gave me two physicians assistants and one optometrist as results for psychiatry.
A customer service rep said I should just call each of my providers and ask which plan they've signed. It's more complicated than that. In my case, I'll select a plan based on one of my providers. Then, if the others aren't on that plan, I'll need to call around and find ones on the right plan and taking patients and hopefully not too long of a drive. Then, I have to check both the pharmacy and hospital. Referrals to specialists will get very complicated. For example, the U of Iowa signed with ONE plan. That doesn't help all of the people on other plans.
3. The booklet I received on November 28 and its accompanying materials say I can meet with someone to discuss my options because there will be representatives in my area. I called and they were in my area in October. The last community meeting was November 30. I'm also given until December 17 to select my MCO. When you consider the technical problems, unanswered questions, and that some people will need to search for new doctors, that's completely inadequate.
4. There are repeated assurances that benefits won't change. However, there is a chart in the booklet and it shows changes. Is there a difference in benefits between the various plans and if so, there must be changes.
That leads to the question of why are we changing. Is there a difference in benefits? We're told no, but why are there several companies to choose from if the result is the same. You're asking thousands of people, many of us with serious health issues and several providers to possibly (probably) give up some of the providers we've developed relationships with and search for new ones. We are then to select our new providers based on if they are signed up with the right plan, not because we believe they are the best choice for us.
Thank you for your time,
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