



January 2016

# MEDICAID

## Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage

Accessible Version

# GAO Highlights

Highlights of [GAO-16-221](#), a report to congressional requesters

## Why GAO Did This Study

Medicaid, a federal-state health financing program for certain low-income individuals, offers NEMT benefits to individuals who are unable to provide their own transportation to medical appointments. This benefit can be an important safety net for program enrollees as research has identified the lack of transportation as affecting Medicaid enrollees' access to services. Under PPACA, states can opt to expand eligibility for Medicaid to certain adults. However, some states have excluded the NEMT benefit for these newly eligible enrollees by obtaining a waiver of the requirement under the authority of a Medicaid demonstration project.

GAO was asked to explore state efforts to exclude the NEMT benefit for newly eligible Medicaid enrollees, and the potential implications of such efforts. This report examines (1) the extent to which states have excluded this benefit for newly eligible enrollees, and (2) the potential implications of such efforts on enrollees' access to services.

GAO contacted the 30 states that expanded Medicaid under PPACA as of September 30, 2015; reviewed relevant documents and interviewed officials in the 3 states that have taken efforts to exclude the NEMT benefit; reviewed prior research on transportation for disadvantaged populations; and interviewed officials from CMS, the federal agency that oversees Medicaid, and 10 research and advocacy groups based on referrals from subject-matter experts and knowledge of the NEMT benefit.

HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View [GAO-16-221](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov) or Mark L. Goldstein at (202) 512-2834 or [goldsteinm@gao.gov](mailto:goldsteinm@gao.gov).

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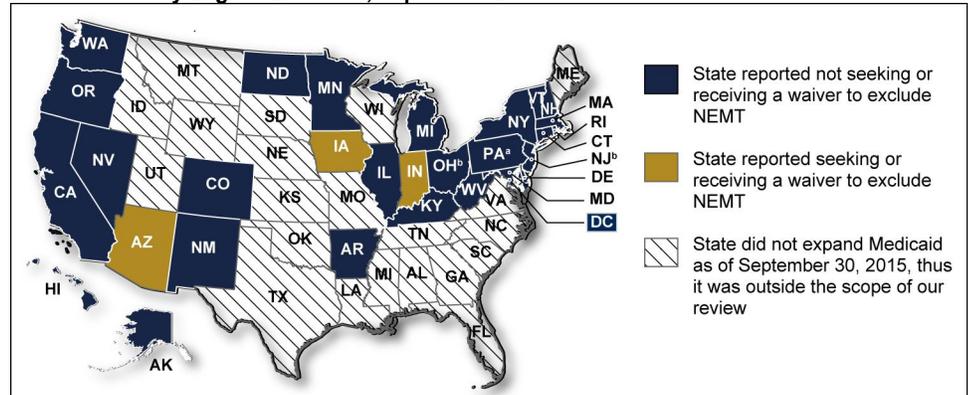
## MEDICAID

# Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage

## What GAO Found

States' efforts to exclude nonemergency medical transportation (NEMT) benefits from enrollees who are newly eligible for Medicaid under the Patient Protection and Affordable Care Act (PPACA) are not widespread. Of the 30 states that expanded Medicaid as of September 30, 2015, 25 reported that they did not undertake efforts to exclude the NEMT benefit for newly eligible enrollees, 3 states reported pursuing such efforts, and 2 states—New Jersey and Ohio—did not respond to GAO's inquiry. However, the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), indicated that neither New Jersey nor Ohio undertook efforts to exclude the NEMT benefit.

**State-Reported Actions to Exclude Medicaid's Nonemergency Medical Transportation (NEMT) Benefit for Newly Eligible Enrollees, September 2015**



Source: State Medicaid officials. | GAO-16-221

<sup>a</sup>As part of Pennsylvania's efforts to expand Medicaid, the state received approval to exclude the NEMT benefit for its newly eligible enrollees; however, the state did not implement this exclusion.

<sup>b</sup>CMS provided information about New Jersey and Ohio's efforts related to the NEMT benefit.

Two of the three states pursuing efforts to exclude the NEMT benefit—Indiana and Iowa—have received waivers from CMS to exclude the benefit, and are in different stages of evaluating the effect these waivers have on enrollees' access to care.

- Indiana's draft evaluation design describes plans to survey enrollee and provider experiences to assess any effect from excluding the NEMT benefit.
- Iowa's evaluation largely found comparable access between enrollees with and without the NEMT benefit; however, it also found that newly eligible enrollees beneath the federal poverty level tended to need more transportation assistance or have more unmet needs than those with higher incomes.

Officials from the groups that GAO interviewed identified potential implications of excluding the NEMT benefit, such as a decrease in enrollee access to services and an increase in the costs of coverage. For example, nearly all of the groups indicated that excluding the NEMT benefit would impede access to services, particularly for those living in rural areas, as well as those with chronic health conditions.

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## Abbreviations

CMS	Centers for Medicare & Medicaid Services
FPL	federal poverty level
HHS	Department of Health and Human Services
NEMT	nonemergency medical transportation
PPACA	Patient Protection and Affordable Care Act

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January 15, 2016

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Frank Pallone, Jr.  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

Recognizing the importance of transportation for many Americans' access to needed medical services, states are required to provide through their Medicaid programs—a federal-state health financing program for certain low-income and medically needy individuals—a nonemergency medical transportation (NEMT) benefit to individuals who are unable to provide their own transportation to medical appointments. A lack of transportation can be a barrier to accessing health care, particularly among low-income populations. For example, we previously reported that Medicaid enrollees most commonly cited a lack of transportation as the reason for delaying care, and that the need for transportation to and from providers presented a barrier to children receiving Medicaid dental services.<sup>1</sup> Other research reiterates the effect that a lack of transportation can have on access. For example, one study cited an estimate that approximately 3.6 million Americans miss or delay care because they lack appropriate transportation to reach their medical appointments.<sup>2</sup> Another study noted that for poorer populations, which tend to encounter more barriers to accessing health care generally, transportation can be a significant issue

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<sup>1</sup>See GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, [GAO-13-55](#) (Washington, D.C.: Nov. 15, 2012); and *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain*, [GAO-09-723](#) (Washington, D.C.: Sept. 30, 2009).

<sup>2</sup>See National Conference of State Legislatures, *Non-Emergency Medical Transportation: A Vital Lifeline for a Health Community*, January 2015.

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to accessing care.<sup>3</sup> Given that transportation limitations can disproportionately affect low-income individuals' access to medical services, Medicaid's NEMT benefit can serve as an important safety net for program enrollees.

Under the Patient Protection and Affordable Care Act (PPACA), states can opt to expand eligibility for Medicaid to most non-elderly, non-pregnant adults who are not eligible for Medicare, and whose incomes are at or below 133 percent of the federal poverty level (FPL).<sup>4</sup> The decision whether to expand Medicaid can be a complex consideration for states, involving competing interests, as well as decisions about the structure and content of states' programs—such as the scope of benefits offered to newly eligible Medicaid enrollees. Although states are required to ensure necessary transportation to and from providers for newly eligible enrollees covered through their state plans, some states have received approval to expand Medicaid coverage through demonstration projects under section 1115 of the Social Security Act.<sup>5</sup> Under this authority, states may obtain a waiver to exclude the NEMT benefit for newly eligible enrollees.<sup>6</sup> As of

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<sup>3</sup>See J Community Health, *Traveling Toward Disease: Transportation Barriers to Health Care Access*, vol. 38, Issue 5 (October 2013), 976 – 993.

<sup>4</sup>PPACA also imposes a 5 percent income disregard when calculating modified adjusted gross income, which, in effect, raises this income limit to 138 percent of the FPL.

<sup>5</sup>A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program. When a state wishes to make a change to its program policies or operational approach, it may submit a state plan amendment that is reviewed for approval by CMS.

<sup>6</sup>States that wish to alter their Medicaid programs in ways that depart from federal requirements may seek approval to implement Medicaid demonstration projects under section 1115 of the Social Security Act. This provision authorizes the Secretary of Health and Human Services (HHS) to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. See 42 U.S.C. § 1315(a). For example, states may seek a waiver of Medicaid's NEMT regulation, which requires state plans to ensure necessary transportation for beneficiaries to and from providers. See 42 C.F.R. § 431.53. In this report, we use the term "demonstration" to refer to state demonstration projects authorized by CMS under section 1115, whereas we use the term "waiver" when referring to waivers of the NEMT requirement under such a demonstration.

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September 2015, 30 states had expanded Medicaid eligibility, some through demonstrations.<sup>7</sup>

Given that states are making decisions about whether to expand Medicaid and how to structure their programs, you asked us to explore state efforts to exclude the NEMT benefit for newly eligible Medicaid enrollees. This report examines

1. the extent to which states have undertaken efforts to exclude the NEMT benefit for newly eligible enrollees; and
2. what is known about the potential implications of excluding the NEMT benefit on newly eligible enrollees' access to Medicaid services.

To examine the extent to which states have undertaken efforts to exclude the NEMT benefit for newly eligible enrollees, we interviewed officials from the Centers for Medicare & Medicaid Services (CMS) and contacted the 30 states that expanded Medicaid as of September 30, 2015. In the states that reported undertaking efforts to exclude the NEMT benefit, we interviewed Medicaid officials and reviewed relevant documents, including special terms and conditions associated with their demonstrations and related approval letters, if available.

To examine what is known about the potential implications of excluding the NEMT benefit on newly eligible enrollees' access to Medicaid services, we reviewed states' waiver evaluation designs, methodologies, and any related reports. Additionally, we evaluated the methodology that one state used in its evaluation of the effect of excluding NEMT for newly eligible Medicaid enrollees. We also interviewed CMS officials regarding their oversight of these states' efforts, including their role in assessing and approving them. In addition, based on referrals from subject-matter experts and knowledge of the organizations' roles related to Medicaid's NEMT benefit, we identified 10 national and local research and advocacy groups to interview, which included groups offering enrollee, underserved population, and provider perspectives on changes to the NEMT benefit. We also reviewed GAO and other research on transportation services for disadvantaged populations, and the role of transportation in the Medicaid expansion population's efforts to obtain health care services.

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<sup>7</sup>For purposes of this report, "state" includes the District of Columbia. Montana has also opted to expand Medicaid, but its expansion does not go into effect until January 1, 2016.

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We conducted this performance audit from June 2015 to January 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Within the Department of Health and Human Services (HHS), CMS is responsible for overseeing Medicaid at the federal level, while states are responsible for the day-to-day operations of their Medicaid programs. Under section 1115 of the Social Security Act, the Secretary of HHS may waive certain Medicaid requirements to allow states to implement demonstrations through which states can test and evaluate new approaches for delivering Medicaid services that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.<sup>8</sup> Prior to the enactment of PPACA, states that wanted to expand Medicaid coverage to childless adults could do so only under a demonstration. While states may now expand their programs to cover these individuals through a state plan amendment, some states have expanded coverage under demonstrations in order to tailor coverage for this group in a manner that differs from what federal law requires. For example, states are not permitted to exclude coverage of mandatory benefits, such as NEMT,

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<sup>8</sup>See 42 U.S.C. § 1315(a). Generally, demonstrations are approved for an initial 5-year period and can be extended for additional years.

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under their state plans, but they may do so by obtaining a waiver of the requirement under a demonstration.<sup>9</sup>

Recently, the Secretary of HHS approved various states' demonstrations to test alternative approaches, such as allowing states to use Medicaid funds to provide newly eligible enrollees with premium assistance to purchase private health plans in their respective state marketplace, or to exclude from coverage certain mandatory Medicaid benefits, such as NEMT, for newly eligible enrollees.<sup>10</sup> CMS has required those states that have obtained approval to exclude the NEMT benefit for one year under a demonstration to submit annual evaluations on the effect of this change on access to care, which will inform the agency's decision to approve any extension requests.

Evaluations by research organizations identified the lack of transportation as a barrier to care that can affect costs and health outcomes. For example, a survey of adults in the National Health Interview Survey found that limited transportation disproportionately affected Medicaid enrollees' access to primary care.<sup>11</sup> A study by the Transportation Research Board found that individuals who miss medical appointments due to transportation issues could potentially exacerbate diseases, thus leading to costly subsequent care,

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<sup>9</sup>While state plans may not exclude coverage of NEMT services, states may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. See 42 C.F.R. § 440.230(d). For example, CMS approved a state plan amendment in Arkansas that requires most newly eligible Medicaid enrollees to obtain prior authorization after eight NEMT trips. According to Arkansas officials, after the eighth trip, such enrollees must call into the designated NEMT contractor and answer a series of questions to demonstrate their need for transportation. This prior authorization requirement does not apply to newly eligible Medicaid enrollees that are deemed medically frail, which account for about 10 percent of the state's newly eligible enrollees, according to Arkansas officials. States have some flexibility to define who is medically frail; however, they must, at a minimum, include individuals who have (1) disabling mental disorders; (2) chronic substance use disorders; (3) serious and complex medical conditions; (4) a disability determination based on Social Security criteria or more restrictive state criteria, if applicable; or individuals (5) who are described in 42 C.F.R. § 438.50(d)(3), such as those who are dually eligible. 42 C.F.R. 440.315(f).

<sup>10</sup>Marketplaces are a single point-of-access for individuals to enroll in private health insurance plans and apply for income-based financial assistance.

<sup>11</sup>Cheung, P., J. Wiler, R. Lowe, A. Ginde, "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," *Annals of Emergency Medicine* (July 2012).

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such as emergency room visits and hospitalizations.<sup>12</sup> We also previously reported that there are many federal programs, including Medicaid, that provide the NEMT benefit to the transportation-disadvantaged population.<sup>13</sup> However, in this work we found that coordination of NEMT programs at the federal level is limited, and there is fragmentation, overlap, and the potential for duplication across NEMT programs. As a result, individuals who rely on these programs may encounter fragmented services that are narrowly focused and difficult to navigate, possibly resulting in NEMT service gaps.<sup>14</sup>

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## State Efforts to Exclude Medicaid NEMT Benefits Are Not Widespread

Among the 30 states that expanded Medicaid as of September 30, 2015, 25 reported that they did not undertake efforts to exclude the NEMT benefit for newly eligible Medicaid enrollees and were not considering doing so.<sup>15</sup> Three states reported pursuing such efforts, and two states did not respond to our inquiry, although CMS indicated that neither of these states undertook efforts to exclude the NEMT benefit. (See fig. 1.)

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<sup>12</sup>Transit Cooperative Research Program, *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, October 2005, accessed on September 15, 2015, [http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp\\_webdoc\\_29.pdf](http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf).

<sup>13</sup>The transportation-disadvantaged population generally includes those individuals who cannot provide their own transportation due to age, disability, or income constraints.

<sup>14</sup>For example, see GAO, *Transportation Disadvantaged Populations: Nonemergency Medical Transportation Not Well Coordinated, and Additional Federal Leadership Needed*, [GAO-15-110](#) (Washington, D.C.: Dec. 10, 2014); and *Transportation Disadvantaged Populations: Federal Coordination Efforts Could be Further Strengthened*, [GAO-12-647](#) (Washington, D.C.: June 20, 2012).

<sup>15</sup>As part of Pennsylvania's efforts to expand Medicaid under a demonstration, the state received approval to exclude the NEMT benefit for its newly eligible enrollees; however, the state ultimately did not implement this waiver. Thus, newly eligible enrollees remained eligible for the NEMT benefit.



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enrollees. Indiana's efforts to implement its Medicaid expansion are based, in part, on another demonstration that the state has had in place since 2008.<sup>16</sup> Under this older demonstration, which provided authority for the state to offer Medicaid coverage to certain uninsured adults, NEMT was not a covered benefit for this population.

- Iowa: Iowa expanded Medicaid in response to PPACA through two demonstrations beginning in January 2014. Under these demonstrations, the state offers two separate programs for newly eligible enrollees: one that offers Medicaid coverage administered by the state to enrollees with incomes up to 100 percent of the FPL, and a second that offers premium assistance to purchase private coverage through the state's health insurance marketplace for those enrollees with incomes from 100 to 133 percent of the FPL.<sup>17</sup> For both of these demonstrations, the state received approval to exclude the NEMT benefit. Similar to Indiana, Iowa's effort to exclude the NEMT benefit for a portion of its Medicaid population pre-dates PPACA. In July 2005, Iowa expanded Medicaid to certain populations under a demonstration with limited benefits that did not include NEMT.<sup>18</sup>
- Arizona: When Arizona expanded Medicaid in January 2014, it had not sought to exclude the NEMT benefit for newly eligible enrollees. However, when the state submitted a request on September 30, 2015, to extend its longstanding demonstration, it sought approval to

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<sup>16</sup>Indiana's Medicaid expansion is called the Healthy Indiana Plan (HIP) 2.0—which is based, in part, on a previous section 1115 demonstration called HIP 1.0. While HIP 1.0 covered certain health services, it did not offer the NEMT benefit to enrollees.

<sup>17</sup>Iowa's Medicaid expansion is called the Iowa Health and Wellness Plan. Within this program, enrollees with incomes under 100 percent of the FPL are enrolled in the Wellness Plan, and enrollees with incomes from 101 to 138 percent of the FPL are enrolled in the Marketplace Choice Plan. Because there is only one health plan participating in the program, Marketplace Choice enrollees, as of December 2014, are no longer required to enroll in premium assistance as a condition of eligibility, but may choose to participate in the Wellness Plan.

<sup>18</sup>Iowa's 2005 demonstration—called IowaCare—provided Medicaid coverage for individuals aged 19 through 64 with incomes up to 200 percent of the FPL and pregnant women with incomes up to 300 percent of the FPL who have incurred medical expenses that reduced their income to 200 percent of the FPL. This demonstration also required enrollees to obtain services from certain provider networks.

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exclude the NEMT benefit.<sup>19</sup> Arizona’s proposed extension would require newly eligible adults, including those with incomes from 100 to 133 percent of the FPL, to enroll in a new Medicaid program that includes enrollee contributions into an account that can be used for non-covered services and an employment incentive program.<sup>20</sup> The proposed extension, including the request to exclude the NEMT benefit, was under review, as of November 2015.

Officials from these three states cited several reasons for their efforts to exclude the NEMT benefit, including a desire to align Medicaid benefits with private insurance plans, which typically do not cover this benefit.

- Indiana officials indicated that when the state initially developed its demonstration in 2008, they designed benefits for a low-income population that tended to be employed. Thus, under that demonstration they offered benefits that resembled private insurance in an effort to familiarize enrollees with private coverage. This experience largely influenced the state’s decision under its current demonstration to exclude the NEMT benefit for newly eligible enrollees.
- Iowa officials reported that when the state expanded Medicaid, they wanted Medicaid benefits to look like a private insurance plan—with the hope of limiting disruptions in service as fluctuations in income could result in changes to enrollees’ coverage.
- While Arizona officials also cited the state’s intent to align Medicaid benefits with private health insurance, they also noted that excluding the NEMT benefit would be one way to contain costs.

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<sup>19</sup>Since 1982, Arizona has offered Medicaid coverage through a demonstration that established the Arizona Health Care Cost Containment System. This demonstration allowed Arizona to mandate managed care, provide long term care services in home and community-based settings, and implement administrative simplifications, among other things. It is scheduled to expire on September 30, 2016.

<sup>20</sup>Arizona’s demonstration application specifically excludes from the NEMT benefit waiver individuals with a serious mental illness, American Indians and Alaska Natives, individuals who are medically frail (to be defined through discussion with CMS), and individuals who serve as caregivers to an individual who is elderly or disabled. Similarly, Indiana’s and Iowa’s approved waivers of the NEMT benefit exempt individuals that the states define as medically frail.

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Of the remaining 25 Medicaid expansion states, 14 offered reasons for why they did not exclude the NEMT benefit for newly eligible enrollees.<sup>21</sup>

- Officials from 8 states reported they did not pursue such efforts because they considered the NEMT benefit critical to ensuring enrollees' access to care.
- Officials from an additional 4 states reported that they wanted to align benefits for the newly eligible enrollees with those offered to enrollees covered under the traditional Medicaid state plan.
- Officials from 2 other states reported that the newly eligible Medicaid enrollees did not significantly increase their program enrollment, and therefore, there was no need to alter this benefit.

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## Two States are Evaluating Implications of Excluding NEMT; Researchers and Advocates Raised Concerns about Altering the Benefit

The two states that excluded the NEMT benefit are in different stages of completing required evaluations of the effect of this exclusion on access to care. Research and advocacy groups indicated that excluding the NEMT benefit could affect enrollees' access to services and costs of coverage, and could set a precedent for the Medicaid program moving forward.

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<sup>21</sup>While we did not specifically ask officials in these 25 states for the reasons that they did not seek to exclude the NEMT benefit for newly eligible Medicaid enrollees, 14 states offered reasons for their decisions to maintain the benefit.

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## Evaluations of Efforts to Exclude the NEMT Benefit in Two States Assess Comparability of Access for Enrollees With and Without Benefit

The two states that obtained approval to exclude the NEMT benefit for newly eligible Medicaid enrollees—Indiana and Iowa—are at different stages of evaluating the effect this will have on enrollees and have different time frames for reporting their results. Indiana officials indicated that the state is currently working with CMS on the design of its evaluation and must submit results to CMS by February 29, 2016.<sup>22</sup> According to a draft of the evaluation design, the state plans to survey enrollees and providers to compare the experiences of Medicaid enrollees with and without the NEMT benefit with respect to missed appointments, preventative care, and overall health outcomes; the state also seeks to determine whether enrollees residing in certain parts of the state are more affected by a lack of this benefit.<sup>23</sup>

Similarly, Iowa, which excluded the NEMT benefit for all newly eligible enrollees beginning in January 2014, was required to submit a series of independent analyses to CMS and recently received approval to continue its exclusion of this benefit until March 2016.<sup>24</sup> The state conducted an analysis to determine whether newly eligible enrollees' access to services was affected and reported its results in April 2015. Developed in close consultation with CMS, the analysis focused on the comparability of experiences of enrollees covered under the Medicaid state plan (who have the NEMT benefit) with newly eligible Medicaid expansion enrollees (who do not have the NEMT benefit).<sup>25</sup> With such a focus, the analysis sought to

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<sup>22</sup>In working with the state, CMS recently approved a temporary extension of the NEMT waiver through November 30, 2016.

<sup>23</sup>Indiana officials indicated that because the state had excluded the NEMT benefit for a segment of its Medicaid population since 2008 under its initial demonstration, it had already studied the effect that this waiver had on enrollees' access to services. In a 2012 survey conducted by researchers retained by the state, 800 enrollees were asked why they had not visited a doctor for a routine check-up in the last 12 months and 2.33 percent of respondents indicated that it takes too long to get there or they had a transportation problem in 2012.

<sup>24</sup>The state contracted with the University of Iowa, Public Policy Center to conduct this analysis. Researchers from the Public Policy Center indicated that they have worked with Iowa's Department of Human Services on a number of evaluations for 25 years—and thus have developed expertise with the state's Medicaid administrative claims and enrollment data.

<sup>25</sup>Researchers from the Public Policy Center told us that they worked closely with CMS for 6 months to develop the evaluation methodology, and although Iowa Medicaid officials were included in the meetings with CMS, they generally did not participate in the methodological discussions. Additionally, the researchers noted that under its contract with the state, the state is provided 30 days to review the Public Policy Center's report for accuracy, but does not have the ability to edit the content.

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determine whether excluding the NEMT benefit presented more of a barrier to obtaining services than an enrollee would have otherwise experienced under the state's Medicaid state plan. Using enrollee surveys, the analysis found little difference in the barriers to care experienced by the two groups of enrollees as a result of transportation-related issues.<sup>26</sup> For example, the analysis noted that about 20 percent of enrollees in both groups reported usually or always needing help from others to get to a health care appointment.<sup>27</sup> Additionally, the analysis identified comparability between both groups of enrollees in terms of their reported unmet need for transportation to medical appointments (about 12 percent of both groups) and reported worry about the ability to pay for the associated costs (13 percent of both groups).

However, looking within the group of newly eligible enrollees without the NEMT benefit, the Iowa evaluation found that those with lower incomes—under 100 percent of the FPL—tended to need more transportation assistance and have more unmet needs than those with higher incomes. For example,

- 25 percent of newly eligible enrollees with incomes under 100 percent of the FPL reported needing help with transportation, compared with 11 percent of higher income newly eligible enrollees;
- 15 percent of newly eligible enrollees with incomes under 100 percent of the FPL reported an unmet need for transportation, compared with

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For the results of Iowa's evaluations, see The University of Iowa Public Policy Center, *Evaluation of the Iowa Health and Wellness Plan, Member Experiences in the First Year* (April 2015); The University of Iowa Public Policy Center, *Non-emergency Transportation Services for IHAWP Members: The Early Experiences of Iowa Health and Wellness Plan Members, A Policy Brief* (March 2015); and The University of Iowa Public Policy Center, *First Look at Iowa's Medicaid Expansion: How Well Did Members Transition to the Iowa Health and Wellness Plan from IowaCare* (October 2014).

<sup>26</sup>The Iowa analysis also included a geographical assessment of distance to primary care providers based on a geocoding/mapping technique. To compare Medicaid state plan enrollees and newly eligible enrollees with incomes under 100 percent of the FPL, enrollees in both groups with at least one claim for preventive care were mapped to the provider who provided this care, and those without a claim for services were mapped to the closest primary care provider. The results from this analysis indicate no practical difference in the distance to a primary care provider in miles or minutes between newly eligible enrollees and enrollees under the state plan.

<sup>27</sup>Specifically, survey results indicated that about 20 percent of enrollees with the NEMT benefit and 22 percent of newly eligible enrollees without the NEMT benefit reported usually or always needing help from other sources to get to health care appointments.

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5 percent of higher income newly eligible enrollees; and

- 14 percent of newly eligible enrollees with incomes under 100 percent of the FPL reported that they worried a lot about paying for transportation, compared with 6 percent of higher income newly eligible enrollees that reported that they worried a lot about paying for transportation.

HHS recently approved Iowa's amendment to continue its waiver of the NEMT benefit, although it noted concern about the lower income enrollees' experience. In approving the state's request, HHS cited the need for Iowa to continue evaluating the effects of the waiver in light of survey results on the type of transportation that newly eligible enrollees reported using to get to health care appointments. These results showed that newly eligible enrollees tended to rely on others, such as family and friends, to reach health care appointments more so than Medicaid state plan enrollees.<sup>28</sup>

Researchers who conducted the evaluation of Iowa's program indicated that they plan to conduct additional analyses, which include some—but not all—of the suggestions we have offered.<sup>29</sup> For example, our review of Iowa's evaluation methodology suggests that linking survey responses from both groups of enrollees directly to their claims could improve the state's understanding of enrollees' patterns of utilization and the implications of transportation difficulties. The researchers indicated that they will link claims data with survey responses in the next evaluation and use regression modeling to determine which group of enrollees was more likely to have an unmet need due to transportation issues. Additionally, we noted that the small sample size could limit their ability to detect differences between the enrollees. The researchers indicated that their next evaluation will survey a larger sample of Medicaid enrollees covered under the state plan who have the NEMT benefit and newly eligible enrollees who do not in an effort to increase their ability to detect these

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<sup>28</sup>See HHS approval letter dated July 31, 2015.

<sup>29</sup>The researchers emphasized that the evaluation was not specific to the NEMT benefit, but was an evaluation of the impact of the state's entire 1115 demonstration. The researchers acknowledged that if their focus was on the NEMT benefit, they may have structured the survey questions and analyses differently. They further noted that in their continued evaluation, keeping the questions similar to those asked previously will allow them to compare the results over time.

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differences. We agree that increasing the sample size could strengthen confidence in the results. We also noted that the researchers did not consider whether survey respondents lived in a rural or urban area, which can be important because research shows that the need to travel longer distances and the lack of public transportation in rural areas can pose challenges for individuals seeking services. The researchers indicated that they did not stratify the groups by rural or urban areas because of a concern about inadequate sample sizes in certain counties and because the need for transportation in Iowa is not unique to the pursuit of health care services, but also poses a challenge in other aspects of residents' lives.<sup>30</sup> While stratifying survey results by rural and urban areas could be relevant in evaluating enrollees' access to care or unmet need, the researchers do not plan to include a rural and urban stratification in the next evaluation.<sup>31</sup> CMS officials recognized the value of a rural and urban distinction, but indicated that there is a need to balance further analysis with the ability to generate results expeditiously and facilitate decision making on the waiver.

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### Research and Advocacy Groups Raised Concerns Regarding the Implications of Altering the Transportation Benefit for Newly Eligible Enrollees

Officials from the 10 research and advocacy groups we interviewed—which represent Medicaid enrollees, underserved populations, and health care providers—noted potential concerns of excluding the NEMT benefit as it relates to enrollee access to services and costs of coverage.

Access to Services: Officials from 9 of the 10 groups we interviewed indicated that excluding the NEMT benefit would impede newly eligible enrollees' ability to access health care services, particularly individuals living in rural or underserved areas, as well as those with chronic health

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<sup>30</sup> Additionally, the researchers noted that they are not considering stratifying results by rural and urban location, in part, because the evaluation is focused on whether there are any differences in experiences between the comparison groups and not on who is or is not receiving the NEMT benefit.

<sup>31</sup> The researchers indicated that they plan to survey about 30,000 enrollees, which will consist of those in the Medicaid state plan who have the NEMT benefit and the newly eligible who do not, and report the results to CMS in the spring of 2016. This is a larger sample than the previous survey, which consisted of 4,050 Medicaid state plan enrollees with the NEMT benefit and 6,750 enrollees without it. For the prior survey, 19 percent of the enrollees with the NEMT benefit responded to the survey, while 30 percent of enrollees without the NEMT benefit responded.

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conditions.<sup>32</sup> For example, officials from one national group that represents underserved populations indicated that the enrollees affected by the lack of the NEMT benefit will be those living in rural areas that must travel long distances for medical services. Another group that represents providers in Iowa also cited the difficulty faced by enrollees that live in rural areas by noting that some of the patients they served have had to cancel their medical appointments because the patients do not have a car, money to pay for gas, or access to public transportation. With respect to enrollees with chronic health conditions, one group that represents transportation providers (and others who support mobility efforts) noted that transportation can be a major barrier for individuals who are chronically ill and need recurring access to life-saving health services. Similarly, another group that represents community health centers specified that those with mental health conditions are particularly vulnerable due to a lack of transportation.<sup>33</sup>

Costs of Coverage: Officials from 5 of the 10 groups we interviewed also noted that efforts to exclude the NEMT benefit can have implications on the costs of care because patients without access to transportation may forgo preventive care or health services and end up needing more expensive care, such as ambulance services or emergency room visits. For example, a national group that represents providers of services for low-income populations noted that for people who are receiving regular substance abuse treatments, missing appointments can make them vulnerable to relapsing, which ultimately drives up the cost of their care. Another national group that represents underserved populations indicated that they have seen low-income individuals who do not have a car and cannot afford public transportation use higher-cost care from emergency rooms for their medical problems because they cannot otherwise access care. One other group that represents providers noted that by driving up

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<sup>32</sup>While certain newly eligible enrollees with chronic conditions in Indiana and Iowa may qualify for the NEMT benefit by being determined medically frail, officials from some of the groups we spoke with cited limitations in terms of who can qualify as medically frail, as well as long wait times for such determinations.

<sup>33</sup>We previously cited Substance Abuse and Mental Health Administration estimates that approximately 3 million (17 percent) of the 17.8 million low-income, uninsured adults nationwide had a behavioral health condition prior to the Medicaid expansion in 2014. See GAO, *Behavioral Health: Options for Low-income Adults to Receive Treatment in Selected States*, [GAO-15-449](#) (Washington, D.C.: June 19, 2015).

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the cost of care, a lack of transportation will ultimately trickle down to lower reimbursement rates for providers.

Despite these potential implications, officials from 9 of the 10 groups we interviewed acknowledged various advantages of a state expanding Medicaid even with a more limited benefit. For example, officials from 4 groups remarked that some coverage is better than no coverage in light of the significant health care needs among low-income populations. These groups recognized the political challenges that have driven state decisions whether to expand Medicaid and the concessions that are needed for an expansion to occur. For example, officials from a group that represents providers in Iowa indicated that although introducing variations in Medicaid programs adds complexity for providers, patients, and the state, flexibility is important in helping a state find a coverage solution that works in its political climate. Similarly, an advocacy group from one state acknowledged that an expansion with full traditional Medicaid benefits was never going to be achieved in that state, given the political environment. As such, groups within that state's provider community broadly supported the state's effort to expand Medicaid—even without the NEMT benefit—because so much of the population was uninsured and needed this coverage.

However, while acknowledging their preference for states to expand Medicaid, three groups we spoke with maintained their concerns about the effects of such efforts on enrollees' access to care. Officials from two of these groups said that improvements in the number of people covered should not be achieved by eroding essential services, while an official from the other group questioned the value of having health coverage if an enrollee is unable to get to the location where services are provided. Further, officials from six of the groups we interviewed were concerned that HHS's approvals of state efforts to exclude the NEMT benefit potentially provide other states with an incentive to pursue similar efforts. These six groups raised concerns that every time HHS approves such an effort, a new baseline is created for what states may request in an effort to exclude core Medicaid services.<sup>34</sup>

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<sup>34</sup>In particular, officials from two of the six groups pointed to Arizona's recent request to exclude the NEMT benefit from coverage for newly eligible enrollees. Arizona had not sought to do so when it initially expanded Medicaid under its demonstration, but then pursued this option after other states were approved to do so.

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## Agency Comments

We provided a draft of this report to HHS for comment. The department provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov), or Mark L. Goldstein at (202) 512-2834 or [goldsteinm@gao.gov](mailto:goldsteinm@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix I.



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# Appendix I: GAO Contact and Staff Acknowledgments

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## Staff Acknowledgments

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