Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

May 29, 2015

Ms. Vikki Wachino
Director
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Wachino:

Iowa is requesting to amend the Iowa Health and Wellness Plan (IHAWP) 1115 Demonstration waiver to continue the waiver of non-emergency medical transportation (NEMT) as a benefit for IHAWP members. We are seeking approval of an extension for the period of August 1, 2015 to December 31, 2016 to keep the program consistent with the original terms of Iowa's approach to expansion.

As noted in the December 30, 2014, approval letter to extend the NEMT waiver through July 1, 2015, additional data is required to evaluate the impact on access to care for members. We understand this information is necessary for consideration of continuation of the waiver. A full assessment of the IHAWP members' early experiences related to access to care is now available for your review.

The following supporting documents for this amendment are enclosed:

- Concept document – IHAWP NEMT Waiver Amendment
- Policy Brief – NEMT survey results
- Summary of Public Comments
- Notice of Public and Tribal comment period

We look forward to providing any additional information necessary to assist with the approval process for this amendment.

Sincerely,

[redacted]

Mikki Stier, MSHA, FACHE
Medicaid Director

JL/dj

Iowa Health and Wellness Plan: NEMT Waiver Amendment

In May of 2013, the Iowa Legislature passed the bi-partisan Iowa Health and Wellness Plan. The Iowa Health and Wellness Plan provides modern access to healthcare for all Iowans while implementing a benefit design intended to address liabilities associated with simply expanding the number of lives in traditional Medicaid coverage. The plan's design seeks to improve outcomes, increase personal responsibility and ultimately lower costs while supporting a population that is often new to full healthcare coverage.

Key goals among legislators that helped enable a bipartisan compromise were: 1) ensure the Health and Wellness population (0-138% of the federal poverty level) had access to high-quality local provider networks and modern benefits that worked to improve health outcomes and 2) help drive overall healthcare system transformation by encouraging a shift to value based provider payments that will align with important developments in the state occurring in both private insurance and Medicare markets. A key piece of the compromise was that the coverage would look more like a commercial benefit than traditional Medicaid and that the design would include a financial stake in coverage for members and an emphasis on healthy behaviors. The Iowa Health and Wellness design has met these goals. Members have access to local providers and all Essential Health Benefits. The benefits are based on the state employees' commercial health insurance plan and do not contain the extensive benefits traditionally associated with Medicaid under the State Plan. This commercial approach specifically excluded non-emergency medical transportation (NEMT).

On December 30, 2014, the Centers for Medicare and Medicaid services (CMS) approved the extension of the NEMT waiver from January 1, 2015 through July 31, 2015. Thereafter, CMS and the Iowa Medicaid Enterprise (IME) established the criteria necessary for the IME to continue the NEMT waiver beyond July 31, 2015. CMS proposed that Medicaid member survey responses on difficulties with transportation for beneficiaries subject to the NEMT waiver be compared to the survey responses of persons who have access to NEMT services and that the responses not have statistically significant differences. IME agreed to compare survey responses of the Iowa Health and Wellness plan (IHAWP) members to survey responses to survey responses of persons receiving 'traditional' Medicaid benefits through the State Plan.

Iowa conducted the analysis and found that the survey responses of the two populations do not have statistically significant differences. As such, Iowa requests to continue waiving the NEMT service for members under IHAWP who are not medically exempt and who are not eligible for

EPSDT services.[1] Iowa requests this waiver be extended for the remainder of the IHAWP[2] demonstration period, December 31, 2016.

As required by the IHAWP Special Terms and Conditions for the amendment process, Iowa is providing the information below and corresponding attachments to support the continuance of the NEMT waiver.

a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;

> The IME posted public notice in nine newspapers statewide for a 30-day public comment period running from April 24, 2015 through May 24, 2015. The IME also provided tribal notice for this comment period. Additionally, the IME sent email blasts to various stakeholders lists to inform them of the IME's request to amend the NEMT waiver and public comment period. The notice and a draft of the NEMT waiver amendment were posted online. Please see the attachment entitled, *Public Notice-NEMT waiver extension* for more details. A summary of the public and Tribal comments received is included in the attachment entitled, *Public and Tribal comment summary 05.29.15.*

b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

> NEMT is currently an excluded benefit for IHAWP members who do not have a medically exempt status and who are not eligible for EPSDT services. IME is requesting to continue this process. As this amendment request does not reflect a change to the current program, there is no impact to the budget neutrality agreement.

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

> Not applicable as the CHIP population is not covered under IHAWP.

d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 63;

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[1] Iowa is and will continue providing NEMT services to persons who have a medically exempt status and EPSDT eligible IHAWP members.

[2] IHAWP includes the Iowa Wellness plan 1115 demonstration (Project Number 11-W-00289/5) and the Iowa Marketplace Choice 1115 demonstration (Project Number11-W-00288/5).

As discussed above, the IME and CMS established the criteria necessary for IME to be able to continue to waive NEMT services. As such, the Public Policy Center of the University of Iowa compared the survey responses on transportation questions from IHAWP members to members who receive Medicaid State plan services. These analyses indicated that there was little, if any, difference in the barriers to care for IHAWP vs. Medicaid members as a result of transportation-related issues. Overall, nearly 20% of Medicaid and IHAWP members reported usually or always needing help from others to get to a health care visit and nearly 13% reported an unmet need for transportation to or from a health care visit in the six months prior to the survey. Geocoding and network analysis indicated that IHAWP members live as close, or closer, to a primary care provider than Medicaid State Plan members. For complete results, see the attachment entitled: *Non-Emergency Transportation Services for IHAWP Members: The early experiences of Iowa Health and Wellness plan members*.

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

The evaluation design will not need to be modified if this waiver continues because exclusion of this service is incorporated into the design for most of the IHAWP population.

Non-Emergency Transportation Services for IHAWP Members:

The early experiences of Iowa Health and Wellness Plan members

A Policy Brief

University of Iowa
Public Policy Center

Peter C. Damiano
Suzanne E. Bentler
Mark J. Pooley
Susan C. McKernan
Elizabeth T. Momany

March 2015

Non-emergency Transportation Services for Iowa Health and Wellness Plan members: Early Experiences

Research findings

The primary research question in this study was to determine if there were differences in the access to care for members of the Iowa Health and Wellness Plan (IHAWP-Iowa's Medicaid expansion program) for whom non-emergent transportation services were waived and the traditional Iowa Medicaid State Plan, whose members receive non-emergent transportation services. The study consisted of responses to member surveys and a network analysis to assess travel distance to available providers.

These analyses indicated that there was little, if any, difference in the barriers to care for IHAWP vs Medicaid members as a result of transportation-related issues as assessed in our surveys. Overall, around 20% of Medicaid and IHAWP members reported usually or always needing help from others to get to a health care visit and around 13% reported an unmet need for transportation to or from a health care visit in the six months prior to the survey.

Geocoding and network analysis indicated that IHAWP members live as close, or closer, to a primary care provider than Medicaid State Plan members. In addition, previous IowaCare members who have enrolled in IHAWP reside closer to a PCP than they did to their assigned provider in IowaCare.

Introduction

The Iowa Health and Wellness Plan (IHAWP) is Iowa's version of the Medicaid expansion, allowed as part of the Affordable Care Act (ACA). The IHAWP includes two separate programs: 1) the Wellness Plan (WP), which is a more traditional Medicaid-like program, for individuals from 0-100% of the federal poverty level (FPL), operated by the Iowa Medicaid Enterprise, and 2) the Marketplace Choice (MPC) Program, where individuals select a Qualified Health Plan (QHP), from eligible private plans in the Health Insurance Marketplace. The IHAWP began on January 1, 2014.

This policy brief focuses on the issues related to non-emergency medical transportation (NEMT). NEMT is a service that is covered for Medicaid members but is not covered for members in either of the IHAWP programs. To evaluate the impact of Iowa's waiver from providing NEMT services on access to care, we conducted a multi-factorial approach including:

I. A comparison of the perceptions of people who do and do not receive NEMT services from questions in consumer surveys conducted in the Fall of 2014 with members of IHAWP and Medicaid State Plan and
II. A geographical assessment of distance to primary care providers based on a geocoding/mapping technique.

I. Consumer survey of NEMT-related issues

Surveys were conducted with both IHAWP and Medicaid members in the fall of 2014 to compare these populations on a series of transportation-related questions to explore the impact of not covering NEMT services in the IHAWP program.

Methods for the IHAWP and Medicaid surveys

The 2014 Survey of IHAWP members was conducted during the fall and winter of 2014/2015 using a mixed-mode methodology. Surveys were mailed to a stratified random sample of 6,750 IHAWP members who had been in their current plan for at least the previous six months. We selected a sample of

1,350 from each of five groups (according to the members' initial IHAWP assignment): WP Fee-for-Service (FFS), WP Health Maintenance Organization (HMO), WP Managed Care, MPC—CoOportunity Health, and MPC—Coventry Health. We also conducted a survey of 4,050 Medicaid members during this same period of time, using the same methodology. We selected a sample of 1,350 from each of three member groups: HMO, MediPASS, and FFS.

Both mail and web-based surveys were used for these assessments. The initial mailings were sent to the sample of IHAWP and Medicaid members in October, 2014. The first mailing included a $2 bill as an incentive, regardless of survey completion. A reminder postcard was sent fourteen days after the initial mailing. About fourteen days after the postcard reminder, a second mailing was sent to those who had not responded to the initial mailing. In the mailed cover letter and on the reminder postcard, enrollees were also given the option of completing the survey online and were provided the website address for that purpose.

There were 670 Medicaid members and 1792 IHAWP members (1101 WP and 691 MPC members) who responded to the survey for an overall adjusted response rates of 30% for the IHAWP sample and 19% for the Medicaid sample. Response rates were adjusted by removing from the denominator those ineligible to complete a survey because of incorrect or out-of-state addresses.

Transportation-related questions in surveys covered the following topics:.

- The enrollees' mode for traveling for health care
- How frequently they needed assistance traveling for health care in the last 6 months
- Unmet need for NEMT in the last 6 months
- Any past use of NEMT paid for by Medicaid
- Concern about costs associated with NEMT in the last 6 months
- Transportation as a barrier to using the emergency department instead of going to a doctor's office or clinic for care (only asked of IHAWP members)
- Transportation as a barrier to obtaining a physical exam (only asked of IHAWP members)

Data were tabulated and bivariate analyses (i.e., chi-square and t-tests for group differences) were conducted using SAS. NEMT is a service that is covered for Medicaid members but is not a covered service in the IHAWP. Thus, the primary analyses were comparisons between members of IHAWP (WP and MPC combined) and members of Medicaid. A secondary analysis was conducted looking at potential differences between WP and MPC members within the IHAWP.

The data was post-stratified to control for potential systematic biases created from collecting data from a stratified sample. We used a simple weighting factor to make the data representative of all IHAWP and Medicaid members statewide and to account for that fact that there were not equal numbers of enrolled members in each sampled group. Thus, the percentages reported were weighted to reflect the statewide membership in each group.

Limitations

There are some limitations with survey research that can affect the interpretation of the results. First, those who choose to respond to the survey may be different from those who choose not to respond and this can create biased results. In this evaluation, respondents (both to the Medicaid and the IHAWP surveys) were more likely to be female, white, and older than those who did not respond to the surveys. Second, respondents may have difficulty accurately remembering events which may introduce recall bias. This risk may not be high because of the relatively short time period for recalling events (6 months). Third, there may be variables that confound the interpretation of these results. One such example is the

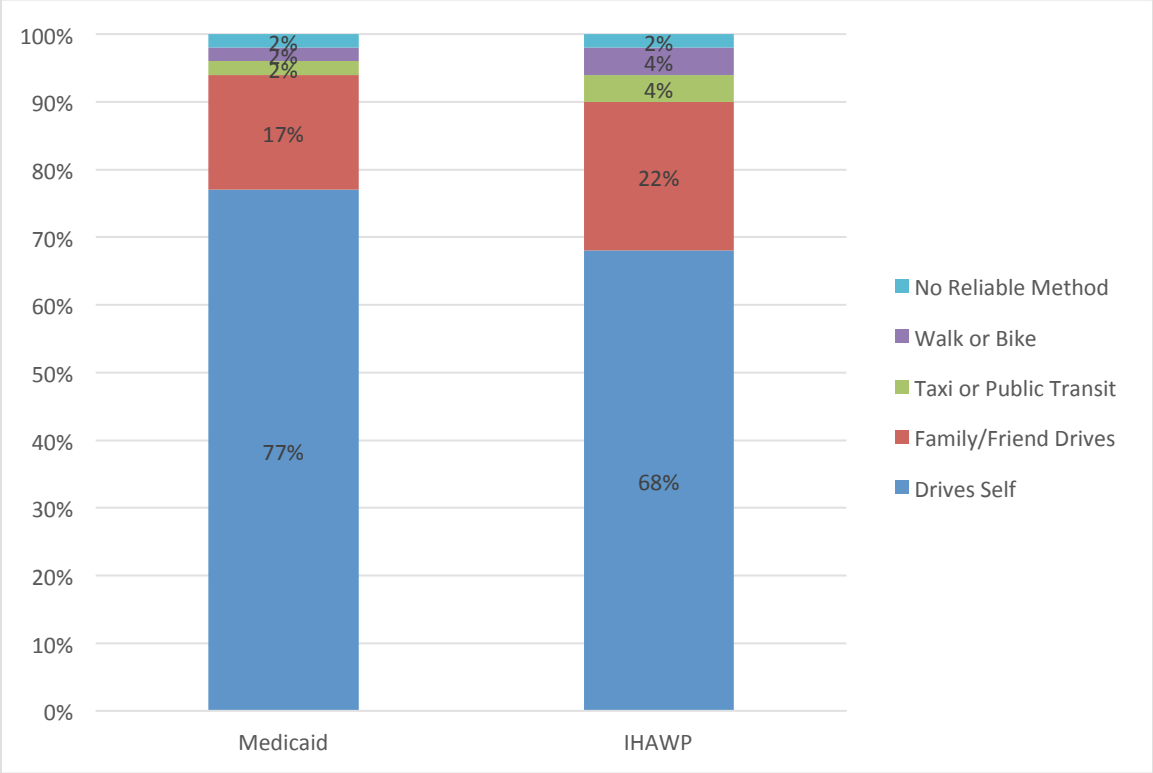
fact that one of the MPC plans (CoOportunity) pulled out of the MPC around the time of the administration of this survey which may affect the experiences of those members differently than the members of the other MPC plan, Coventry Health.

Results

Mode of Transportation to Health Care Visits

In the surveys, members were asked: *"When you need to get health care, what is the type of transportation you use most often to get to your visit?* (Please choose only one answer.)" Figure 1 provides a summary of the responses from both Medicaid and IHAWP members.

Figure 1. Modes of Transportation to Health Care Visits

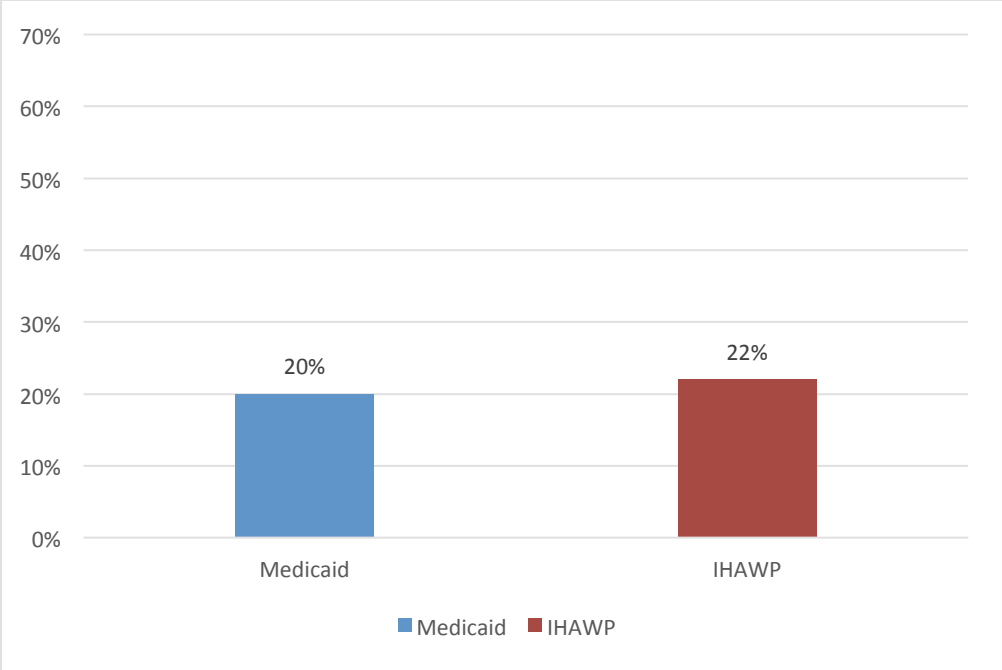


The majority of respondents of both groups drive themselves (77% Medicaid, 68% IHAWP) or are driven by family or friends (17% Medicaid, 22% IHAWP) to their health care appointments. There was no difference between Medicaid and IHAWP in the reporting of not having a reliable method to get to health care visits with around 2% reporting no reliable transportation. Within the IHAWP, 3% of WP and 1% of MPC members reported no reliable way to get to visits and this difference was statistically significant (p=.02).

Need for Assistance to Get to Health Care Visits

Members were asked: *"In the last 6 months, how often did you need assistance from other sources (such as friends, family, public transportation, etc.) to get to your health care visit?"* Figure 2 summarizes the percentage of those who 'usually' or 'always' needed assistance from others.

Figure 2. Usually or Always Needed Assistance

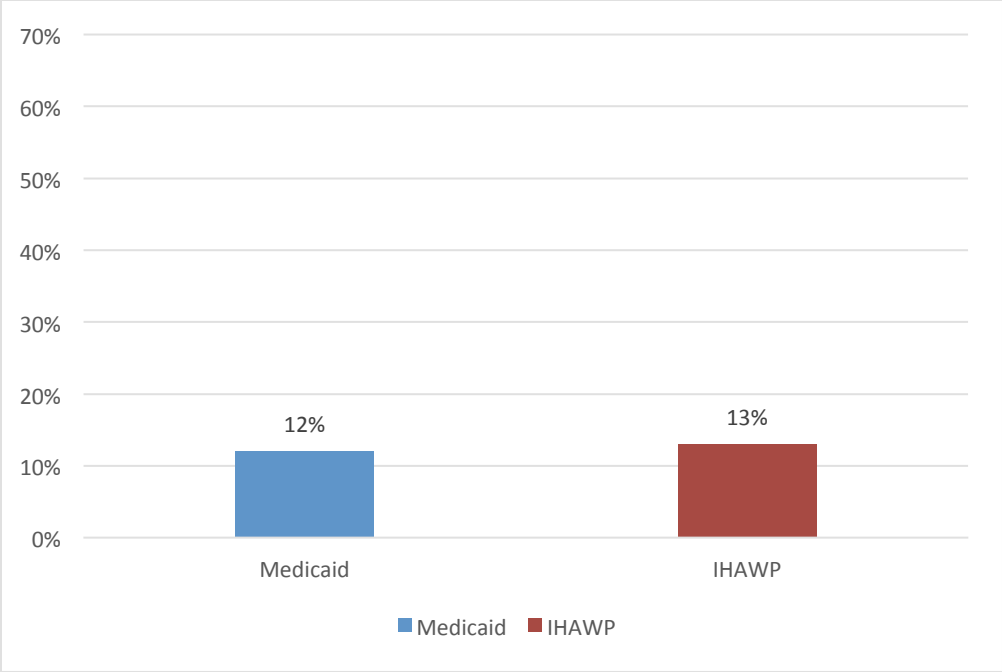


Around 20% of Medicaid and 22% of IHAWP members reported usually or always needing help from other sources to get to health care visits and this was not a statistically significant difference. Within IHAWP, a higher percentage of WP members reported this need (25%) compared to MPC members (11%) and this difference was statistically significant ($p<.001$).

Unmet Need for Transportation to or from Health Care Visits

Members were asked: *"In the last 6 months, was there any time when you needed transportation to or from a health care visit but could not get it for any reason?"* Figure 3 provides a summary of the unmet need for transportation to health care visits by plan.

Figure 3. Unmet Need for Transportation To or From a Health Care Visit

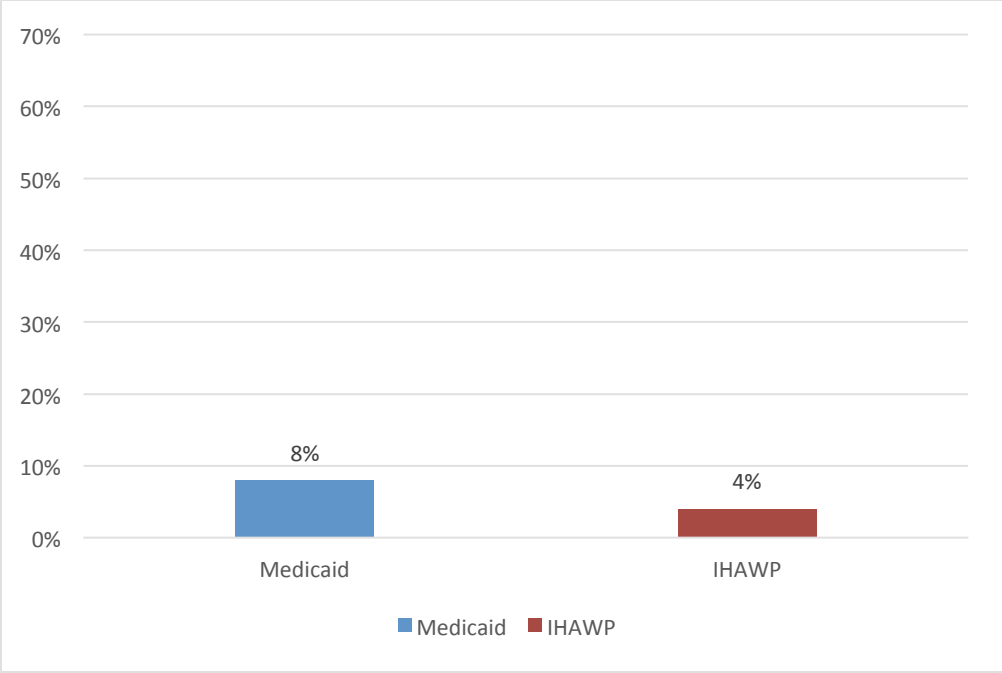


Overall, less than 15% reported an unmet need for transportation to medical appointments. The reported unmet need for transportation was not statistically different for Medicaid members (12%) and IHAWP members (13%). However, within IHAWP, a higher percentage of WP members (15%) than MPC members (5%) reported an unmet need for transportation and this difference was statistically significant ($p<.001$).

Past Use of the Medicaid Transportation Benefit

Members were asked: "*Have you ever used transportation paid for by Medicaid to get to or from a health care visit?*" Figure 4 provides a summary of the use of the Medicaid NEMT benefit by these members.

Figure 4. Percentage Reporting Any Past Use of Medicaid Transportation Benefit

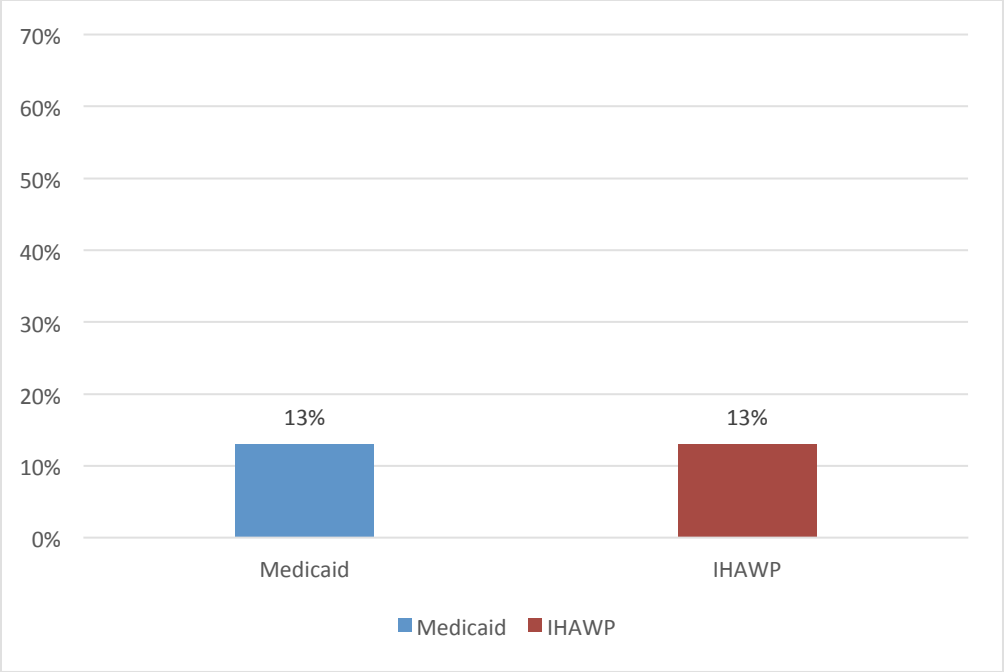


Overall, less than 10% of members of these plans reported ever having used the Medicaid transportation benefit. Not unexpectedly, there was a significant difference between Medicaid (8%) and IHAWP (4%) members in ever having used the benefit ($p<.001$). Among IHAWP members, there was no difference between WP and MPC members in the use of the NEMT benefit.

Worry about the Cost of Transportation to Health Care Visits

Members were asked: *"In the last 6 months, how much, if at all, have you worried about your ability to pay for the cost of transportation to or from a health care visit?"* Figure 5 provides a summary of the members' perceptions of the burden of transportation costs.

Figure 5. Worry about Ability to Pay for NEMT



There was no difference between Medicaid and IHAWP in reported worry about the cost of transportation with 13% of each reporting that they worried "a lot" about their ability to pay for the cost of transportation to or from a health care visit. Within IHAWP, a higher percentage of WP members (14%) than MPC members (6%) worried "a lot" about transportation costs ($p<.001$).

Transportation Problems as a Barrier to Health Care

Two transportation-related questions were asked on the IHAWP survey but not on the Medicaid survey. Both questions asked respondents to give reasons why they were not able to obtain particular health care services:

1) Do you think the care you received at your most recent visit to the ER could have been provided in a doctor's office if one was available at the time? If so,
    - What was the main reason you did not go to a doctor's office or clinic for this care [care received at the emergency room (ER) that could have been provided at a doctor's office or clinic]?

Around half of the IHAWP members reported that the care they received at their most recent visit to an ER could have been provided in a doctor's office instead (51% WP, 50% MPC; n=250 total). The majority of IHAWP members (around 64%) reported using the ER instead of the doctor's office or clinic because the doctor's office or clinic was not open when they needed care. Five percent of WP members and 2% of MPC members who used the ER when they might have gone to a doctor's office reported that it was because of transportation problems. Statistical comparisons between these two groups with regard to transportation as a barrier were not done due to low sample sizes (Table 1).

Table 1. Barriers to Going to a Doctor's Office Instead of the ER for Health Care

WP (n=164)	MPC (n=83)	Response Options
63%	64%	A doctor's office or clinic was not open when I needed care
15%	20%	I had to wait too long for an appointment with the doctor's office or clinic
12%	12%	Other
5%	**2%**	**I had transportation problems getting to a doctor's office or clinic**
4%	1%	My insurance plan would not cover the care I needed if I went to a doctor's office or clinic

2) Do you think any of the following reasons would keep you from getting a physical exam this year? (Choose all that apply).

Transportation difficulties were the sixth most reported barrier to obtaining a physical exam for WP members (6%) and the eighth most reported for MPC members (2%). The difference between WP and MPC with regard to transportation as a barrier to obtaining a physical exam was statistically significant at p=.02 (Table 2).

Table 2. Barriers to Obtaining a Physical Exam

WP (n=1101)	MPC (n=691)	Response options
52%	40%	I have already had a physical exam this year
10%	12%	I don't believe I need a physical exam
8%	9%	I am not sure where to go to get a physical exam
7%	13%	I don't currently have a doctor/don't like my current doctor
6%	9%	I don't like getting a physical exam
6%	**2%**	**Getting transportation to my doctor's office is hard**
5%	4%	It is hard to get an appointment for a physical exam from my doctor
4%	8%	I can't get the time off of work/can't get child care

Conclusions

There was little, if any, difference in the barriers to care for IHAWP vs Medicaid members as a result of transportation-related issues assessed in our surveys. Overall, around 20% of Medicaid and IHAWP members reported usually or always needing help from others to get to a health care visit and around 13% reported an unmet need for transportation to or from a health care visit in the six months prior to the survey.

For those who do not have the benefit (IHAWP members), there were significant differences in the need for transportation between those in the WP and those in the MPC. This finding mirrors those found in our previous work when we surveyed IowaCare members who were transitioning into the IHAWP.[1] In that report, we surveyed former IowaCare members about their transition into the IHAWP and included the same transportation-related questions summarized in this report. As in this report, we found that WP members experienced more transportation-related issues than MPC members. However, the unmet need for transportation reported by IHAWP members in the current survey are somewhat lower than those found in the previous study (20% WP unmet need in the IowaCare transition survey, 15% WP in current survey; 10% MPC unmet need in in the IowaCare transition survey, 5% MPC unmet need in current survey) which could be due to the inclusion of all IHAWP members in the sample (which includes other populations in addition to former IowaCare members).

[1] Bentler SE, Damiano PC, Momany ET, et. al. First Look at Iowa's Medicaid Expansion: How Well did Members Transition to the Iowa Health and Wellness Plan from IowaCare. October, 2014. Available at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan

II. Distance calculations

Methods

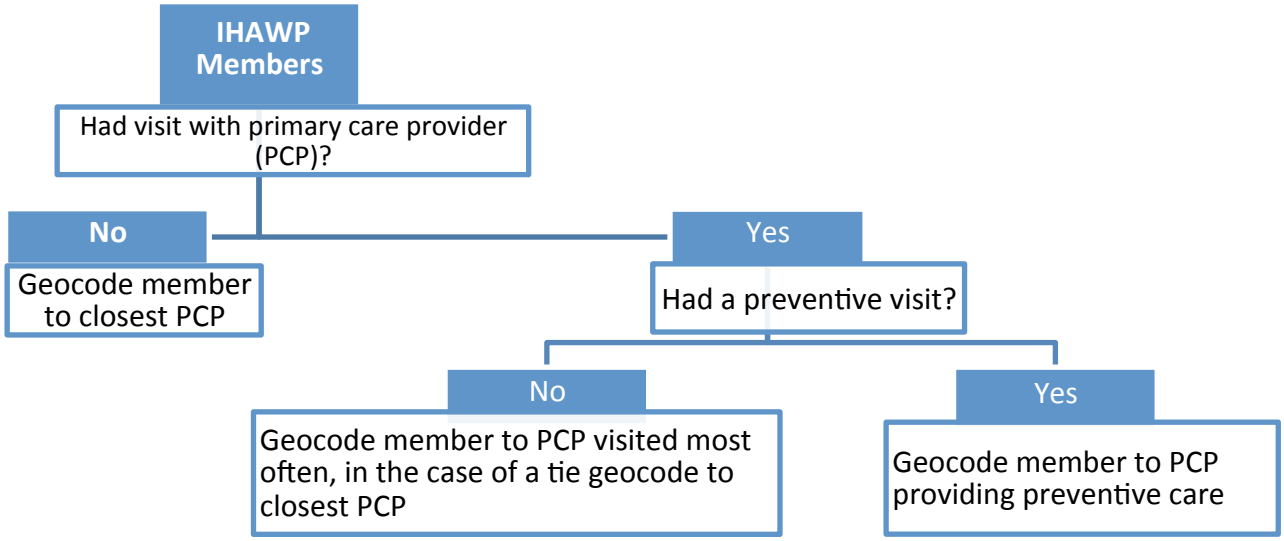
Geocoding combined with network analysis was used to determine the distance and travel time to a primary care provider (PCP) for IHAWP and Medicaid State Plan members. All members were enrolled for at least 1 month during the period January-June 2014 in IHAWP (Wellness Plan or MarketPlace Choice) or Medicaid State Plan (MediPASS or Fee-for-Service).

- IHAWP
    - Marketplace Choice-Coventry and CoOpportunity
      This group is only included in the mapping for members without claims as the QHP claims were not ready for analyses.
    - Wellness Plan and Medicaid State Plan
      These two group are included in both types of mapping as Medicaid claims were available.
    - IowaCare
      This group is included in both types of mapping. We did not utilize claims as IowaCare members were assigned a specific PCP. As they were required to utilize care at this location, we did not require claims for assignment purposes.

Primary care providers (PCPs) were defined as physicians or nurse practitioners who had a specialty of General Practice, Family Practice, OB/GYN, or Internal Medicine for women, we removed OB/Gyn as a primary care specialty for men. Internal Medicine specialists who listed a secondary specialty such as cardiology or endocrinology and clinics or providers that had no specialty or method of identifying specialty, even if they had provided a primary care visit, were removed.

Members with at least one claim for preventive care were mapped to the provider who provided this care as defined by the V70.X diagnosis codes or 99385 or 99386 CPT codes. If there were no claims for preventive care, the member was mapped to the provider with the most claims. In the case of a tie the member was be mapped to the closest provider. Members with no visits or with visits to providers that we could not match as primary care were mapped to the closest provider (Figure 6). Marketplace Choice members were not matched to PCP through claims as Marketplace Choice claims are not yet ready for analyses.

Figure 6. Process for geocoding/mapping PCPs to IHAWP enrollees



Location/Address data are cleaned prior to geocoding. Incomplete addresses and Post Office Box address are omitted from the dataset.[2] Geocoding was carried out in multiple steps. Locations were initially geocoded using an address locator created in ESRI ArcMap using the "North American Detailed Streets" dataset maintained by ESRI. Addresses incorrectly located, or unlocated after this process were located using a combination of ESRI geocoding API and Google Maps geocoding API.

To determine the nearest provider for each member, a network dataset was created using the North American Detailed Streets dataset maintained by ESRI. Non road pathways (i.e. bike trails) were omitted and a travel time for each section of roadway was calculated using the posted speed limit and section length. A small subset of roads lacking speed limit data were edited to have a 15 mph speed limit in order to avoid inflated travel times. The ESRI Network Analyst OD Cost Matrix tool was used to determine the closest provider to each enrollee without a provider number, which calculated the travel time and distance for each enrollee to the closest provider along the fastest travel route on the network (Manhattan distance). This may not be the shortest route, but better reflects actual route choice.

For members with a provider number the Straight-line (Euclidean) distance was calculated for each member to the identified provider. Straight-line distance was used for these cases due to time and processing limitations.

2 Hurley SE, et al. 2003. Post office box addresses: A challenge for geographic information system-based studies. Epidemiology 14(4):386-391.

Results

Members without a claim were mapped to the nearest PCP. IowaCare members are included in these analyses as claims were not needed to assign the PCP. Table 3 and Figures 7 and 8 provide information regarding time and distance to the nearest provider for IHAWP, Medicaid State Plan (MediPASS and Fee-for-Service) and IowaCare members. IHAWP members are generally closer to a PCP in both time and distance. As expected due to the nature of the program (8 providers in the state), IowaCare members were much further from a PCP. Practically all IHAWP and Medicaid State Plan members resided within 30 minutes or 30 miles of a PCP.

Table 3. Time and distance to nearest PCP

Study group	**Time (Minutes)**		**Distance (Miles)**	
	Mean	Maximum	Mean	Maximum
IHAWP-All	4.02	53.97	2.33	35.70
Medicaid	4.65	42.01	2.73	27.39
IowaCare	40.50	372.90	33.48	380.98

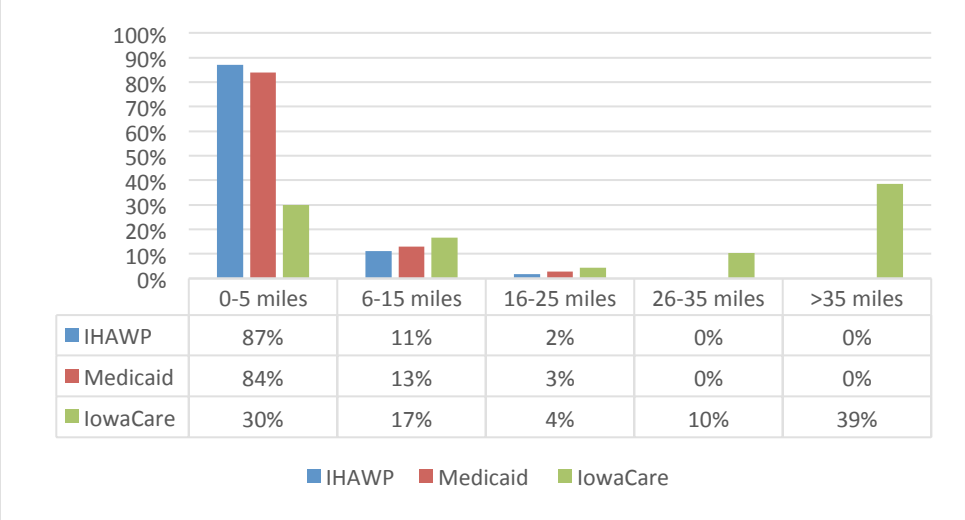


Figure 7. Distance in miles to nearest PCP by program

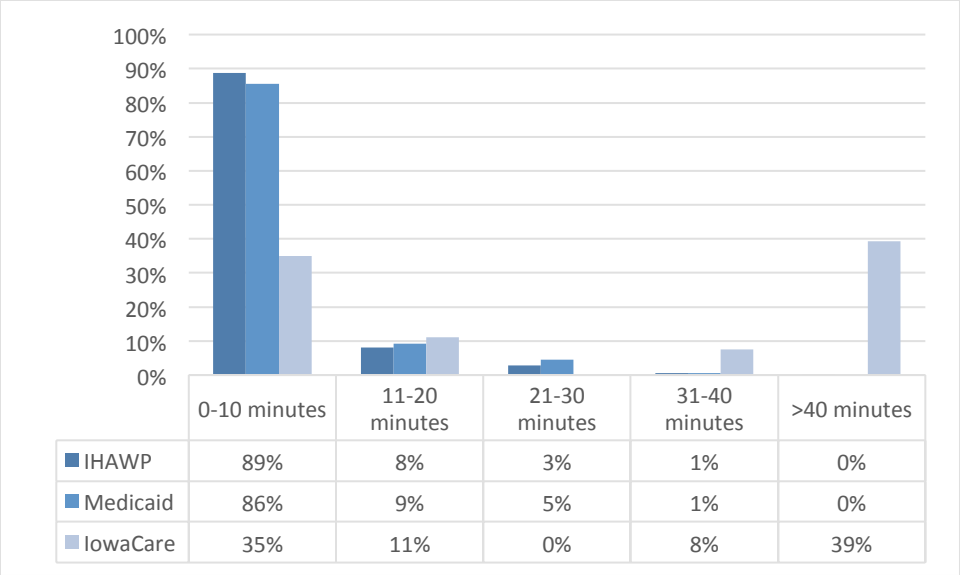


Figure 8. Time in minutes to nearest PCP by program

Members with a claim

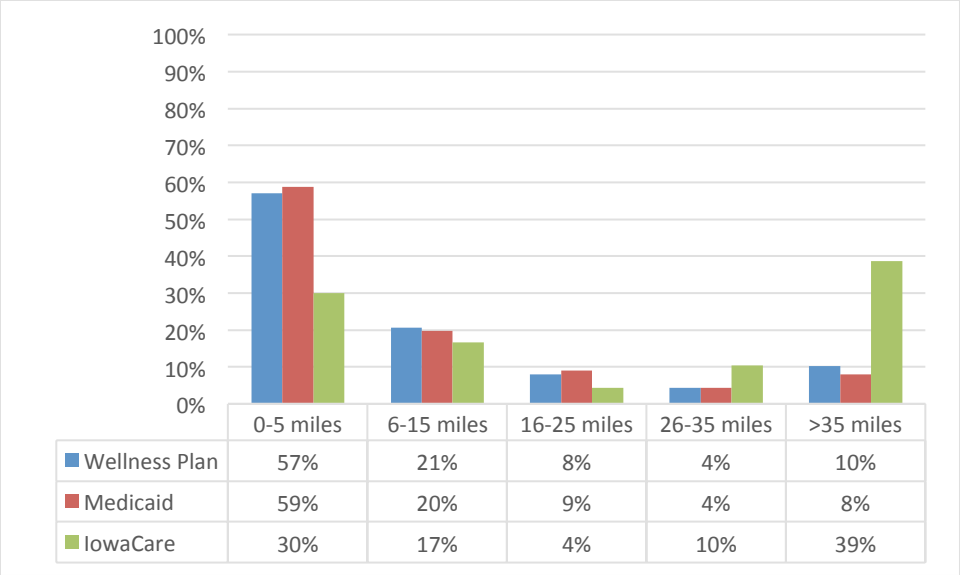
Medicaid and Wellness Plan members who had a visit(s) with a PCP were mapped to the PCP with whom they had the most visits and in the case of ties were mapped to the nearest provider. Often there were multiple ties resulting in a complex matrix structure (described above). The most efficient data manipulation allowed us to calculate straight line distances only as shown in Table 4 and Figure 9.

Results

Members with a claim were mapped to the PCP identified as providing the majority of preventive care. IowaCare members are included in these analyses as they are assigned a PCP. Table 4 and Figure 9 provide information regarding distance to the nearest provider for Wellness Plan, Medicaid State Plan (MediPASS and Fee-for-Service) and IowaCare members. Both Wellness Plan and Medicaid State Plan members travel nearly equal distances for care, while IowaCare members were much further from a PCP. For both Wellness Plan and Medicaid State plan 10% or less of the members had to travel more than 35 miles.

Table 4. Distance to nearest PCP

Study group	**Distance (Miles)**	
	Mean	Maximum
IHAWP-WP	11.24	291.63
Medicaid	12.85	353.91
IowaCare	40.50	372.90



	0-5 miles	6-15 miles	16-25 miles	26-35 miles	>35 miles
Wellness Plan	57%	21%	8%	4%	10%
Medicaid	59%	20%	9%	4%	8%
IowaCare	30%	17%	4%	10%	39%

Figure 9. Distance in miles to nearest PCP by program for members with at least one primary care visit

Conclusions

There appears to be no practical difference in the distance to a PCP in miles or minutes, as measured by network analysis, between IHAWP and Medicaid members. IHAWP members who were previously enrolled in IowaCare are closer to PCPs as part of this new program.

Analysis of Survey Results

Questions from the Survey

Q1. When you need to get to health care, what is the type of transportation you use most often to get to your visit? Response = No reliable method.

Q2. In the last 6 months, how often did you need assistance from other sources (such as friends, family, public transportation, etc.) to get to your health care visit? Response = Usually or Always needed assistance

Q3. In the last 6 months, was there any time when you needed transportation to or from a health care visit but could not get it for any reason? Response = Yes, Unmet need

Q4. Have you ever used transportation paid for by Medicaid to get to or from a health care visit? Response = Yes, used NEMT benefit

Q5. In the last 6 months, how much, if at all, have you worried about your ability to pay for the cost of transportation to or from a health care visit? Response = Worried a lot about ability to pay for transportation to/from health care visits

The tables include the following information:

- Table 1 provides the information that is already included in the brief with the comparison of the Medicaid State Plan to the combined IHAWP group. However, it includes the raw numbers for each question and the p-values and confidence intervals.
- Tables 2 and 3 compare each demo population separately to the Medicaid State Plan. Table 2 compares the Medicaid State Plan to the Wellness Plan and Table 3 compares the Medicaid State Plan to Marketplace Choice. Sample sizes, p-values, and confidence intervals are also provided for these comparisons.

Items were statistically significantly different if the $p<0.05$. Statistically significant differences are noted after each table.

Analysis of Survey Results

Table 1. Medicaid State Plan (MSP) v Iowa Health and Wellness Plan (IHAWP)

	Medicaid State Plan (n=670)	IHAWP (n=1792)	p-value	95% CI around Difference (IHAWP – MSP)
Q1. No reliable method to get to visits	1.9% (n=16/668)	2.5% (n=38/1780)	0.38	(-0.7, 1.9)
Q2. Usually or always needed help getting to health care visits	19.9% (n=131/667)	22.1% (n=331/1779)	0.24	(-1.4, 5.8)
Q3. Unmet need for transportation to health care visits	12.4% (n=85/662)	13.2% (207/1776)	0.59	(-2.2, 3.8)
Q4. Ever used Medicaid NEMT benefit	7.6% (n=50/664)	3.6% (n=53/1777)	<.001*	(-5.8, -2.1)
Q5. Worried a lot about ability to pay for transportation to/from health care visits	12.7% (n=83/661)	12.8% (n=196/1769)	0.99	(-3.0, 3.0)

* There was a statistically significant difference with IHAWP members being less likely to have used the Medicaid NEMT benefit in the past

Table 2. Medicaid State Plan v Wellness Plan

	Medicaid State Plan (n=670)	Wellness Plan (n=1101)	p-value	95% CI around Difference (WP – MSP)
Q1. No reliable method to get to visits	1.9% (n=16/668)	2.9% (n=33/1093)	0.22	(-0.6, 2.6)
Q2. Usually or always needed help getting to health care visits	19.9% (n=131/667)	24.5% (n=253/1090)	0.03*	(0.4, 8.9)
Q3. Unmet need for transportation to health care visits	12.4% (n=85/662)	15.1% (n=172/1088)	0.13	(-0.8, 6.2)
Q4. Ever used Medicaid NEMT benefit	7.6% (n=50/664)	4.0% (n=39/1089)	0.002**	(-5.8, -1.4)
Q5. Worried a lot about ability to pay for transportation to/from health care visits	12.7% (n=83/661)	14.4% (n=158/1083)	0.35	(-1.8, 5.2)

* There was a statistically significant difference with Wellness Plan members more likely to have usually or always needed help getting to their health care visits

** There was a statistically significant difference with Wellness Plan members less likely to have used the Medicaid NEMT benefit in the past

Table 3. Medicaid State Plan v Marketplace Choice

	Medicaid State Plan (n=670)	Marketplace Choice (n=691)	p-value	95% CI around Difference (MPC – MSP)
Q1. No reliable method to get to visits	1.9% (n=16/668)	0.7% (n=5/687)	0.10	(-1.2, 1.1)
Q2. Usually or always needed help getting to health care visits	19.9% (n=131/667)	11.3% (n=78/689)	<.001*	(-6.4, -2.2)
Q3. Unmet need for transportation to health care visits	12.4% (n=85/662)	5.1% (n=35/688)	<.001**	(-5.3, -2.0)
Q4. Ever used Medicaid NEMT benefit	7.6% (n=50/664)	2.0% (n=14/688)	<.001†	(-4.1, -1.5)
Q5. Worried a lot about ability to pay for transportation to/from health care visits	12.7% (n=83/661)	5.6% (n=38/686)	<.001††	(-5.3, -1.9)

* There was a statistically significant difference with Marketplace Choice members less likely to have needed help getting to their health care visits

** There was a statistically significant difference with Marketplace Choice members less likely to have unmet need for transportation to their health care visits

† There was a statistically significant difference with Marketplace Choice members less likely to have ever used Medicaid NEMT benefits in the past

†† There was a statistically significant difference with Marketplace Choice members less likely to have worried a lot about their ability to pay for transportation to/from health care visits

Iowa Department of Human Services
Notice of Public Comment Period for Changes in the Iowa Health and Wellness Plan

The Iowa Health and Wellness Plan, that began on January 1, 2014, is a Medicaid program created to provide comprehensive health care coverage to low-income, uninsured Iowans ages 19 to 64.

The Iowa Health and Wellness Plan is one program that includes two separate coverage options. Eligibility is based on household income.

- *Iowa Wellness Plan*: Covers adults ages 19 to 64 whose income is at or below 100 percent of the Federal Poverty Level. The Iowa Wellness Plan is administered by Iowa Medicaid. Members have access to the statewide Medicaid provider network which means they have access to care from providers and hospitals in their local communities.
- *Marketplace Choice Plan*: Covers adults age 19 to 64 with income from 101 percent through 133 percent of the Federal Poverty Level. The Marketplace Choice Plan allows members to select from participating commercial health care coverage plans available through the Health Insurance Marketplace. Medicaid pays the premiums to the commercial health plan on behalf of the member. Members have access to the network of local health care providers and hospitals served by the commercial insurance plan.

Benefits of the Iowa Health and Wellness Plan are based on the state employees' commercial health insurance plan and do not contain the extensive benefits traditionally associated with Medicaid under the State Plan. This commercial approach specifically excluded non-emergency medical transportation (NEMT). The Centers for Medicare and Medicaid Services (CMS) granted the state a waiver of NEMT through December 31, 2014, with possible extensions based on an evaluation of the impact on access to care. On December 30, 2014, the CMS approved the extension of the NEMT waiver from January 1, 2015 through July 31, 2015.

This serves as the Department of Human Services' (DHS) notice of the request to extend the NEMT waiver after July 31, 2015, with a **30-day public comment period, which closes May 24, 2015, at 4:30 pm.**

As required by 42 CFR § 440.386, DHS also provides notice that this change will not impede EPSDT eligible individuals from having access to the full EPSDT benefit available at 42 CFR § 440.345.

Information about the Iowa Health and Wellness Plan and the NEMT waiver is available at: http://dhs.iowa.gov/ime/about/iowa-health-and-wellness-plan.

Written comments may be addressed to Nick Peters, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent to the attention of: **DHS, Iowa Health and Wellness Plan** at:

DHSIMEHealthandWellnesPlan@dhs.state.ia.us through May 24, 2015. The public, by contacting Nick Peters at the above address, may review comments received.

Submitted by:
Julie Lovelady
Interim Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services

NEMT Waiver Amendment - Public and Tribal Comment Summary

The state is requesting to continue waiving Non-Emergency Medical Transportation (NEMT) services for members under the Iowa Health and Wellness Plan (IHAWP) through December 31, 2016. The state gave public and Tribal notice in April 2015, which included a 30-day public comment period of April 24 through May 24, 2015. A 30-day Tribal comment period ran from April 16 through May 16, 2015. The state received a total of five public comments. No Tribal comments were received.

None of the public comments supported extension of the NEMT. A summary of these comments is provided below:

- The majority of the comments expressed the need for NEMT as a critical service that plays an essential role in helping the most vulnerable population access necessary healthcare.
- References were made to historical data that supports the need for NEMT for low-income individuals and that transportation barriers can lead to poor outcomes and increased costs overall.
- Some comments indicated the study revealed significant differences between the comparison groups (IHAWP and traditional Medicaid).

Summary reflects comments from the following organizations:

1. Child and Family Policy Center
2. Peoples Community Health Clinic
3. Community Transportation Association of America
4. Iowa's Olmstead Consumer Task Force
5. Iowa Primary Care Association

Additional comments were shared by individuals during the Medical Assistance Advisory Council (MAAC) meeting on May 28, 2015. The majority of individuals expressed concerns that some members will have unmet needs for transportation to medical visits and were not in support of extending the NEMT waiver.