



Getting to Care: A Look at Medi-Cal's Transportation Benefit

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Executive Summary

To improve access to care for Medi-Cal (California’s Medicaid program) enrollees, state lawmakers significantly expanded transportation coverage in 2016. Before the expansion, Medi-Cal’s transportation benefit included non-emergency medical transportation (NEMT), which covers transportation to medical appointments for those who need specialized transport by ambulance, wheelchair van, or litter/gurney van, and require door-to-door assistance. The 2016 law — AB 2394¹ — created a second, complementary benefit called non-medical transportation (NMT), which covers transportation to non-emergency medical services for enrollees who can reasonably walk or move about and can therefore use public (e.g., bus or train) or private (e.g., rideshare, taxi, car) modes, and who have no other means of transportation. Together, the two benefits (NEMT and NMT) cover transportation to non-emergency medical services for most Medi-Cal enrollees.²

This report was commissioned to provide an overview of the implementation and experiences of the NMT benefit established in 2016. The information and analysis in this report draws from interviews with key informants including representatives from Medi-Cal managed care plans (MCPs), state officials from the Department of Health Care Services (DHCS), a small group of Medi-Cal enrollees who have used the benefit,³ consumer advocates, transportation brokers, providers, policy experts, and other state Medicaid officials. The report also draws on utilization and cost data provided to the authors by five MCPs and through publicly available policy and regulatory documents.

The research for this report was conducted before the COVID-19 pandemic, so the data and findings do not reflect the impact of the pandemic on NMT implementation, utilization, or experience. Of note, the COVID-19 pandemic has reduced use of routine health care services, as many enrollees have delayed or avoided in-person care. Additionally, new federal and state policy flexibilities have increased the ability for enrollees to access providers through technology

such as telehealth and e-visits. If these policies are retained in the long term and enrollees continue to access some care remotely, the impact on NMT demand and use should be studied.

Key Findings

The paper goes into detail on several key findings: NMT is a comprehensive benefit valued by a small fraction of Medi-Cal enrollees with recurring needs. Enrollees who have used the benefit reported that NMT is the main source of transportation to their medical appointments and that transportation supports are critical to maintaining their health.

NMT has the potential for ballooning costs due to limited service authorization requirements and heavy reliance on rideshare companies. MCPs were required to implement the benefit quickly, amid shifting policy guidance, and most decided to delegate the responsibility to transportation brokers. Some provider organizations and consumer groups representing Medi-Cal enrollees report significant administrative and operational challenges with the NMT benefit that cause frustration and limit access. Most Medi-Cal enrollees do not use the benefit, potentially because either they are unaware of its availability or they have less need for the service. Medi-Cal enrollees may still have unmet transportation needs, especially in rural and frontier areas.

The paper outlines several potential policy considerations to improve the NMT benefit and make it easier for more enrollees to use including:

- ▶ **Merge NEMT and NMT into a single comprehensive benefit.** Lawmakers may want to consider if the distinction between the NMT and NEMT benefits is necessary, or if merging the benefits would reduce confusion and improve access.
- ▶ **Require more outreach and communication to providers and enrollees.** DHCS should explore information gaps and opportunities to communicate

effectively with providers, enrollees, and MCPs about the NMT benefit and how to use it.

- ▶ *Address rural and frontier area barriers to service.* Transportation services in rural and frontier communities are limited and creative solutions are needed.
- ▶ *Evaluate the feasibility of including transportation to social services and supports in the NMT benefit.* For enrollees with high needs, providing access to social services and supports could help to address social needs and improve enrollee health and well-being.
- ▶ *Explore NMT driver credentialing or other transportation provider oversight.* Proper quality oversight should be put in place while balancing the need to ensure broad access.
- ▶ *Analyze and publish statewide utilization and cost data reported to DHCS.* Analysis of the existing DHCS data would help answer important questions and inform the directionality of Medi-Cal transportation policy and programs.

Introduction

Acknowledging that access to transportation can be a major obstacle for many Medicaid enrollees and that missed or delayed health care can result in exacerbated medical conditions, poorer health outcomes, and increased costs of care, federal law requires all state Medicaid programs to include a transportation benefit.⁴ While the exact scope and design varies by state, the Medicaid benefits typically include transportation by wheelchair van, private vehicle (either by rideshare, taxi, and/or mileage reimbursement), and public transportation. In general, Medicaid enrollees are eligible for the transportation benefit if (1) the transportation is necessary to get to a covered medical appointment or service, (2) the enrollee does not have another means of transportation, and (3) it is the lowest-cost option that meets the enrollee's needs.

California's Medicaid program, Medi-Cal, through its NEMT benefit, has long covered transportation to medical appointments for enrollees who need specialized transport by ambulance, wheelchair van, or litter/gurney van. Historically, Medi-Cal also covered a more expansive transportation benefit for enrollees under age 21 to access Early and Periodic Screening, Diagnostic, and Treatment services.

In response to concerns that transportation remained a critical barrier to health care for many Medi-Cal enrollees, especially those living in rural and frontier areas,⁵ in 2016 California passed legislation to expand its transportation coverage.⁶ The legislation created a non-medical transportation (NMT) benefit for all Medi-Cal enrollees, and expanded on the transportation options available. NMT provides transportation to medical services for Medi-Cal enrollees who can reasonably ambulate and can therefore use public transportation (e.g., bus or train) or private transportation (e.g., rideshare, taxi, car). Despite its name, California's NMT benefit does not cover transportation to appointments or services that are not medically related, such as those that may address social needs.

This report was commissioned to provide an overview of the implementation and experiences of the NMT benefit. Specifically, the report:

- ▶ Distinguishes between Medi-Cal's two transportation benefits — NEMT and NMT
- ▶ Explores NMT benefit implementation, operations, utilization, and impact
- ▶ Offers considerations for improving NMT policy and programs

Methods

The findings provided in this report are based on information obtained in structured interviews, analysis of utilization and cost data from a subset of Medi-Cal managed care plans (MCPs), and additional policy and regulatory research.

Interviews

The authors of this report completed more than 40 structured interviews in June and July of 2019 (see the appendix). Interviewees included staff from 19 of the 24 MCPs, as well as safety-net providers, trade association representatives, consumer advocates, health policy researchers, and other state Medicaid officials. Emphasis was placed on getting input from key informants in rural and frontier areas, since the implementation of the NMT benefit had an explicit focus on increasing access to transportation in these areas.

The research firm PerryUndem worked with two MCPs to identify and recruit Medi-Cal enrollees who have accessed the NMT benefit, and then conducted 16 telephone interviews (2 in Spanish and 14 in English) in January and February 2020. Findings from those interviews are incorporated here.

Data Analysis

DHCS collects monthly utilization data from MCPs on the NMT benefit. While the authors requested these data, DHCS did not provide them. In the absence of statewide data, the authors received and analyzed data from the beginning of 2017 through the end of 2019 provided by five MCPs: three County Organized Health Systems (COHS), one local initiative, and one commercial plan.⁷ Since MCPs collect and analyze their internal transportation data differently, the data received were not consistent across plans. In some analyses the authors integrated the monthly MCP enrollment data from the California Health and Human Services Agency's Open Data Portal.⁸

For the reasons above, the data presented throughout this report allow for narrow quantitative illustrations of the NMT benefit implementation and cannot be generalized to the statewide experience. Given the small number of plans that submitted data, plan names have been omitted from the analysis.

Limitations

This paper presents an early look at implementation of the NMT benefit, informed primarily by qualitative interviews. A few important limitations should be considered when interpreting findings:

- ▶ Statewide data were unavailable and therefore, conclusions about benefit utilization and cost should be interpreted with caution. Quantitative data from individual health plans are shared as illustrative or in combination with qualitative data and may not be representative of statewide trends.
- ▶ This paper does not attempt to estimate underlying need for transportation services among Medi-Cal enrollees, and it is unknown the extent to which transportation remains a barrier to care after NMT benefit implementation.

- ▶ A small number of Medi-Cal enrollees were interviewed for this research. These enrollees were well connected to NMT through their health plans. This research may not have adequately captured the experiences of enrollees who have had less success with NMT and have unmet transportation needs.

NEMT and NMT: What Is the Difference?

California's Medicaid program distinguishes between NEMT and NMT. Other states offer a comprehensive Medicaid transportation benefit referred to as NEMT, which is inclusive of what California covers in its separate NEMT and NMT benefits. Understanding that the distinction between NEMT and NMT has caused confusion among enrollees, providers, and other stakeholders, this report provides more detail to describe and differentiate the two benefits. See Table 1 on page 7 and the flowchart on page 8 for more information.

Table 1. NEMT and NMT Eligibility, Benefits, and Transportation Types

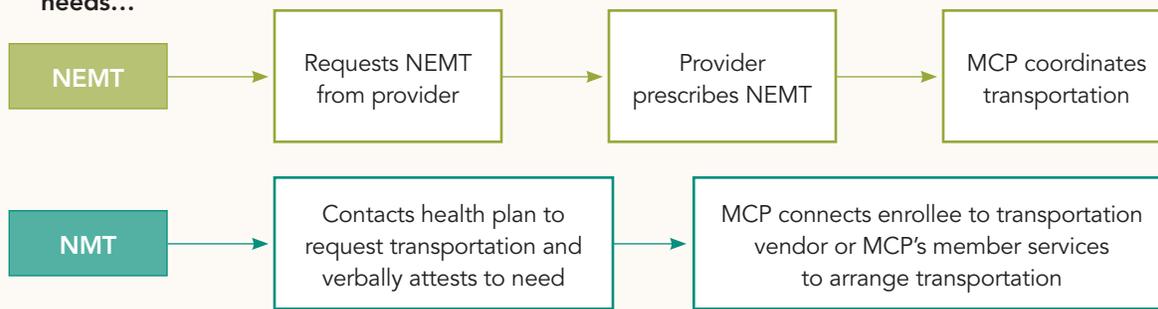
	NEMT	NMT
Eligibility	Available to both limited and full-scope fee-for-service (FFS), and to MCP enrollees.	Available only to full-scope FFS and MCP enrollees and limited-scope pregnant women (including 60 days postpartum).
Transportation providers	Provided by specialized vehicle: ambulance, wheelchair van, or litter/gurney van, and specially trained staff.	Provided by non-specialized vehicles: bus, train, rideshare (Uber/Lyft), taxi, and mileage reimbursement in some circumstances.
Authorization	Enrollees must have a signed Physician Certification Statement (PCS) form that verifies the enrollee is unable to travel by bus, passenger car, taxicab, or another form of public or private transportation and may require door-to-door assistance. ⁹	Enrollees must be ambulatory and attest that all other transportation options have been reasonably exhausted. Enrollees must attest that any of the following applies: the enrollee does not have a valid drivers license, there is no working vehicle available in the household, the enrollee is unable to travel or wait for covered Medi-Cal services alone, or the enrollee has a physical, cognitive, mental, or developmental limitation. ¹⁰
Accessing services	Enrollees in Medi-Cal managed care must provide a PCS form and use the health plan’s member services department to request NEMT. FFS Medi-Cal enrollees needing NEMT must obtain a prescription from their health care provider who will then work with a transportation provider to coordinate rides to and from their medical appointments, or they can contact a Medi-Cal FFS field office for assistance. Approval times vary by MCP, but are generally between 3 and 5 days, and DHCS guidance suggests requesting NEMT at least 5 days in advance.	Enrollees in Medi-Cal managed care contact their plan’s member services department to request NMT or contact the plan’s broker directly. Full-scope FFS enrollees may contact enrolled transportation providers directly if they live in one of the 26 counties where transportation providers are enrolled; otherwise, they must email DHCS for assistance with arranging transportation. NMT generally requires 72 hours’ advance notice (except when urgent), and MCPs must make NMT arrangements available 24/7.
Transportation to out-of-network providers and noncovered services	MCPs must fulfill an NEMT request from an out-of-network provider if the enrollee has been referred to or approved to see that out-of-network provider. For a service not covered by the MCP, the MCP is required make its best effort to refer and coordinate NEMT but is not required to provide it. For FFS, NEMT is provided for all covered Medi-Cal services.	MCPs must coordinate transportation to appointments not covered by the MCP contract, such as serious behavioral health and substance use disorder (SUD) services, and other health care–related activities including picking up prescriptions or medical supplies and equipment.* For FFS, NMT is provided as noted above for all covered Medi-Cal services.

*Pharmacy benefits are currently provided by MCPs, but will be provided through the FFS delivery system effective January 2021. [Executive Order N-01-19](#) (PDF) (January 7, 2019).

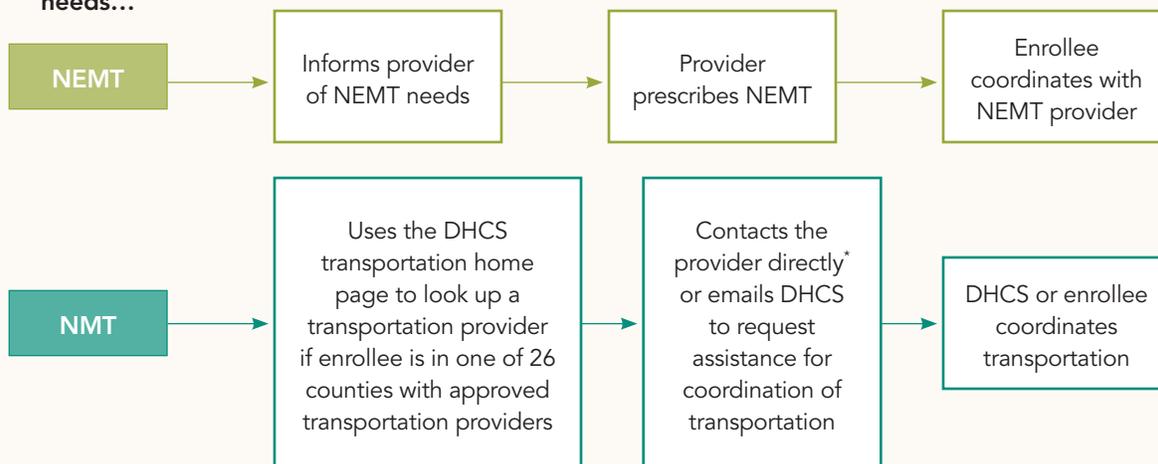
Navigating Med-Cal Transportation Benefits Is Confusing

The following flowcharts outline the various processes enrollees (and their health care providers) must follow to obtain transportation services in Medi-Cal. Of note, the process varies by whether the enrollee is trying to access NEMT or NMT, as well as by whether the enrollee is an MCP enrollee or a FFS enrollee.

MCP enrollee needs...



FFS enrollee needs...



*"Transportation Services," DHCS, last modified September 25, 2020.

Findings

Interviewed Medi-Cal Enrollees Say NMT Improves Access to Care

Most of the 16 enrollees interviewed by PerryUndem reported that NMT is the main source of transportation to their medical appointments and that transportation supports are critical to maintaining their health. Enrollees reported using NMT services for several reasons:

- ▶ Unable to drive due to health issues or major life events (e.g., accidents, major health conditions that preclude them from driving, or experiencing financial difficulties)
- ▶ Not owning a car or having a drivers license
- ▶ Not having the money to pay for gas or other transportation services (e.g., bus, Lyft, Uber)
- ▶ Unavailability of family members and friends to give them a ride
- ▶ Not feeling comfortable driving to their medical appointments

One woman used the NMT service because of a high-risk pregnancy that made it difficult for her to take a bus to appointments, and she said she could not afford other options like Lyft and Uber. Another enrollee had to travel far distances for appointments — up to 240 miles round trip for one in a frontier area — which would have been cost-prohibitive without NMT.

Many of the enrollees reported that before the availability of the NMT benefit, they often relied on public transportation and in most cases, this was the bus. Enrollees reported that taking the bus meant long waits and long walks to and from bus stops, turning what would be a 20-minute car ride into an “all-day” event on the bus. One enrollee seeking care for mental health challenges described how difficult it was to get motivated to leave her home and walk to the bus stop knowing she was facing a long commute to her appointment.

The enrollees interviewed were thankful for the NMT benefit and reported that the availability of NMT is key to the management of their health and believe they would struggle if the service were no longer available. Lacking reliable or affordable transportation options before the implementation of NMT, some enrollees said they missed medical appointments and could not consistently access the pharmacy to obtain prescribed medications. A few said they lived in fear that their doctor would drop them if they missed too many appointments. Enrollees reported that without NMT, missed appointments would become a fact of life again.

“I did have doctors’ appointments, but I was missing them due to not being able to get a ride. I was not getting my medication, and I wasn’t taking my medication right because they won’t give them to you if you can’t get to a doctor, and you can’t get to the doctor if you don’t have a ride.”

“It’s all very different, because like I said, 40 days of taking me to and from the doctor, imagine how much that would have cost me. And I didn’t pay a single cent when they were taking me every day. And at day 40 I was declared cancer free!”

Delivery of NMT Benefit Relies Heavily on Transportation Brokers and Rideshare Companies, Which Has Quickly Expanded Access but Created Concerns Around Cost and Quality

The Majority of MCPs Delegate NMT to Transportation Brokers

Due to the requirement that NMT must be available 24 hours a day, 7 days a week, most MCPs found that it was necessary to delegate the benefit to transportation brokers. Transportation brokers have long provided NEMT services in California,¹¹ and MCPs were able to build upon existing relationships or quickly engage these companies to manage NMT. Transportation brokers manage the entire transportation benefit including prior authorization; utilization management; customer service; provider credentialing, licensing, and oversight; and network development.¹² As of July 2019, 18 MCPs reported using a transportation broker, 4 are managing the transportation benefit internally, and 2 are contracting with providers for use of their fleet but are otherwise managing the benefit internally.

Other states have also found it necessary to rely on transportation brokers to manage their transportation benefit. For example, in Colorado, the state legislature approved a move to a statewide broker, and the Medicaid agency began a contract with IntelliRide on September 1, 2019, to arrange for all Colorado Medicaid transportation services. State officials in Idaho also moved to a contract with a transportation broker because of the added oversight of vehicle safety and driver credentialing required of their contracted providers.

Despite the increased oversight and administrative simplification that transportation brokers can provide to MCPs, some challenges with this model were noted during the key informant interviews. Consumer advocates reported that communication difficulties between

NMT drivers and enrollees were more prevalent when a transportation broker was handling the NMT benefit. These communication issues were reported to cause delays in notification to an enrollee about the status of their ride and delays in access. It was explained that this break in communications occurs because of the established process: The enrollee generally contacts the MCP or broker to request the benefit, the MCP or broker communicates with the driver, and the enrollee is cut out of any communication with their assigned driver. When drivers do not have a way to directly communicate with the enrollee, confusion and delays in scheduling rides or resolving issues are often the result. Broker arrangements that allow for direct communication with the enrollee can help mitigate these access issues.

The enrollee interviews also revealed some complaints regarding customer service, including long hold times while trying to schedule a ride, or lacking a helpful customer service representative. One enrollee described a time when a driver only dropped her at her appointment but never returned to pick her up as scheduled. When she tried to contact customer service, they were closed since it was Saturday and she had to find another way to get back home. This demonstrates that the scope and delivery of the Medi-Cal transportation benefit requires improved communication between plans, brokers, and enrollees.

Several MCPs reported that creating a no-wrong-door approach, where enrollee phone calls would be automatically routed to the transportation broker regardless of where they called, was very helpful in streamlining the NMT process and reducing enrollee confusion when using a transportation broker. MCPs also educated member services staff on how to best assist enrollees seeking transportation.

Most NMT Trips Are Provided by Rideshare Drivers

MCPs reported that the number of trips provided by rideshare drivers such as Lyft and Uber are exceeding the number provided by bus or other means of public or private transportation. Quantitative data provided by three MCPs support that conclusion, with rideshare trips accounting for just over 89% of the NMT trips, although the share has varied by plan and over time, as shown in Figure 1.

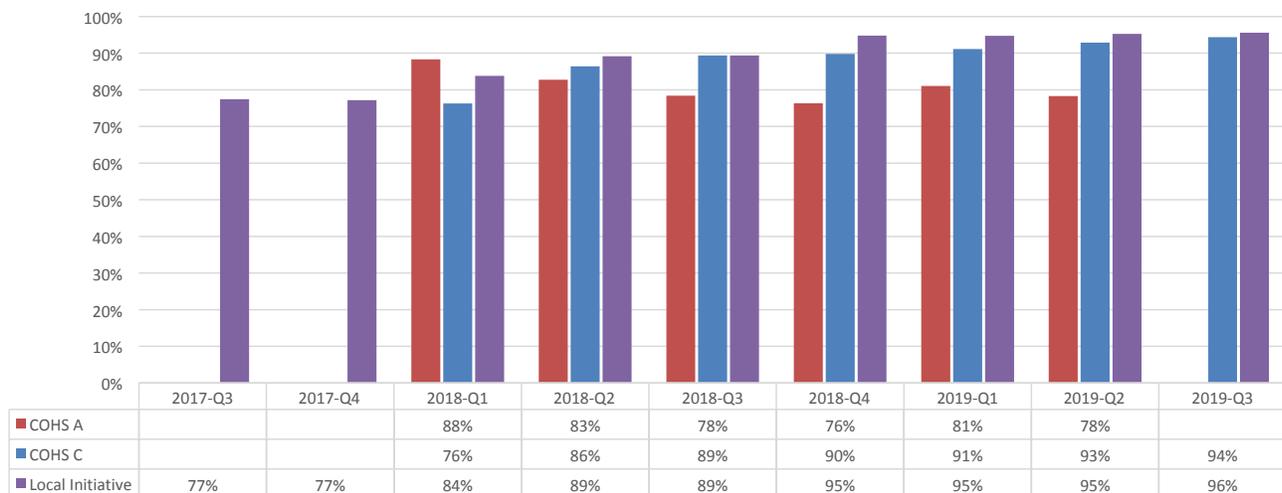
Key informant interviews attributed the high volume of rideshare use in part to enrollee preference and lack of public transit options. Enrollees often request this mode of NMT because it provides curb-to-curb services. In addition, several plans cover rural and frontier geographies where public transportation may be inadequate. Even in mostly urban geography, MCPs noted that using public transit between cities requires using different metropolitan bus systems that do not necessarily offer easy connections or reciprocal transfer passes. Consequently, rideshare is a more effective transportation option in these circumstances.

Rideshare also has advantages for MCPs. It allowed them to quickly expand their transportation networks and respond to enrollee transportation needs, and rideshare companies make it easy to track in real time where enrollees are going to ensure the ride is completed to and from the correct location.

While rideshare may be the most accessible and enrollee-preferred mode of transportation, MCP staff reported concerns with the high cost compared to alternative options. As a result, many MCPs have implemented utilization controls intended to ensure the most cost-effective transportation option is used, as required by regulation. These and other utilization management controls are described later in the paper.

In addition to the concerns about cost, rideshare may not offer enough support for some Medi-Cal enrollees or sufficient oversight of drivers. Consumer advocates expressed concerns that MCPs are using NMT rideshare when more supportive transportation services (e.g., door-to-door instead of curb-to-curb service) would be appropriate. Additionally, rideshare drivers

Figure 1. Share of Non-Medical Transportation Trips Provided by Rideshare Services, California, 2017-Q3 to 2019-Q3



The data used for these analyses were provided by five Medi-Cal managed care plans, including three County Organized Health Systems (COHS), one local initiative plan, and one commercial plan. Given the small number of plans that submitted data, plan names have been omitted from the analysis; instead, the three COHS plans are referred to as COHS A, COHS B, and COHS C, and the other two plans are simply described as “Local Initiative” and “Commercial Plan,” respectively.

Source: Data were provided by three Medi-Cal managed care plans.

are not required to have any specialized training or certification to assist Medi-Cal enrollees who may have specialized needs. Uber and Lyft are only required to review an individual's driving record and criminal history. By contrast, NEMT companies (which generally serve different population with different needs) are required to be enrolled as Medi-Cal providers, and drivers must be credentialed. The credentialing process includes verification of first aid / CPR certification; defensive driving certification; HIPAA compliance attestation; fraud, waste, and abuse training; passenger-assistance training certification; drug screening; and background checks.¹³

To address this need, there has been a movement in the rideshare industry to adjust and create specialized transportation options for Medicaid. For example, both Uber and Lyft have launched health care arms and are working with the industry to create unique platforms that are HIPAA compliant. By making these changes, the rideshare industry is working towards demonstrating that it can meet regulatory requirements of Medicaid programs and that solutions that

recognize the needs for medical transportation must be made available if it wants to expand this line of business.

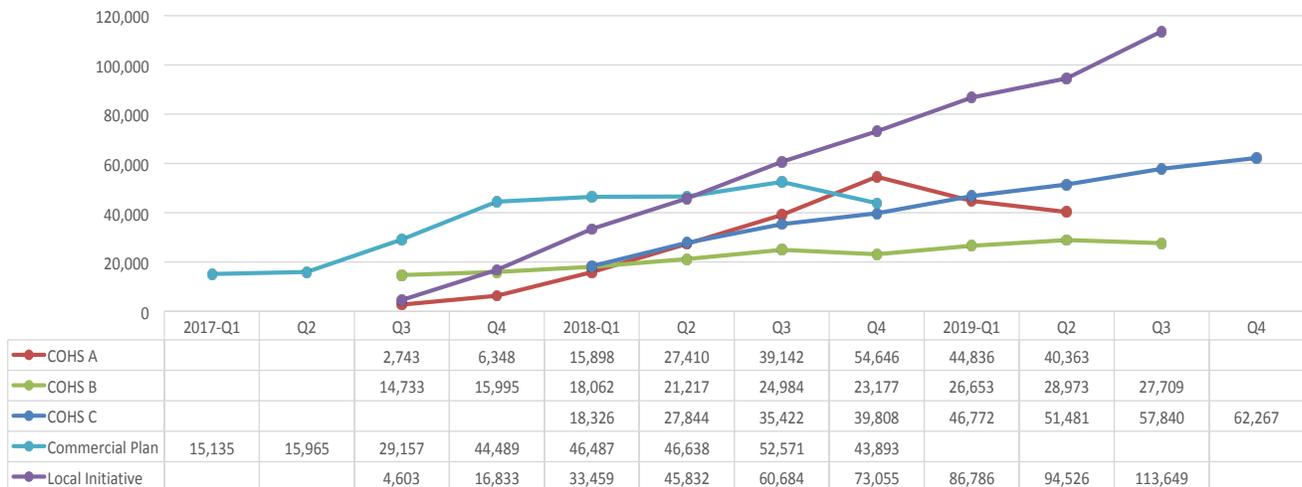
Medi-Cal Enrollees May Still Have Unmet Transportation Needs

Use, While Increasing, Is Highly Concentrated Among a Small Subset of Members

Quantitative data provided by the five MCPs for this study indicate that NMT use, as measured by trips, has increased since 2017 (see Figure 2). However, only a small fraction of MCP members appear to use NMT services. Of the five MCPs that shared data for this report, only one (COHS B) provided data on the number of unique NMT users (see Figure 3 on page 12). For this health plan, NMT use has been limited to less than 0.5% of enrollees in any given month.

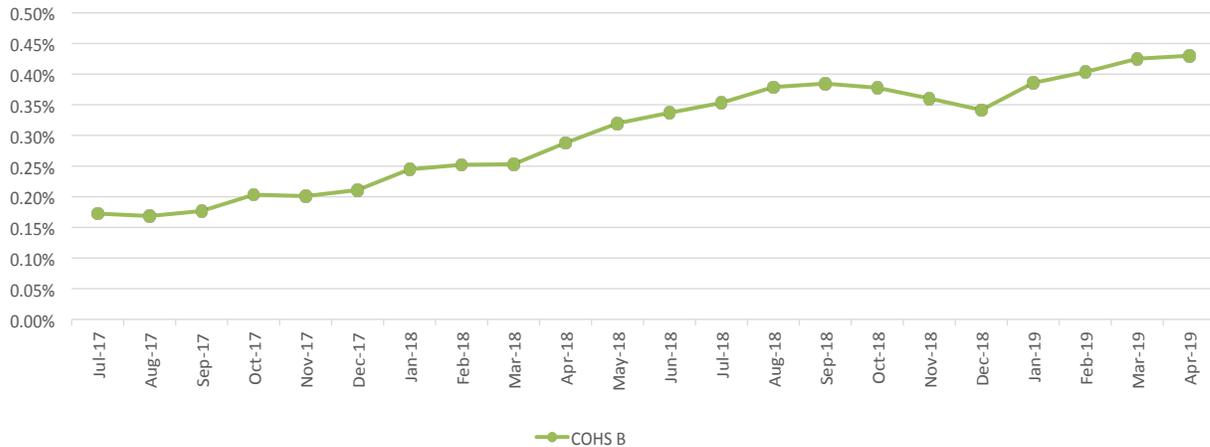
Consistent with the data that were provided by COHS B, other plans reported during interviews that approximately 1% of enrollees use NMT. MCPs,

Figure 2. Completed Non-Medical Transportation Trips, California, 2017 to 2019



Source: Data were provided by three Medi-Cal managed care plans.

Figure 3. Monthly Unique Non-Medical Transportation Users as a Percentage of Total Members, California, July 2017 to April 2019



Source: Unique rider data were provided by the Medi-Cal County Organized Health System. Membership data were downloaded from the California Health and Human Services Agency's Open Data Portal.

providers, and advocates all reported that the highest volume of NMT trips are for dialysis appointments, followed by other specialty care needs that require frequent appointments like substance use disorder treatment, chemotherapy, or physical therapy. Of note, Medicaid officials from Rhode Island also reported that only a small fraction of its Medicaid enrollees (about 3%) utilize the benefit, and many are repeat users. For Rhode Island, the more frequent rides are to dialysis, SUD treatments, and adult day care.

Access to Transportation in Rural and Frontier Areas Remains a Challenge

In rural and frontier areas of the state, providers interviewed remarked at the limited provision of the benefit by the responsible MCP. They attributed this mainly to the lack of transportation providers — ride-share or vans — in remote areas but also to limited investment and staff resources from the MCP. Clinics located in rural and frontier areas noted that arranging a ride through the MCP transportation broker took too long, and frequently no ride was ultimately available.

Additionally, the challenges of using rideshare for NMT in rural and frontier counties was noted by several key informants. In an eastern frontier county, the county representative interviewed noted that Uber and Lyft only provide service in a single population area and not in the rather sprawling outlying areas. In addition, a Lyft policy restricted one-way distances to under 117 miles, and most enrollees needing specialty services or outpatient surgery must travel as many as 200 miles each way.

Another major challenge identified with rideshare use in these counties was the high rate of “no-shows,” meaning either the driver or the enrollee did not show as expected. Both MCPs and consumer advocates reported that drivers would cancel rides or not show up in rural or frontier areas. Transportation brokers confirmed that because drivers are not compensated for their time if the enrollee does not complete the ride (aside from a flat rate for the ride out), and because it is unlikely the driver will be able to pick up another rider in a rural area, it is a real challenge to secure rideshare drivers. One MCP reported utilizing taxis instead of ridesharing services, but this results in MCPs paying for the transportation whether or not the ride is completed.

To address these access issues, providers in rural areas have taken additional steps to alleviate the barriers for enrollees, often working around the NMT program. One clinic noted that they use their own van and finance the cost directly. Another clinic found it easier to simply provide the cellphone number of their van driver to the small number of patients who use the service. Other providers implemented additional strategies such as scheduling rides with the MCP transportation broker well in advance of an appointment or contracting with the MCP transportation broker directly to use their van for rides. While these approaches and other limited solutions have been used to increase access, challenges remain for NMT to be sustainable in the rural and frontier areas of the state.

Colorado, a largely FFS state, also reported challenges with provider capacity in the rural and frontier areas, especially for enrollees with higher needs for assistance. To address this challenge, Colorado identified that its current rate structure — mileage bands that result in lower reimbursement for longer rural trips — may create a disincentive for providers to cover those areas, thus exacerbating the problem. Colorado also explored the use of ridesharing (Uber/Lyft) to alleviate some of the provider capacity issues but noted that fluctuating prices (peak vs. off-peak) made financing transportation in a FFS environment challenging. The state currently uses taxis to provide transportation for ambulatory enrollees and has standardized reimbursement rates, so there is no fluctuation in the reimbursement for the transportation service. California should examine how a similar evaluation of reimbursement and identification of alternative models may help increase access in rural and frontier areas.

Access to Social Services and Supports Remains a Gap

In key informant interviews with consumer advocates, providers, and MCPs, it was noted that while the NMT benefit is expansive, there remains a gap in available transportation for non-medical needs, such as access to social services and supports. As California explores options to support Medi-Cal enrollee access to social supports, it must also examine how transportation access to these vital services can be improved.

For example, Arizona expanded its Medicaid transportation benefit to include transportation to some noncovered services (e.g., grocery stores, Alcoholics Anonymous meetings, and community activities for social services) when providers determine they are necessary.¹⁴ Colorado operates 10 waiver programs that cover approximately 50,000 enrollees who may qualify for rides to and from non-medical activities such as grocery shopping, visiting family, or art therapy. In both states, the expansion of the transportation benefit to support social needs has included strict eligibility and utilization criteria, which are likely intended to limit utilization and control costs.

Concerned About Cost, MCPs Have Slowly Tightened Utilization Controls

Many MCPs reported concerns that the state had not estimated the true cost of NMT and said that their NMT costs exceeded premium revenues received from the state to provide the benefit. Available data from MCPs suggest that cost of the overall NMT benefit is rising over time, and as access to NMT expands this trend is expected to continue.

In response to rising utilization and costs, MCPs have tightened utilization controls. This reaction may have been somewhat delayed because MCPs reported that, due to the confusion around the implementation of the NMT benefit, and its expansive scope, the general default (and expectation of DHCS) at the initial implementation was to approve most if not all requests to avoid delays or disruption in care.

Utilization management strategies reported by the MCPs include, but are not limited to:

- ▶ Requiring prior authorization processes for NMT services and reauthorization every 12 months for ongoing approvals
- ▶ Requiring enrollees to make travel arrangements as soon as an appointment is scheduled, but at least three days in advance unless there is an urgent need
- ▶ Requiring that NMT rides be scheduled to arrive within one hour of the scheduled appointment time
- ▶ Requiring prior approval for trips over 75 miles
- ▶ Verifying appointments with carved-out providers before approving NMT, especially if it is for multiple scheduled rides
- ▶ Following up with providers to ensure that enrollees completed their appointments
- ▶ Reviewing requests for private modes of transportation and only approving a different mode if the enrollee must travel more than a quarter mile by foot, or if the trip would take longer than two hours on public transportation
- ▶ Verifying that a prescription is ready for pickup before approving an NMT ride to the pharmacy
- ▶ Utilizing the provider directory to verify the location of the provider, and that the provider is in-network (unless the trip is to a provider of a carved-out service)
- ▶ Requesting a frequent-rider report from the vendor for enrollees taking more than five trips per week
- ▶ For enrollees suspected of fraud or abuse, putting a restriction on the enrollee until member services is contacted to resolve issues
- ▶ Implementing “no-show” policies that limit or restrict the use of NMT for a period of time when enrollees repeatedly miss scheduled rides already paid for by the MCP

Better Communication, Coordination Across Systems and Transitions of Care, and Streamlined Operations, Would Improve NMT Benefit Delivery

The rollout of NMT was rushed and fragmented. DHCS staggered the implementation timeline for the NMT benefit due to last-minute policy clarifications that required MCPs to provide NMT for services that enrollees access outside of the MCP contract through fee-for-service (FFS) Medi-Cal. These are commonly referred to as “carved-out” services and include treatment for specialty behavioral health, substance use disorders (SUD), and dental care. The rushed timeline and fragmented policy clarifications hampered benefit implementation (see Table 2).

Table 2. Timeline of NMT Rollout

2016	
September 25	AB 2394 signed into law by the governor
2017	
June 28	DHCS publishes All Plan Letter (APL) 17-010 to provide guidance to the MCPs
July 1	DHCS guidance clarifies that NMT is to be provided by MCPs to all services covered under the contract and that MCPs are required to refer and coordinate NMT for all carved-out services
October 1	MCPs required to transition from referring and coordinating NMT for carved-out services to providing and covering NMT for all Medi-Cal-covered services
2018	
February 2	DHCS provides additional guidance and clarification to the APL in the form of FAQs ¹⁵
July 1	DHCS begins directly arranging for access to NMT to its FFS enrollees

Limited Communication About the Benefit Could Limit Access

Many stakeholders reported minimal communication from MCPs and DHCS about the availability of the NMT benefit. Key informant interviews with both MCPs and DHCS confirmed that in most instances, outreach to providers was minimal and embedded into regular communications such as provider bulletins or monthly updates.

Consumer advocates stated that in their experience, most Medi-Cal enrollees are unaware of the NMT benefit, and those that are aware continue to report confusion about how to access the benefit and the types of services for which NMT would be provided. The enrollee interviews confirmed that many became aware of the NMT benefit via health care providers, social workers, or transportation providers, rather than through outreach from either their MCP or DHCS. For example, an enrollee living in a small town reported that she heard about the NMT program through word of mouth initially and then from staff at her health clinic. Another interviewed enrollee learned about the NMT program from the shuttle driver that was provided by the local clinic she visits.

Providers interviewed for this report also expressed that MCPs and DHCS conducted minimal outreach related to the implementation of the NMT benefit and how to help enrollees with access. Some providers were only aware of the benefit anecdotally and could not recall or find any direct communication from either the MCPs in their service area or from DHCS. Those providers that had heard about the NMT benefit and proactively conducted outreach to either the MCPs or DHCS reported frustration at the lack of consistent information regarding what types of rides were covered, the approved distances the enrollee could travel, and other logistical information. This was specifically noted for rural and frontier populations and those receiving mental health or SUD treatment. Therefore, these providers found little to no benefit to their patients and either referred them to the MCP or worked to provide the transportation directly. Those

that referred the enrollees back to the MCP reported that there is no communication from the MCP to verify whether the enrollee ultimately received NMT or if there is still an unmet need.

MCP Responsibility for Transportation to Services Not Covered Under the Medi-Cal Contract Creates Unique Operational and Oversight Challenges

For NMT to services such as SUD and serious mental illness treatment not under the purview of the MCPs, traditional utilization controls and authorization processes are complex and difficult to apply. This was especially challenging at the start of implementation when MCPs had to quickly develop operational workarounds and relationships with such providers to verify appointments and appropriate transportation needs. These noncontracted providers are not typically part of the MCPs' networks, and therefore MCPs lack the ability to share information due to privacy concerns, especially when related to sensitive services. MCPs also noted that oversight of NMT for these services continues to be especially difficult because there is a very limited ability to verify that an appointment occurred or that the most appropriate and cost-effective mode of transportation is being utilized.

Continuity Through Transitions of Care Is Also a Challenge, Especially for Dialysis Patients

MCPs, providers, and consumer advocates all expressed that transporting dialysis patients with complex needs presents unique challenges. To bypass the intake process for each appointment, MCPs have set up processes to arrange for and authorize transportation for three- to six-month periods. However, even with these extended approvals there can be issues with access. For example, if an enrollee is hospitalized the NMT benefit can take time to be updated. Then, if the transportation coordinator is not notified when the enrollee is discharged, NMT may be delayed and the enrollee may miss routine appointments because the service was suspended while they were hospitalized.

Enrollees Report Some Concerns with Ride Logistics

While most of the 16 enrollees interviewed for this report said they were generally satisfied with the NMT benefit, many were able to point to challenges with the benefit's implementation. These included customer service representatives not being helpful, appointments being missed because the driver did not show up or was late, language barriers between rider and driver, drivers arriving in a vehicle that could not transport the enrollee and their stroller or wheelchair, drivers arriving with other service users, and "hassle" when trying to schedule an appointment that does not fit into the required authorization time frame. One enrollee said that on several occasions, drivers picked her up in a vehicle that was inappropriate for her limited mobility. Other enrollees had last-minute cancellations and had to reschedule their appointments if customer service was unable to send them another ride on time. As mentioned earlier in this report, these logistical challenges can be multiplied due to the many potential points of contact and interaction (i.e., enrollee, provider, managed care organization, transportation broker, driver).

Considerations for Improvement

To address challenges and improve the benefit for enrollees, policymakers could consider the programmatic and policy changes detailed below.

Merge NEMT and NMT into a Single Comprehensive Benefit

Lawmakers and DHCS may want to consider if the distinction between the NMT and NEMT benefit is necessary and if consolidating them would reduce confusion and improve access. Other states have effectively implemented similar, and even more expansive, transportation benefits without creating siloed programs. One approach that has worked in other states and is recommended as a best practice would be to classify all rides to medical appointments

and services as NEMT and to reserve the distinction of NMT to mean transportation to social services and supports.

Require More Outreach and Communications to Providers and Enrollees

DHCS should explore information gaps and opportunities to communicate effectively with providers, enrollees, and MCPs about the NMT benefit and how to use it. Based on the key informant interviews and the use of the benefit by a small fraction of enrollees, it appears that there is significant opportunity for DHCS and MCPs to create a comprehensive outreach and communications strategy with resources for all stakeholders so that there is a consistent understanding of the benefit and how to help enrollees access transportation services.

Address Barriers in Rural and Frontier Areas

It appears that despite the original intention of the NMT legislation, challenges with implementation and access in rural communities persist, and creative solutions are needed. To start, DHCS could further diagnose the problem by analyzing the available data on rural implementation. Some initial ideas for addressing rural transportation barriers include these:

- ▶ Utilize brokers to develop more-robust regional transportation networks that could be made available to all Medi-Cal enrollees regardless of their MCP enrollment. This could increase access by giving the broker increased purchasing power by leveraging all the Medi-Cal lives in a rural service area under one contract, increasing the likelihood that more-robust networks could be made available.
- ▶ The state and/or MCPs could explore options to increase access to local transportation networks through partnerships with existing regional public and private transportation entities. Working directly with local transportation providers who know the

unique needs of the community could result in innovative partnerships and approaches to address rural transportation barriers.

- ▶ California could consider a rate supplement for hard-to-reach rural areas so that transportation providers serving these areas would be better incentivized.

Evaluate Feasibility of Covering NMT for Social Services and Supports

The NMT benefit has been most widely used for regularly occurring appointments such as those for dialysis and SUD services. Some consumer advocates have promoted the expansion of the NMT benefit to include coverage for non-medical-related trips to address social isolation and other social determinants that can negatively impact health status. Given the challenges with the implementation and oversight of the current NMT benefit, the potential cost of providing a more expansive benefit to millions of enrollees, and the capacity issues referenced throughout our interviews, such an expansion would potentially be expensive and complex. As was noted, states that have developed an NMT benefit to address non-medical needs have limited eligibility to very specific populations rather than a program-wide NMT benefit.

Explore NMT Driver Credentialing or Other Transportation Provider Oversight

It was suggested during key informant interviews with transportation brokers that the state should consider requiring a standardized credentialing process for all transportation providers and drivers that would include background checks, drug testing, and sensitivity training for drivers. While this could potentially address some of the concerns around the handling of Medi-Cal NMT rides, it could also exacerbate network issues (especially in rural areas) and increase costs significantly. Coordination with the rideshare industry would be required.

Analyze and Publish Utilization and Cost Data Reported to DHCS

DHCS collects data from managed care organizations on NMT benefit implementation, which were not made available to the authors of this report. Analysis of the existing DHCS data would help answer important questions and inform the directionality of Medi-Cal transportation policy and programs. Analysis of DHCS data should prioritize understanding utilization trends statewide and by health plan and identifying remaining gaps in transportation access for Medi-Cal enrollees.

Conclusion

NMT has resulted in greater access to medical care for a small group of high-need Medi-Cal enrollees. Enrollees interviewed for this report were thankful for the benefit and said it works well for the most part.

Nevertheless, significant challenges remain to making this benefit accessible and useful to the broader Medi-Cal population. The state and MCPs should take the information known to date and consider the recommendations in this report to improve the delivery of the NMT benefit.

Going forward, it will be key for DHCS to provide data on utilization rates and the true cost of the transportation benefit across the state. This will provide a better picture of implementation and unmet need and what additional steps should be considered by the state to ensure a financially sustainable transportation benefit and access to covered Medi-Cal services.

Appendix. Interviewees

ORGANIZATION	INTERVIEWEES
Health Plans	
Aetna Better Health	Jeff Dziedzic
Alameda Alliance for Health	Scott Coffin
Anthem	David Mosher and team
Blue Shield	Tracie Howell and team
CalOptima	Albert Cardenas and T. C. Roady
Central California Alliance for Health	Marina Owen
Contra Costa Health Plan	Frank Lee and team
Gold Coast Health Plan	Marlen Torres
Health Plan of San Joaquin	Cheron Vail and team
Health Plan of San Mateo	Pat Curran
IEHP	Keenan Freeman
Kaiser	Martha Shenkenberg
Kern	Jeremy McGuire and team
L.A. Care	AJ Lopez and Victoria Truong
Molina	Michael Nguyen and Bob O'Reilly
Partnership HealthPlan	Amy Turnipseed and Wendi Peterson
San Francisco Health Plan	Sumi Sousa
Santa Clara Family Health Plan	Christine Turner
United HealthCare	Kerri Balbone
State Officials	
DHCS — Managed Care	Aaron Toyama and Nathan Nau
DHCS — FFS Benefits	Rene Mollow and team
Health Services Advisory Group (DHCS's External Quality Review Organization)	Paul Niemann
Consumer Advocates	
NHelp	Abbi Coursolle and Alicia Kauk
Justice in Aging	Denny Chan
Western Center on Law and Poverty	Linda Nguy
Neighborhood Legal Services Los Angeles	Toni Vargas

ORGANIZATION

INTERVIEWEES

Transportation Providers/Brokers

Veyo

Stanton Sipes

Non-Emergency Medical Transportation Accreditation Commission (NEMTAC)

Michael Shabkie

Providers

Inyo County Health and Human Services Agency

Meaghan McCamman

Janus of Santa Cruz County (SUDS)

Rudy Escalante

Livingston Community Health (FQHC)

Leslie Abasta-Cummings

MedPoint Management

Russel Soria and team

Mountain Valley Health Centers (FQHC)

Brandon Watkins

River City Medical Group

Cordia Losh

Santa Cruz County Health Services Agency

Joey Crottoni

WellSpace Health (FQHC)

Jonathan Porteus

Other States

Arizona

Christina Quast

Colorado

Cassandra Keller

Idaho

Sara Sith

Rhode Island

Mario Olivieri and Jason Lyon

Endnotes

1. [AB 2394, 2015–16, Reg. Sess. \(Cal. 2016\)](#).
2. The descriptor of medical or non-medical transportation in the Medi-Cal program refers to the type of vehicle needed to transport the enrollee, versus the service to which the enrollee is being transported. Non-emergency medical transportation is transportation in a medically equipped vehicle (e.g., wheelchair van) by a specially trained driver. Non-medical transportation is transportation by traditional car, bus, etc. Medi-Cal only covers transportation to medical services, versus non-medical services like social services and supports.
3. Medi-Cal enrollee interviews conducted by PerryUndem.
4. [42 C.F.R. § 431.53](#).
5. Assembly Committee on Health's April 8, 2016, analysis of AB 2394.
6. AB 2394.
7. These five MCPs collectively represent 1.7 million of the 13 million total enrollees statewide for the period analyzed. For detailed descriptions of the different plans see [Medi-Cal Managed Care Program Fact Sheet - Managed Care Models](#) (PDF), California Dept. of Health Care Services (DHCS), January 2, 2020.
8. Monthly Medi-Cal enrollment data by plan were downloaded from the [California Health and Human Services Open Data Portal](#).
9. [Frequently Asked Questions for Medi-Cal Transportation Services](#) (PDF), DHCS, last updated February 6, 2019.
10. Nathan Nau (chief, Managed Care Quality and Monitoring Div., DHCS) to all Medi-Cal Managed Care Plans, [all-plan letter 17-010](#) (PDF), July 17, 2017.
11. Several large transportation brokers operate in California. The most used are (1) Logisticare, (2) Call the Car, (3) American Logistics Company, and (4) Medical Transportation Management.
12. In the industry, transportation brokers are often referred to as *transportation specialty benefit management companies*, since they provide more than just access to transportation, but for simplicity the term transportation brokers will be used in this report.
13. ["Medical Transportation Provider and Non-Emergency Transportation Provider \(NEMT\) Application Information,"](#) DHCS, last modified June 19, 2020.
14. [AHCCCS Medical Policy Manual: Section 310 – Covered Services](#) (PDF), Arizona Health Care Cost Containment System, effective May 1, 2019.
15. [DHCS Transportation Workgroup Frequently Asked Questions \(FAQs\)](#) (PDF), DHCS, September 8, 2020.