Addressing Barriers to Well-Child Visits and Preventive Care: Promising Approaches to Transportation in Medicaid and CHIP

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Susan Ruiz:

Good afternoon, everyone. My name is Susan Ruiz, and I work on EPSDT and quality improvement here at CMS, and I'd like to welcome you to our third webinar in our series on early childhood preventive care.

Today's webinar will review the non-emergency medical transportation benefit and some common delivery models. We're going to share some transportation resources and look at how some specific states have approached transportation challenges in order to promote well-child care. And with that, I'm going to hand it off to Laura Armistead at Mathematica Policy Research. Laura?

Laura Armistead:

Thank you, Susan. Next slide, please. So, my name is Laura Armistead, and I'm a researcher with Mathematica. Here is our agenda for today. I'm going to start with a brief overview of the Medicaid and CHIP NEMT benefit, and then we'll hear from three states, Nevada, Tennessee, and Texas, who will each describe approaches for administering their NEMT programs and discuss strategies for addressing beneficiary transportation barriers. We'll open up the floor for audience questions after all three states have presented and then close out by highlighting some upcoming quality improvement opportunities and resources. We have a great webinar planned and a lot to cover, so we're going to jump right in. Next slide, please.

So, in the next few slides, we'll provide a brief overview of the Medicaid NEMT benefit and associated state delivery models, as well as discuss common transportation-related barriers that beneficiaries face. Next slide, please.

Susan mentioned this webinar is part of a series focused on state efforts to improve early childhood preventive care. And throughout the series, we focused quite a bit on opportunities to improve access to well-child visits in early childhood, because it's a critical vehicle for delivering recommended preventive health services and monitoring a child's growth and development. To support children in accessing these needed health services, transportation is essential. However, many families have cited difficulty accessing transportation as a barrier to healthcare that can result in missed or delayed care.

As of 2018, the most recently reported data, 2.1 million Medicaid beneficiaries under age 65 reported delaying healthcare because of a lack of transportation, of which 43% were children ages 0 to 18. Some evidence even indicates an association between lack of access to transportation and emergency department utilization and hospitalizations. One study found that Americans reporting unmet transportation needs were 2.6 times more likely to report multiple emergency department visits per year compared to those with access to transportation. Next slide, please.

When Medicaid beneficiaries report transportation related barriers, this can be due to a wide range of issues. Some examples of these transportation barriers include lack of a car or a driver's license or an inability to afford the cost of transportation, such as paying for gas, parking, fares for public transportation, or even the cost of repairing a vehicle. Some beneficiaries may have access to a household vehicle, but it may not always be available during appointment times. For example, if another family member also uses the vehicle to get to work. Other beneficiaries may face barriers in accessing specialty vehicles, such as wheelchair vans, or they may reside in areas where public transportation is unavailable

or difficult to access, which is particularly common for beneficiaries living in more rural areas. Even when public transportation is available, beneficiaries and their families may face challenges safely using these options because of their medical conditions. Next slide, please.

Now to say a few words on the Medicaid and CHIP NEMT benefit. Federal law requires that state Medicaid programs ensure necessary transportation to and from medical appointments for beneficiaries with no other means of accessing transportation, a benefit known as non-emergency medical transportation, or NEMT. Beyond the general transportation assurance requirement, Medicaid's Early and Periodic Screening, Diagnostic, and Treatment Benefit, or EPSDT, further specifies that states must offer and provide children under age 21 who are beneficiaries of EPSDT services with necessary assistance with transportation, including covering the cost of transportation for any person who needs to accompany an eligible child to their medical service when necessary. States must also inform EPSDT-eligible children and their families in clear and non-technical language that assistance with transportation is available.

Though NEMT programs must meet certain federal requirements, states have considerable flexibility in the design and operation of their NEMT program. Depending on the state's structure and the needs of its population, states may deliver NEMT at the state, regional, or county level, or through a combination of approaches. Next slide, please.

The scope of the benefit varies by state, but NEMT can be offered through a range of transportation options, including trips in taxis, vans, ambulances, facilitating use of public transportation, and providing mileage reimbursement for personal vehicles belonging to beneficiaries and their families or friends. Increasingly, states are also offering services through transportation network companies, or TNCs, which are also known as rideshare organizations. Generally, TNCs allow passengers to connect with drivers through a digital network using an app on a mobile device. State Medicaid and CHIP programs and their NEMT administrators, such as managed care plans or brokers, may contract TNCs to augment their NEMT provider network, often using them as a flexible or backup option. Next slide, please.

In a few minutes, we'll hear from a few states who will share more specific details on their NEMT approaches, but it's helpful to first understand some of the common delivery models states use to deliver NEMT. One approach is in-house management, where the state Medicaid agency manages NEMT directly and pays for transportation services on a fee-for-service basis, either statewide or at a regional or county level. Another approach, and one that is most commonly used by states, is the brokerage model. Some states contract with one broker to provide NEMT services statewide, while other states contract with multiple brokers that may operate in one or several regions. Brokers may receive a capitated payment from the state or be paid on a fee-for-service basis.

Other states integrate or carve in NEMT services into their Medicaid managed care programs. Plans may administer the benefit directly or contract with a broker to coordinate NEMT services. There are also states that choose to use the combination of these approaches to accommodate varying beneficiary needs, delivery systems, and geographic areas. For example, a state may choose to have managed care plans deliver NEMT services for beneficiaries enrolled in managed care and use a third-party broker to coordinate NEMT for its fee-for-service population. Next slide, please.

Before we wrap up our overview, we wanted to briefly highlight some helpful NEMT resources for state Medicaid agencies and their partners. These include NEMT sub-regulatory guidance published by CMS, including the Medicaid Transportation Coverage Guide shown in the first link. The second link is to the CMS State Health Official Letter, which summarized best practices for adhering to EPSDT requirements, which includes information on EPSDT transportation policies, strategies, and best practices.

We've also included links to other NEMT-related resources, including one published in 2021 by the Medicaid and CHIP Payment and Access Commission, or MACPAC, and one published earlier this year by Health Management Associates, both of which summarize state approaches for administering NEMT programs. Next slide, please.

So now we're going to move into our state presentations. We are first going to hear from Kirsten Coulombe. Kirsten is the Social Services Chief with the Nevada Division of Health Care Financing and Policy. As a reminder, if you have questions for our state presenters, please drop them in the Q&A panel throughout the presentation. We will get to as many as we can at the end of the webinar. Kirsten, the floor is yours.

Kristen Coulombe:

Thank you, Laura. Next slide, please. Thanks for having Nevada on today. This is just wanting to give you a little bit of a background for our Medicaid and CHIP enrollment in Nevada. And in terms of non-emergency medical transportation, it is available to individuals that need it to obtain medically necessary services. And thinking of the different options that Laura just spoke of, we do currently offer our NEMT services through a single statewide broker for both fee-for-service and managed care individuals.

However, Nevada is moving towards that mixed model starting in January of next year. So, we will have a single broker for our statewide and actually for the managed care members in the urban areas only. And then we will have managed care oversight for the rural members only. So, I know that might be a little confusing, but that is a new service delivery model that we're working towards starting next year. Next slide, please.

So, in terms of what services Nevada covers for NEMT, we cover most of those options that Laura did mention in terms of offering fixed route bus passes. We do offer door-to-door for the paratransit, which is that wheelchair accessible. We also offer ambulances and stretchers for individuals that might need some assistance either with oxygen or whatever might be needed for those assistance to getting home or to a facility from a hospital discharge.

We do also offer taxi and TNCs. And then in Nevada, we also have our community volunteer drivers. So that's an option for individuals that oftentimes live in the rural areas where they might have members of their community that volunteer. They can go through training and receive reimbursement. So that's been a great option that we use. And then we also offer gas mileage reimbursement for individuals that do have access to a vehicle, but just maybe because of financial obligations, they struggle with having the ability for gas. That has also been helpful in our rural areas when it's a long distance, between 100 miles or more, to get to a medical appointment.

So, we do offer it for individuals that don't have transportation, and it has to be the least expensive mode. We do have prior authorization requirements that would be through our NEMT brokers statewide. And we do require that three days in advance for local and non-urgent trips. We do have the option for the same day because we understand that needs come up and not everyone can schedule their transportation with a three-day notice. And so, we do allow those same day transportation options specific to hospital discharges. Individuals have to go to urgent care and then for pharmacy pickups that is often utilized when someone's being discharged from the hospital, or they might recently have had a new change in their medication after seeing their physician. We do allow those same days for those.

And how individuals can schedule their NEMT services through our broker, we have, of course, an 800 number and then we have an MTM link, essentially an app. So, when you get access to these slides later, you can click on that link and it will take you to the platform that does have a video that explains how the app works. But essentially, recipients or family members, whoever has that app downloaded, can schedule

their appointments. They can view those appointments that are coming up. They'll also give them a reminder and then they can manage those from that mobile device or computer. So that's been a really nice addition. So not everyone has to call our 800 number. And then we'll speak about it in a little bit more detail, but we also offer a community partners line specific to facility staff. Next slide, please.

So, although we have the NEMT services available, there can certainly be challenges. And, you know, these are the kind of primary areas that Nevada has seen challenges for our NEMT. So, in Nevada, of our 17 counties, 15 are rural and frontier and every single one of our counties are considered a healthcare shortage designation. As you can guess in the rural areas, there's little to no public transit or TNCs available.

As mentioned, the distances between towns and the urban areas, which is where the majority of our medical providers are, could be hundreds of miles in between. And then the way that we have our authorization set up, we don't necessarily have it set up to have as much flexibility for the rural areas in terms of calling in advance or distances that are over 100 miles. You know, it has two weeks' notice required. And then in addition, we often struggle with finding transportation providers when someone is in the urban area being discharged and having returned to the rural area. And then for our pregnant recipients, we have seen that they have missed appointments because individuals in our urban areas often are required to use public transportation, a fixed route bus. And so that can be challenging when someone is pregnant.

And then lastly, finding attendance for minors. So, you know, our policy in Nevada requires that children under 18 do have a parent or guardian with them for that transportation. But parents are not always available because they must work, or they have other children with no childcare. And then I'll speak to it in a little bit more detail, but our partial hospitalization program can also be a particularly difficult service to transport because an attendant is needed, and that service is oftentimes six hours. And so, I'll speak a little bit about ways that we've tried to improve that. Next slide.

So, what we've done to try to overcome some of those challenges. In terms of scheduling, we did a town hall in preparation for our request for procurement for a broker. And some of the feedback was really trying to have an avenue for facility providers to schedule those appointments. And so, we created a separate community partners line, so this would be independent of our 800 number that recipients can call into. This one is specific for scheduling discharges or transferring to other medical facilities, some of our frequent trips such as dialysis or also our trips for the high-risk pregnancies, and then it can also serve as a liaison for our tribal entities. So that's been, I think, a helpful success in trying to have individuals that are very familiar with our services. And the individuals that are scheduling that transportation on behalf of the recipients often, I think, have less frustration than calling just an 800 number.

And then during COVID, we added TNCs in order to respond to those same day needs. So, during COVID, we added it for the COVID testing and then vaccines. So that has been, I think, a help, and being able to have that real-time response instead of being able to try to find a transportation provider to schedule that in advance. And then in the rural areas, you know, as mentioned, we did not previously have sort of a rural-specific policy in terms of scheduling. So, what we have done to try to address that is we removed the long-distance verification form, which was a form trying to ensure that recipients are going to providers that are in the location closest to them.

And so, if a recipient does need to travel a long distance for an appointment, our standard process is to have a verification of that. And so, we removed that specific to the rural areas because 90% of our rural counties already meet that 100-mile distance. So, I think that has been a great help to reduce that administrative burden. We also removed a 14-day out-of-state notice requirement because in the rural areas, recipients are allowed to go to bordering states. So that was something that we had in our urban

process that we tried to make it a little bit more flexible for our rural areas to just try to increase access. Next slide, please.

And then in terms of pregnant women, so anyone that's considered to be high-risk or past their eight-month, we did implement an exception that they did not have to follow our fixed bus route option. And so, they could be authorized to hire mode. And so, we certainly want to make sure that pregnant women and individuals who are considered high-risk are getting to those appointments and accessing those services. And so that is something we allow them to bypass.

And then for children specifically, Nevada during the recession did remove transportation as an option from CHIP as a cost-saving measure since there was not a lot of access to it. Certainly, anything that fell under EPSDT, we would just do an administrative override. But we are adding that back in January, and we will be doing a lot of education with those families to try to increase that access. And then for children that are in the custody of our child welfare agencies in Nevada, we are working closely with those child welfare entities to try to assist them in ensuring that those children in their custody are receiving access to their Medicaid appointments. And so, some of the ways that we've done that is to allow gas mileage reimbursement for state agencies. We are offering meal reimbursement for children and state staff that travel over 100 miles. We don't currently necessarily allow that. We only allow meal reimbursement when it's out of state. So that's something that we are making an exception to allow for the children that have those long distances.

And then we've also determined that it's beneficial to have a dedicated staff within our broker system to work directly with the child welfare agencies, because sometimes appointments come up at the last minute. And so, we want to make sure that we can get those individuals addressed with those appointments that come up. And then we also, with those long appointments with the partial hospitalization, we're working with providers to offer a sole source contract to try to address those issues, and then also evaluating whether we should offer transportation in the reimbursement methodology. Next slide, please.

And then in terms of lessons learned, I think a lot of the changes that we made that came about in terms of trying to overcome the challenges were direct feedback from our recipients and their families when we did listening sessions through town halls in preparation for our procurement for our broker. And then also trying to just be as flexible as possible for children, particularly those with intellectual disabilities that, you know, might benefit from having some flexibilities in terms of who their transportation providers are. And then, as we mentioned, kind of engaging with the child welfare agencies. In having those conversations with our sister agencies, we found they're already providing transportation, so seeing where Medicaid can be a fit into what they've already set up.

And then lastly, you know, that CMS transportation guide has been a great help. And we're evaluating how we can look at addressing the long wait times and unloaded miles in the rural areas. And then we will also be monitoring closely our new changes to the managed care in the rural areas to see if we should be looking at an expansion for that in other areas. And I think that is my – there might be one more slide after that, I think. Well, thank you. Perfect. That's our contact information and I'll transition it back over to Laura.

Laura Armistead:

Thank you so much, Kirsten. That was a great presentation. Next slide, please. So, a reminder, we're going to hold questions to the end. So, we're going to roll right into our next presentation. Tammy Mihm is the Director of Compliance Oversight and NEMT at Tennessee's Division of TennCare. And she's going to describe their specific approaches for administering NEMT benefit and addressing transportation challenges. Tammy, take it away.

Tammy Mihm:

Thank you. Today, I would like to share with you what sets Tennessee apart. If you're interested on the requirements that we have, what we do, which is probably most similar to other states, you can find our contract on the TennCare website. But today, I wanted to focus on what we do that may be different than your state. TennCare started their NEMT program in 2008. And we delegate the responsibility of NEMT to our managed care organizations. We include this in their monthly capitation payment between TennCare and the MCOs. TennCare allows the MCOs to administer this benefit as they determine best. We have three statewide MCOs in each contract with a statewide broker. Two of our MCOs utilize Tennessee carriers as their broker, and the other MCO utilizes Verida as their broker. Next slide, please.

TennCare receives standardized data on a monthly, quarterly, and annual basis. The MCOs and their broker utilize reporting templates that have been provided to them by TennCare. This more easily allows for data comparison that supports TennCare's ability to evaluate and easily identify systemic issues and trends. We continuously look for areas within reporting that can be improved upon. Today, as we focus on children and their access to healthcare, I want to highlight these numbers. Over the last three years, we have focused on member and provider education. And in this area, we see an increase in utilization for the population under age 21. And between the years 2022 and 2023, there's an 8.72 increase. And then between 2023 and 2024, you see an increase there as well. The ‘over the age 21’ percentage of trips remained consistent. Next slide, please.

Here you see all of our standardized reports. Tennessee has worked very hard and included our partners to strategize with us to make sure that the data is captured and reported the same across all MCOs and their brokers. We have created a data dictionary defining keywords and how they apply to each of these reports. To highlight a few, I will talk about the pickup and delivery report. We recently implemented an overall performance benchmark on trips performed. And this report also tells us the number of trips that do not occur because of the provider availability. This is not included – the trips that do not occur, of course, are not included in the pickup and delivery performance benchmark, which we started with 90%. We plan on increasing that as we improve upon our program moving forward.

Another report I will talk about is the member no-show. And what we decided to do with this report is, first of all, we want to know the overall number of members that are no-showing, whether it's one trip, two or six, ten. So, what we do is we get those numbers monthly. But if a member exceeds six trips, six or more trips, then we want to know additional detail. We want to know what the service type was that this member was seeking each time and their location, and what type of provider, whether it's behavioral health, dialysis or others. Next slide, please.

In 2022, TennCare began brainstorming sessions with key stakeholders. We had these meetings with internal stakeholders and then with external stakeholders. The internal being our CMO team. And we wanted to hear their concerns and what they're hearing specific to transportation, what they're hearing from providers, members, any stakeholder that they come in contact with. Our external stakeholders are our MCOs, our brokers and our providers. This led to our monthly strategy meetings that began in 2023. If I highlight anything that we do and we do well, I think it's our collaboration. These meetings have continued to strengthen our program, and we have seen improvements along the way.

Our attendees include representatives from each of our MCOs, our two brokers and Tennessee's NEMT team. 2025 started with the implementation of small workgroups, which were derived from this larger monthly meeting. It includes stakeholders from each of our MCOs, our brokers and, of course, TennCare. Examples of some of these workgroups would be mileage reimbursement, no-shows and educational opportunities where we look for ways to share with our members and even providers necessary steps to take to make sure that their trip is successful and make sure the providers, the medical providers

understand what is provided to the members so that their expectations are aligned with ours. Next slide, please.

Some of the benefits we have seen from these meetings would be improved relationships. We're really a team. We cross organizational boundaries for the benefits of the NEMT program and our members. This is done without sharing proprietary data, and each of our MCOs and brokers are very willing to be a part of those meetings. We continue to work on individual ownership of issues and their solutions. This has improved as a result of our small workgroups and each workgroup has a lead person that schedules and delegates and then updates our larger group on a monthly basis. Next slide, please.

This slide gives you a few more examples of our work groups. The initiatives will change as we determine whether the topic has resolved or needs no further action. The work group may pause and reconstruct for another purpose. This allows us to continuously move forward. The implementation of these small groups has improved our follow-up. We found that month to month, things would fall off our radar and it may be three months before we circle back to something and then we had to start over. So doing the small groups has really made a difference and holds each of us accountable. And next slide, please.

One before that, sorry. So, challenges and solutions, here you will see some of the primary issues we've identified through our meetings, what the issues were, what caused it and how we addressed each one.

For example, extra passengers, when the member would schedule the appointment, they would not tell this call center agent that they had multiple children that needed to be with them in their appointment. The appointment may have been for one child and they have three more. So, when the provider arrives for pickup, there's not enough space in the vehicle for the member and their children. So, we have enhanced the call center scripts and asked about additional riders, including extra children. The same goes for car seats. The trip would be scheduled. The member would not have the necessary car seat available, which we do require them to have. We've added that determination in our call center scripts and even some of our brokers have partnerships with local agencies that provide car seats to members that may not have what they need.

Network deficiency, missed appointments, late cancellations, we've targeted education and outreach for mileage reimbursement and also are working to pilot with facilities, behavioral health facilities, to provide their own transports.

And lastly, school pickups, traffic delays, and lack of escorts, we've worked internally to plan more carefully and increase the communication and even gotten case management involved. Back to you, Laura. Thank you.

Laura Armistead:

Thank you so much, Tammy. We really appreciate your sharing today. Next slide. Okay, so just before we go into our final presentation, you are able to submit questions in the Q&A panel, so please feel free to do so. And then after Texas presents, we will open up the floor for questions. But go ahead and send them in as you have them.

But for our final state presentation, we are going to hear from Kate Layman, the Director of Program Policy with the Medicaid and CHIP Services Division of the Texas Health and Human Services Commission, who will describe transportation approaches used by Texas to support access to well-child visits and preventive care. Kate?

Kate Layman:

Yes. Good afternoon. Thank you. You can go to the next slide. Perfect. So, I'm going to first just give a little bit of background on Texas Medicaid and the specific programs that I'm going to be talking about today. These are only a few of our Medicaid programs in Texas, but they are the most relevant for the population and the services that we're talking about. The current Texas Medicaid program in general serves children and their caretakers, pregnant women, people over age 65, and then individuals with disabilities.

We have two programs that really emphasize the delivery of acute care services to children. The first is our STAR Kids program, and this is a program that integrates both acute care, behavioral health and long term services and supports for children who have a disability and who generally are going to require that broader array of services. We also have our STAR program, which serves primarily pregnant women and then generally healthy children. So, your STAR program is going to have children who are mostly receiving preventive care, incidental care when they have an acute illness or injury, as opposed to those long-term services and support services that a child or young adult in STAR Kids would be receiving. Children in both STAR and STAR Kids receive their services through managed care organizations, that is the case for most of our Medicaid programs or Medicaid services in Texas, where we have carved them into managed care. Next slide.

For our non-emergency medical transportation services, again, most of these are carved into managed care. We do, though, have some individuals that remain in fee-for-service, and so we do also maintain a fee-for-service non-emergency medical transportation system. For a person who is in managed care, their NEMT will come through the same managed care organization that their healthcare services come through. So, this is extremely helpful in terms of allowing HHSC to really connect transportation services with the healthcare services that individuals are receiving that they need the NEMT services to access. We do have 16 managed care organizations, so a large number. And again, the vast majority of our Texas Medicaid beneficiaries are going to be receiving NEMT through managed care.

Because Texas does not have an automatic enrollment into managed care when someone becomes eligible for Medicaid, we always have a very small number of beneficiaries that are in fee-for-service Medicaid, usually for less than 45 days. We do also have some populations more broadly that are optional for managed care. So because of this, as I said, we do operate a parallel program that delivers NEMT services to those individuals who are not enrolled with a managed care organization. And for the fee-for-service program, the Health and Human Services Commission, or HHSC, actually provides the oversight and ensuring those services are delivered.

We do have, as far as services are concerned for NEMT, I think the standard services that we've heard already from Nevada and from Tennessee, your traditional demand response. We do offer bus vouchers and other fixed-route public transportation options. We also have mileage reimbursements. We refer to this as individual transportation participants where an individual, or someone that they can find who can provide the transportation to them, can receive mileage reimbursement for providing them with transportation to their service. We also include, specifically for children, we include some air travel. Again, it's limited in the population. And then also meals and lodging for children. So again, it is a little more limited than the other NEMT services that are available to anyone. Next slide, please.

The first legislative initiative that I'm going to talk about is House Bill 25, which came out of the 86th legislature back in 2019. One of the frequent barriers that's identified for pregnant women who are in the STAR program being able to access their prenatal and postnatal care is the fact that the non-emergency medical transportation option is only available to the person who's receiving the healthcare service. And for a mother who has other children, the challenge of either finding childcare while she is at her

appointment or figuring out a way to somehow get them to the appointment with her is just a challenge that's very difficult to overcome.

So, House Bill 25 directed HHSC to implement a pilot that would have included NEMT services for the children that were traveling with their pregnant mother or postpartum mother when she was going to receive her prenatal or postnatal care. Our goal was to reduce missed appointments to impact maternal health outcomes and just to enhance overall access. You can see how this challenge – while House Bill 25 was aimed at pregnant women, that that same challenge of having more children than are actually going to an appointment would impact just your general well-child visits and access in the same manner. Next slide, please.

We did analyze the cost impact, the use of the services and the quality of services through member feedback. Unfortunately, as you might have guessed based on the date of this, we implemented the pilot right as the COVID-19 pandemic was really hitting its stride. And so, in Texas, as I'm assuming probably a lot of states, we saw a dramatic drop in NEMT period across the board, including providers who had zero trips in some months. So that impact combined with another initiative that I'm going to talk about in a moment really made it difficult for us to actually meaningfully evaluate the impact of this pilot and to isolate what the pilot itself was actually impacting. So, we did terminate that pilot, but we did recommend that we continue to monitor those barriers specific to prenatal and postpartum care. Next slide, please.

At the same time as we were trying to implement the pilot for House Bill 25, we were also carving into managed care our entire NEMT program and adding new providers, specifically transportation network companies, and adding more flexibility around trips with less than 48-hour notice. So there was a lot happening all at the same time. When we included the transportation network companies, that in particular offered a new option to address those same needs that the pilot was aimed at addressing, as well as the related ability of a parent to bring more than one child along with them for non-emergency medical transportation.

And this is just because with the use of a transportation network company option, most likely that parent is going to be traveling within their own – not their vehicle, but their transportation network company vehicle, as opposed to sharing that ride with other people as well. And so to the extent that the car has seats available, they do have the option of bringing more children with them and more people in general with them without impacting the reimbursement or the ability of that provider to make sure that they're delivering services in the most cost-effective way. Just the act of carving in NEMT also, as I said earlier, gave the MCO service coordinators new insights and new opportunities to really find ways to use transportation more effectively to help meet the needs of their beneficiaries.

So really, instead of having to be almost sometimes blind to that NEMT use and what options might be available to the individual, the service coordinator is able to monitor utilization of NEMT. If they are seeing a low utilization of healthcare, including preventive care, also looking to see, are they accessing NEMT? Do they have a lot of no-shows? Is there some sort of connection there that we might be able to address? Again, though, making all of these changes at one time combined with the COVID impact really made it difficult for us to isolate what might be impacting either the carve-in or the pilot program's impact on service delivery. So, if you can go to the next slide, please.

While we're looking for new ways to evaluate the impact of both the carve-in and the new providers in NEMT, we do continue to just conduct general oversight activities that look at improving access and trying to ensure that people are able to access both NEMT and the healthcare services that NEMT is helping them to attend. This includes monitoring complaints closely. We work with our external quality review organization who conducts member satisfaction surveys for those individuals who are in managed care receiving NEMT.

And then HHSC conducts its own operational reviews of its managed care organizations every two years. And these reviews include site visits and desk reviews of the policies and procedures that an MCO might have. And this helps us to make sure, one, that the MCO is delivering services the way we require them to. But then also, beyond just what is required, it can help give us some insight as to where there may be challenges or things that are going really, really well, especially if an MCO has implemented something on its own that is really having a positive impact. Next slide, please.

We also monitor the actual service delivery, and we use this to inform our oversight of our managed care organizations. But we do monitor the percentage of trips that are completed, the timeliness that individuals are picked up and dropped off, and then also when they are picked up after their appointment and are dropped off back at home. And I am watching the clock.

I think – if you can go to the next slide – some of our main challenges are around repeated no-shows, which can lead to providers being reluctant to continue to participate in NEMT. We also see a lack of awareness of the availability of these services. And then as far as the geography of Texas, we have some parts of the state that just don't have very many providers. We're really unique in the sense that Texas has three of the top ten largest cities in America and three of the top ten least populated counties in America. So we are trying to serve both Houston and West Texas where there might be one ranch in the entire county. So, trying to have an array of providers that can meet the needs of those unique communities is something that we really focus on. Next slide, please.

Which takes us into that first lesson learned, which is to the importance of offering a range of both service options and provider types to make sure that across the state, we're able to meet the needs of individuals. We include mileage reimbursement and regional transportation districts, which can help in some of those more rural areas. Having the transportation network companies and the more traditional demand response transportation providers and public transportation in our more urban areas is really helpful and being able to take advantage of that. So we really do sort of look broad at what we can do in different parts of the state.

We also have been working with our external stakeholders on how to get out the awareness of the NEMT benefit. We have worked closely with our intellectual and developmental disability stakeholder group to create materials that they can share with their stakeholders to help those individuals get a better idea of what is available to them. We've also had a number of other conversations with external stakeholders about different ways that we can just increase that awareness and knowledge, especially of the broad array of what's available, that it's not just the big white van that might come and pick you up. And that is my last slide. So, I tried to leave a little bit of time for questions for all of us, but I will turn it back over to, I think, Laura.

Laura Armistead:

Yep. Thank you, Kate. Thank you. And thank you to all of our state presenters. Next slide, please. So, we covered a lot of ground and we're going to transition into our question and discussion time. Next slide.

We just have a few minutes for questions. We're going to do our best to get through them. As a reminder, here's how to submit a question, but we already have quite a few that have come through in the chat. So, the first question is for Nevada. The question is asking about how you advertise your various transportation services that are available to beneficiaries. How do members know of the different benefits that are available to them? Can you speak to that, Kirsten?

Kristen Coulombe:

Yeah. So, when someone is eligible for Medicaid as a whole, they receive like an information booklet that has a high-level list of services available, and transportation is one of them. And then the managed care team also, you know, works with them if they have any questions. We do have a community outreach. So, we work closely with the hospital providers and any of the other providers that may need that assistance. So, yeah, not a perfect system, certainly. We do have a Medicaid app that we're working out on pushing notifications out to recipients that are savvy and have access to an app. But yeah, I think that's always a, you know, ever-changing issue to try to just ensure that they're aware of those services. But yeah, at minimum, they have it as part of paperwork that they get that hopefully they read.

Laura Armistead:

Thanks, Kirsten. That's really helpful. So, we have a question for Tennessee. Tammy, one of our attendees asked, does Tennessee have a set or maximum number of children that the transportation vendor can accommodate for NEMT services?

Tammy Mihm:

We do not. Our providers are required to accommodate. That's the importance of disclosing that information during scheduling so that the appropriate vehicle type can be sent. And since most of our vehicle types or processes are based on ride share, it easily accommodates multiple riders.

Laura Armistead:

Great. Thank you so much, Tammy. And then we have a question for Kate. An attendee asked, for Texas, what have you been hearing as for reasons for no-shows on appointments?

Kate Layman:

Yeah, thank you. We hear various reasons. Just plain forgetting sometimes with also some confusion around time of their appointment. Sometimes we do have as part of our contract requirements for the managed care organizations, requirements for them to check in and do a reminder call with the individual. Which I think helps some, but in the end, sometimes it's just a matter of either something coming up at the last minute or just forgetfulness again, I think are probably the biggest reasons.

Laura Armistead:

Thank you, Kate. Okay, so we have just one final question. Kirsten, if in one minute you can respond to this. An attendee asked if you could say more about why Nevada is moving rural areas back into managed care.

Kristen Coulombe:

Yeah, so they've actually never been into managed care to my knowledge. We're hoping that the managed care organizations might have a little bit more flexibility in terms of how they work with that network of providers. You know, managed care can offer value-based, you know, benefits that on the fee-for-service side we don't. And we are also, I should say, moving to statewide managed care in the rural areas, so that is also new from the service side. So, in terms of the services, we were hoping that having transportation be part of that option might increase access to those services that will be new for managed care to cover in the rural areas as well. So, stay tuned. We'll hopefully have more information soon.

Laura Armistead:

Thanks, Kirsten. And thank you all for sending in your questions. We wish you had more time to cover them, but we're going to wrap up now with some final items. Next slide, please.

So many of you may be aware, but this webinar series is actually teeing up the Improving Early Child and Preventive Care Affinity Group, which will launch later this summer for interested state Medicaid and CHIP program teams. To participate in the affinity group, an individual from either the state Medicaid or CHIP program must complete and submit an expression of interest by 8:00 p.m. on Monday, June 30th. The EOI form is live and it's available at the link shown on the slide. We're going to drop it in the chat as well. So please submit one if you'd like to participate. Next slide, please.

This is just a quick plug for some QI, quality improvement, resources that are available on the well-child care page on Medicaid.gov. That includes materials from webinars in this series. The recording and slides from our first two webinars in this series are posted now. And you can also access resources that were developed from a previous and related affinity group focused on improving infant well-child visits. So, lots more resources there if you visit at the link on the bottom right of the screen. Next slide, please.

And finally, we wanted to briefly highlight a new upcoming quality improvement opportunity. CMS will be launching a webinar series and affinity group related to promoting children's preventive dental visits. It's tentatively slated to start in late summer or early fall of this year with the affinity group beginning in late 2025. More information on that is coming soon, so please stay tuned. Next slide.

And that's all we have for you today. So again, you'll be prompted to complete a survey as you exit the webinar. You can provide feedback. We love to hear it. If you have any questions, if your question didn't get answered today, you can send them to the email on the screen: MedicaidCHIPQI@CMS.HHS.gov. Thank you so much for joining us today. We really appreciate your time. Have a great rest of your day.