Center for Health Care Strategies

Addressing Travel Costs for Providers of Field-Based Services in Medi-Cal

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TAKEAWAYS

- Medicaid does not directly reimburse providers for travel to deliver field-based services.
- Recent changes in Medi-Cal have highlighted the challenges of covering travel costs for these services.
- Providers who are not adequately reimbursed for travel time and costs to deliver field-based services may stop offering these services in some geographic areas or may rely more on telehealth delivery.
- This brief highlights state level and Medi-Cal managed care approaches to maximize access to field-based services by addressing travel costs for three types of providers: community health workers/promotores/community health representatives, doulas, and behavioral health providers. While developed for California, the insights can inform all states in improving access to field-based services through travel and transportation coverage.

For people with complex health and social needs, traveling to appointments in traditional health care settings can be a barrier to accessing care. Providers working in home, community, and school-based settings can support person-centered care by meeting Medicaid members where they are, and delivering health care and supportive services that are responsive to their individual needs and preferences. The Centers for Medicare & Medicaid Services (CMS) describes transportation for *Medicaid enrollees* as a "critical part of access to care for many beneficiaries, [with] a key role in health equity." However, transportation for *providers* of field-based services is not directly covered by Medicaid.

As Medi-Cal (California's Medicaid program) offers new field-based services such as doula services and community health worker services, and reforms its specialty county behavioral health payment system, providers are confronting challenges to adequately cover the costs associated with travel. These costs include direct expenses, such as mileage or public transportation costs, as well as indirect costs, such as unreimbursed

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travel time that impacts productivity. Many providers of field-based services are accustomed to cost-based reimbursement or grant funding that has paid for travel expenses. When providers of field-based services transition to new reimbursement pathways in Medi-Cal, they must factor in the full costs associated with provider travel to different sites to sustain their operations and ensure consistent member access to these services. Providers delivering field-based services who incur significant unreimbursed travel costs may stop offering these services or switch to telehealth delivery — which may not be as effective for some services or with some individuals. These outcomes may especially impact Medi-Cal members living in hard-to-reach geographic areas such as rural and frontier regions, who may experience reduced overall access to care or an over-reliance on telehealth delivery.

This brief, developed with support from the California Health Care Foundation, summarizes relevant Medicaid policies on reimbursement for provider transportation costs to deliver field-based services, and highlights approaches both within California and across the country for states and managed care entities to address these issues for three types of providers: community health workers/promotores/community health representatives (CHW/P/Rs), doulas, and field-based behavioral health providers.

Background: Relevant Medicaid Policies on Travel Expenses for Field-Based Providers

Medicaid funding for transportation is authorized to assist Medicaid members who have no other way to travel to a covered service. Federal regulation authorizes Medicaid funding for member travel to covered services; non-emergency medical transportation is a required Medicaid benefit to address transportation-related barriers; and the Early and Periodic Screening, Diagnostic, and Treatment benefit includes transportation assistance for children and their families. However, provider travel costs are not covered by Medicaid, as stated in the CMS 2023 Medicaid Transportation Coverage Guide.

However, states and managed care plans (MCPs) can develop service rates to reflect provider travel costs for delivering field-based services. For example, travel expenses can be used as an input to develop rates, considered as a reasonable cost of delivering a unit of service. This flexibility is noted in CMS' 2023 transportation coverage guide, as well as a 2014 guidance letter on Fair Labor Standards Act requirements. States can also consider regional adjustments or incentive payments to reflect higher travel costs in certain areas or services with significant access issues. In addition, plans may negotiate rates with individual providers to account for differences in travel costs.

Implications for Select California Services

Following are implications related to covering travel and transportation for states and managed care entities. They outline the evolving policy landscape and travel considerations for three types of providers: CHW/P/Rs, doulas, and field-based behavioral health providers. While the primary focus is on the California context, the insights can inform efforts in other states.

1. Community Health Workers, Promotores, and Community Health Representative Services

CHW/P/Rs provide outreach, coaching, navigation of health and social services, and social support for individuals and communities, and draw on their shared life experiences and understanding of the impacts of health inequities to connect with the communities they serve. There is strong evidence for how CHW/P/Rs can increase access to preventive care, improve chronic care management, and reduce health inequities and use of acute care.

Approximately half of all states currently reimburse for CHW/P/R services in Medicaid, as authorized through state plan amendments (SPAs) or section 1115 demonstration waivers. In California, CHW/P/R services were authorized as a preventive service through an SPA that went into effect in July 2022. The CHW benefit includes health education, health navigation, screening and assessment, individual support or advocacy, asthma remediation services, and violence prevention services. Under the benefit, services can be delivered virtually or in-person in any setting, such as homes, clinics, or community-based locations. The fee-for-service (FFS) rate for the CHW/P/R benefit is approximately $27 for a 30-minute visit. Each member may receive up to two hours of services per day, with additional time only when approved for medical necessity.

In development of the managed care capitation rate for 2024, the California Department of Health Care Services (DHCS) estimated that approximately five percent of the managed care population may use CHW services. This rate assumed 2.0 service hours per month on average for eligible members, and included inputs related to contact types (in-person or telehealth), frequency and duration of contacts, and member level of need.

Provider participation in the CHW benefit has been significantly lower than expected. Providers have cited the relatively low rates for this benefit and report that many CHW/P/R employers have pivoted to telehealth due to the rate not sustaining the costs of delivering in-person services. A recently published article in the *Journal of Community Health* reported on a microsimulation model that identified CHW program costs across

the country, accounting for variations by state and metro area. This model estimated that California's minimum payment threshold FFS rate to sustain CHW programs is approximately $68 per 30 minutes, more than twice the current rate. Notably, transportation costs were identified as the largest overhead cost for CHW/P/R programs, with a national average of approximately $28 per hour. California was calculated to have the second-highest transportation time per CHW visit among all states.

California's final 2024-2025 budget included a rate increase for CHW/P/R services to match Medicare rates, using Medicare relative value units. A recent analysis published by Transform Health estimated that this increase, set to go into effect on January 1, 2025, will increase the Medi-Cal CHW rate by approximately 15 percent to approximately $32 per 30 minutes. These rates are significantly less than the Medicare rates for community health integration (CHI) services designed to be delivered by CHW/P/Rs. CHI reimbursement rates are adjusted by geographic area and range in California from approximately $42 to $51 per 30 minutes.

State and Managed Care Plan Levers to Address Travel Costs and Enhance Sustainability of CHW/P/R Services

Examples of state Medicaid approaches to increase access to CHW/P/R services by addressing provider travel costs, as well as MCP opportunities to incorporate travel time in rate negotiations for services, are outlined below.

- **Increase rates set by the state to account for travel assumptions.** For example, while South Dakota does not permit reimbursement for travel time, the state recently implemented a major rate increase to support time spent on travel and documentation, as reported by state CHW/P/R leaders. As of January 2024, South Dakota has the second-highest FFS rate (approximately $32 per 30 minutes) for CHW/P/R services among all SPA states, behind only New York.
- **Adjust service limitations, such as by increasing the daily maximum or changing it to a monthly maximum to facilitate longer appointments.** If CHW/P/Rs travel long distances to meet with a client, they may seek to have longer appointments to increase efficiency, reducing the need for as many in-person appointments, and establishing trusting relationships as part of a hybrid approach. While California limits CHW/P/R services to two hours per day, Rhode Island does not set a daily limit and Michigan only sets a monthly limit.
- **Explore opportunities to align Medicare and Medicaid codes for CHW/P/R services.** While travel time is not reimbursable in the new Medicare benefit for community health integration (CHI) services, higher Medicare rates for CHI may offer additional flexibilities to support sustainable delivery of CHW/P/R services.

One pathway for states to support uptake of CHI services is to "turn on" Medicaid codes for these CHI services. For example, in Minnesota CHI services can be provided to eligible Medicaid as well as Medicare members, and Colorado is exploring how to align these codes in Medicare and Medicaid. Introducing these CHI codes in Medicaid may reduce administrative burden.

- **Develop rates for providers of CHW/P/R services that reflect local context and expectations for time spent outside of direct client services**. They can also authorize longer service for initial visits in specific geographies.

2. Doula Services

Doulas are non-clinical professionals who provide emotional, physical, and informational support to individuals and families during pregnancy and in the postpartum period. There is strong evidence on the benefits of doula care for birthing parents and infants, and expanding access to doula coverage can advance greater birth equity.

DHCS implemented a Medi-Cal doula benefit in January 2023, making California one of 13 states (as of April 2024) that cover doula services in Medicaid through an SPA. In states where doula services are not a state plan service, MCPs can also provide doula services as an expanded benefit. The Medi-Cal doula benefit includes a statewide standing recommendation that authorizes an initial visit; up to eight additional visits; support during labor and delivery, abortion, or a miscarriage; and two extended postpartum visits. With an additional provider recommendation, the benefit authorizes nine additional postpartum visits.

Visits are reimbursed FFS, and a targeted rate increase went into effect as of January 1, 2024, that raised the maximum reimbursement rate for doula services from $1,500 to $3,100. California now has the highest Medicaid reimbursement rates for doula services in the country, though many states are pursuing new coverage pathways and increased reimbursement rates. While uptake of the benefit has been slower than desired, DHCS has reported steady growth in enrolled doulas and doulas contracted with MCPs.

Doula benefit services can be provided virtually or in person in settings such as homes, offices, hospitals, or birth centers. In California, the rates for doula services are consistent across settings and are not adjusted based on the provider's time spent traveling to a client. Doulas serving rural areas frequently travel long distances for client visits and can include overnight stays for labor and delivery. Addressing travel costs is one strategy that researchers have suggested to support increased access to doula care for people living in rural areas. While virtual delivery of doula services has increased in recent years, there is a lack of available data and consensus on the best approach and practice for delivering virtual doula services within hybrid care models.

State and Managed Care Plan Levers to Address Travel Costs and Enhance Sustainability of Doula Services

Examples of state Medicaid approaches to increase access to doula services by addressing provider travel costs, as well as MCP opportunities to incorporate travel time in rate negotiations for services, are outlined below.

- **Consider developing an incentive structure for doulas to serve rural areas.** For example, Nevada passed legislation that increased doula reimbursement rates, including a 10 percent rate increase for visits and labor and delivery services delivered to clients in rural areas. This policy was designed to address limited access to maternity care in rural regions of the state.
- **Explore developing a rate structure for doulas that accounts for the variability of travel-related costs for prepartum, labor and delivery, and/or postpartum care.** As one example, MCPs could potentially pursue development of a case rate for labor and delivery support that varies depending on whether distance traveled to the delivering hospital or birthing center (especially in a rural area) requires an overnight stay for the doula.

3. Field-Based Behavioral Health Services

Some outpatient behavioral health services may be delivered in field-based settings, such as in homes and schools, to engage individuals where they are and to support more frequent delivery of services as part of an individual's treatment plan. As one example in Medi-Cal, intensive home-based services are a service category inclusive of assessment, therapy, and rehabilitation for children and youth with higher levels of mental health needs.

In Medi-Cal, DHCS establishes rates to reimburse county behavioral health agencies, such as Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, for behavioral health services rendered. These county agencies then negotiate rates with their respective provider networks, which may include county-operated facilities. Counties vary in the respective percentages of the rates that are passed through to providers.

In July 2023, the CalAIM behavioral health payment reform initiative required counties to transition from cost-based reimbursement to FFS reimbursement. While the prior cost-based reimbursement system authorized providers to be reimbursed for all staff time, including travel and documentation, providers are newly required to use Current Procedural Terminology (CPT) coding that does not include time spent on travel and documentation as billable service time.

In the first year following the transition to this methodology in California, providers reported that their contracted rates with MHPs do not distinguish between clinic and field-based settings. Additionally, these rates within a county are the same whether a provider typically delivers field-based services in a compact urban setting or across a more expansive geographic area requiring greater travel time. As a result, many providers have reported considering a shift away from delivering field-based services or closing field-based programs.

State and Managed Care Plan Levers to Address Travel Costs and Enhance Sustainability of Field-Based Behavioral Health Provider Services

Examples of state Medicaid approaches to increase access to field-based behavioral health services by addressing provider travel costs, as well as MCP opportunities to incorporate travel time in rate negotiations for services, are outlined below.

- **Explore opportunities for state coverage of provider travel time for select services**. For example, Minnesota allows for Medicaid reimbursement for mental health provider travel time for members with an individual treatment plan who require services outside of a provider's usual care setting. Arizona authorizes certain behavioral health providers to bill to Medicaid for travel mileage when travel exceeds 25 miles.

- **Consider requirements for counties to create differential rates or incentive payments to account for delivery of field-based services.** DHCS has acknowledged concerns for field-based providers and wrote in a December 2023 letter to county behavioral health directors that the rates paid to counties were developed to reflect travel time and standards for field-based care. This letter strongly recommended that counties implement rate differentials or enhancements in their rates with providers to "avoid disincentivizing the delivery of clinically appropriate field-based services." Behavioral health providers have reported that the cost to provide services in community-based settings can be approximately 25 percent higher than providing clinic-based services. MHPs can develop rate structures that account for these higher costs for travel and lower anticipated productivity for these providers. As one example, Los Angeles County developed an incentive payment of approximately $38 per hour for providers delivering field-based services, which reflects progress toward covering these costs.

- **Invite providers to share information about travel and documentation time to inform future rate development.** For example, San Francisco Behavioral Health Services requested that providers document time spent outside of direct patient care.
- **Develop different rate structures at the state level to address the range of services for populations needing more intensive community-based services.** Two examples from Washington State illustrate this approach. First, the state developed a case rate payment for its Wraparound with Intensive Services program, which includes a range of services for children and youth with mental health needs requiring intensive services. Development of the rate, which is a tiered monthly PMPM based on acuity of need, included assumptions about the differences in clinic-based and community-based services. As another example, the state implemented a Medicaid team-based rate as a PMPM case rate to cover coordinated specialty care for first-episode psychosis. The case rate includes Medicaid allowable services and incorporated travel time for community-based appointments. A 2023 SAMHSA report noted that Washington State was developing an encounter rate that would be used along with the monthly case rate as needed in certain circumstances to more fully cover team costs. Case rate structures may help ensure flexibility to deliver team-based care in the best settings to meet individual needs.

Looking Ahead

Across these profiled provider types, three key findings emerged on the importance of addressing provider travel costs and the opportunities to do so:

1. **Not addressing provider travel costs may limit access to care for Medi-Cal members who live in hard-to-reach geographic areas.** This includes rural and frontier regions and other areas requiring significant time to reach field-based settings. Providers may also shift toward a greater reliance on telehealth delivery of some services due to cost concerns rather than member needs and preferences.
2. **A one-size-fits-all solution to these challenges may not be viable**. Given the wide variation in the respective structures of field-based services and in the travel time and expenses incurred by providers of field-based services, solutions must be designed to address the specificities of different services and provider types.
3. **States and plans can address these travel cost challenges**. At a high level, states can survey providers of field-based services on their travel requirements and other indirect costs to ensure that rates reflect the full costs of delivering services, and that service limits do not inadvertently increase travel cost burden.

In turn, MCPs and MHPs can ensure that the capitation revenue that they receive is distributed to providers in ways that center equity and maximize access to field-based services for those who need it most. This includes taking the following into account when negotiating rates with providers:

- Enhancements and/or incentives for field-based services;
- Differentiated rates based on travel time and expenses in specific geographies; and
- Differentiated rates for clients that need predominantly field-based services as part of their treatment plan.

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