

PHI Dialogue4Health Web Forum

Non-Emergency Medical Transportation: Trends and Innovative Solutions in Addressing Medicaid Transportation Barriers
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>> Laura Burr: Welcome to today's Dialogue4Health web forum. Non-Emergency Medical Transportation: Trends and Innovative Solutions in Addressing Medical Transportation Barriers. We thank the sponsors of this event, the Center for Health Law and Policy Innovation of Harvard Law School, the Go2 Foundation for Lung Cancer and the Bristol-Myers Squibb Foundation. My name is Laura Burr, and I will be running today's web forum with my colleague, Kathy Piazza.

It is now my pleasure to introduce our moderator for today, Katie Garfield. Katie is a staff attorney at the Center for Health Law and Policy Innovation of Harvard Law School. She joined the Center in 2014 and currently focusing her work on the Center's whole person care initiatives, which seek to ensure access to services that address social determinants of health and health-related social needs.

She received her JD from Harvard Law School and is an active member of the Massachusetts bar.

Welcome to Dialogue4Health, Katie. Thank you so much.

>> Katie Garfield: Thank you so much, Laura. And thank you all on the webinar for joining us today. Before we begin, I would like to just step back and give you a little bit of context on myself and my organization as well as our partner on this project. Sort of who we are and how we came to this work.

I am a staff attorney for the CHLPI. We advocate for policy reforms to improve the health of underserved populations with a particular focus on the needs of low income people living with chronic illnesses. Our Center -- which we also called CHLPI -- for short works with consumers, advocates, community-based organizations and others really across the nation to expand access to high quality healthcare and promote more equitable and effective healthcare systems.

We are also a clinical teaching program of Harvard Law School which means that we have the great opportunity to leverage the wonderful work of students here at the Law School to support all of our projects.

How do we come to this particular topic of transportation barriers? As part of our broader work, our center provides technical assistance to the grantees of the Bristol-Myers Squibb foundation for vulnerable population grants. Through this work we spent a lot of time examining the barriers, for accessing healthcare. One issue that comes up repeatedly with these projects is the issue of transportation. And the way that lack of transportation ultimately interferes with care and outcomes. So to respond to this issue, we worked with the grantee alliance, now known as

the Go2 Foundation for Lung Cancer to produce a series of issue briefs regarding the Medicaid non-emergency medical transportation benefit. These resources are directed towards advocates, patients, healthcare providers and others who are interested in ensuring that low income patients coping with serious conditions have access to the transportation services they need to receive care. You can see the issue brief series on the slide here. Just to give you a sense of what they cover, our first issue brief covers an introduction to non-emergency medical transportation which I'll generally be referring to today as NEMT.

Our second brief covers current trends, challenges and some initial innovative practices in NEMT.

Our third issue brief is a toolkit focused on one particular issue, which is the way that some states are looking to curtail NEMT services through Medicaid Section 1115 demonstration waivers and how advocates on the ground can respond to those efforts.

And then the fourth resource examines the broader landscape of transportation related services and thinks about how states and local policymakers can innovate even more broadly than just directly providing transportation when thinking about ways to overcome distance and transportation barriers to care.

The full series can be found on our website www.CHLPI.org. As some of you may know today's webinar is in fact the second webinar that we are doing to launch this series. Our previous webinar which will soon be available via recording on our website focused very specifically on the third issue brief, which was responding to Medicaid section 1115 demonstration waivers that look to restrict access to services like NEMT.

Today's webinar will briefly cover that topic because we are going through sort of the full spectrum of what is covered in this issue brief series. We will largely be taking a step back and providing an overview and placing a much greater emphasis on the issue of innovative strategies for implementing or supplementing NEMT benefits.

But before we dive into that I would like to introduce our partner in this work, Maureen Rigney of the Go2 Foundation for Lung Cancer.

Maureen Rigney is a licensed clinical social worker with Go2 Foundation for Lung Cancer, formerly Lung Cancer Alliance. She is currently the director of support initiatives and worked in a variety of capacities at the organization since 2005. Maureen got her Master's of social work degree at Jane Adams College of Social Work at the University of Illinois at Chicago; and prior to joining Go2 worked in community-based behavioral health programs.

I will now turn things over to Maureen to allow her to explain her organization's interest in this topic.

>> Maureen Rigney: Thank you so much, Katie. Again, everyone, I'm Maureen Rigney, director of support initiatives. Go2 Foundation was formed through a merger of Lung Cancer Alliance and the Adario Lung Cancer organization and we are transforming survivorship by saving, extending and improving the lives of those at risk and living with lung cancer.

Through our focus on public health advocacy, raising awareness, promoting excellence in screening and care, developing innovative research collaborations, and providing vital support in education, we understand that few issues impact people with cancer and other chronic diseases as greatly as the lack of access to reliable, non-emergency medical transportation.

This disproportionately affects the most vulnerable in our society and have a negative effect on health outcomes. Through our relationship with the Bristol-Myers Squibb Foundation we are excited to partner with the Center for Health Law and Policy Innovation on the NEMT briefing series and on this webinar. Thanks again, Katie.

>> Katie Garfield: Thank you so much, Maureen. It is a pleasure working with the Go2 Foundation on this important issue.

So now, before we jump into the meat of this webinar I would like to take a moment to do one final poll. On this slide you'll see the poll question. It asks: What population does your organization primarily serve? Check all that apply.

A, Medicaid; B, Medicare; C, dual eligible, those who qualify for both Medicaid and Medicare; D, privately insured; E, uninsured; F, other. So, for example, perhaps if you work for a condition-specific population. Or G, not applicable.

So just take a moment and check off all the choices that you find most applicable to your organization. If you are joining us today based on your own interest in this topic, check off the categories that you are personally most interested in.

Okay. Let's go ahead and close the poll.

My hope in asking this question is to get a sense of the core interests of you all as a web forum audience. While much of today's webinar will focus on coverage of transportation specifically in Medicaid, we will be covering some broader information that is relevant to other populations, such as individuals covered by Medicare or private insurance. By getting a sense of how many of you serve the other populations I can try to adjust the talking points accordingly or highlight those parts most interesting to you.

We now have our results in. It looks like as expected the majority of the audience is interested in Medicaid, about 70 percent. There is also a strong interest across Medicare, dual eligible, privately insured, uninsured. That is helpful to know as we move forward.

Keeping those results in mind let's jump into the substance. We plan to talk about transportation and its essential role in healthcare. For many Americans, a lack of reliable and affordable transportation is a huge barrier to accessing healthcare. This is particularly true for low income vulnerable populations. The focus of our webinar is really on transportation in the Medicaid program.

On this slide you see an overview of the topics we will be covering today. First, we will start with an overview of the Medicaid transportation benefits, non-emergency medical transportation or NEMT. We will discuss some of the current challenges and threats to NEMT that many of you may be facing on the ground in your states right now. And then finally, we will take a deeper dive into innovative approaches to overcoming transportation barriers both within and beyond the Medicaid program.

Let's start with a brief introduction to transportation in the Medicaid program. I know that many of you may be familiar with the basics of NEMT already. So for those of you who already know a fair amount about this benefit and about Medicaid in general, I do ask you to sort of bear with me as I want to begin at the beginning and make sure we are all comfortable with the ideas and terms we will be using throughout the webinar today.

So what is NEMT? NEMT also known as non-emergency medical transportation is a Medicaid benefit that provides Medicaid beneficiaries with transportation to and from necessary non-emergency medical services such as routine preventive care and appointments related to disease management. So this is distinct from emergency medical care. So sort of ambulance services, things like that. This is about routine non-emergency medical transportation. This is a crucial benefit because for many Americans a lack of reliable and affordable transportation is a significant barrier to accessing healthcare. At least 3.6 million people miss or delay medical care every year because they lack available or affordable transportation resulting in the need for later high cost interventions and poorer health outcomes.

To understand why we are thinking about NEMT and how it fits within the Medicaid program, it is essential to briefly go over the structure of Medicaid itself. So the Medicaid program, as I'm sure many of you are aware, is the largest health insurance program in the U.S., covering millions of the poorest individuals and families in the nation.

As of 2018 Medicaid covered more than 72 million people, which is around one in five of the U.S. population.

Medicaid is jointly funded by the federal and state governments. It is administered largely at the state level. States design and implement their own made programs within the broad federal guidelines and requirements.

One such federal requirement is that states provide certain mandatory benefits. A mandatory benefit is exactly what it sounds like. States are required to provide mandatory benefits under federal law. In contrast, states have the choice to cover optional benefits. Optional benefits include things like dental services.

A long standing federal regulation establishes NEMT as a mandatory Medicaid benefit, which means that states are required to provide NEMT coverage.

So while states must provide NEMT services they do have a fair amount of flexibility in how to administer the NEMT programs. So NEMT will look different from state to state. For example, states have flexibility around placing certain limitations on eligibility, thinking about things like ensuring that the recipient does not have access to a working licensed vehicle, things like that. States may impose criteria there.

States can also determine which entities manage their NEMT program. That is, whether the state agency will manage the benefits directly or instead delegate the responsibility to another entity like a Medicaid managed care organization or a transportation broker.

So why is transportation so important to the Medicaid program for so long? Transportation barriers disproportionately affect vulnerable populations such as individuals living with chronic conditions, older adults, women, minority and low income individuals. In fact, one study found that Medicaid enrollees were ten times more likely than people privately insured to report transportation as a barrier to primary care. This issue is particularly acute for the Medicaid population.

Additionally, the transportation barriers can really affect access to care. This is problematic for people already having difficulty with access.

Individuals who lack access to transportation often miss out on critical early services. They miss or postpone preventive care, meaning that they may miss out on an opportunity to prevent the serious health condition. They may also miss appointments that are necessary to identify or manage conditions they already have, meaning if they may not take the necessary steps to control ongoing conditions leading towards health outcomes.

As you can see on this slide, transportation plays a particularly important role in connecting patients to behavioral health services, preventive health services and key services for the management of chronic conditions such as dialysis. To put the impacts in perspective, consider recent science. Research among lung cancer patients in particular has found an association between transportation barriers and under use of chemotherapy and worst outcomes. Recent study found that absence of established usual source of care and inconsistent transportation were associated with a lower survival rate after an acute coronary syndrome.

Transportation to and from care isn't just an inconvenience. So lack of transportation isn't just an inconvenience. It can have a huge impact on the quality of life and even in some cases can become a matter of life or death over time.

But of course, the big test question around any part of the Medicaid question these days is often cost. NEMT is an important benefit not only because it improves care and therefore lives, but also because it makes good financial sense. The provision of transportation services has really been shown to be a cost effective approach to improving patient care which means the costs associated with delivering these services are relatively low in relation to the amount it improves patient health outcomes.

A frequently cited study from 2005 found that Medicaid transportation services are cost effective across all chronic and preventive medical conditions that the study analyzed. For four of these conditions it found that transportation was even cost saving, specifically asthma, pre-natal care, heart disease and diabetes.

These results are really unsurprising given the role that NEMT can play in chronic disease and preventive care. As we discussed on the previous slide, transportation services can help connect patients to ongoing management and help avoid the need for expensive health services by providing greater opportunity to screen, diagnose and treat reducing the need for later interventions. A 2005 study found that providing transportation to patients with asthma could even result in cost savings of roughly \$333 per patient per year.

So given the importance of NEMT to individuals in the Medicaid program, why has it really been controversial at all? Well, in many ways transportation is a unique Medicaid benefit. It involves a very different set of logistical staffing and management challenges than many other benefits in the Medicaid system. Transportation options may look different from state to state or even from town to town within a state.

To deal with these issues, states historically had significant flexibility in how to structure their NEMT systems, each with their own benefits and challenges.

On this slide you'll see a summary of the standard approaches. So first we have the fee-for-service approach. This is really the traditional model of NEMT administration. Under this model, states remain directly responsible for the delivery of NEMT services and states Medicaid agencies are responsible for determining eligibility of transportation providers and beneficiaries, and in authorizing and arranging trips. States that take this approach make contracts with independent contract providers to provide -- transportation providers to provide NEMT services. A number of states use fee-for-service model to deliver some of their NEMT services, but many states are actually a working -- are moving away from the fee-for-service model. The fee-for-service approach gives the states the greatest control over the NEMT programs, but administering NEMT directly could be inefficient or costly for the state Medicaid department as well as there is a perception that this model is potentially vulnerable to fraud and abuse. Instead we are seeing a shift to some of the other models you see on the slide, particularly managed care and brokerage.

So under managed care, under this option state Medicaid agencies can contract with managed care organizations to administer NEMT, typically at a capitated rate. This model is fairly new and only a couple of states are really including NEMT in their contracts with managed care organizations. But this model may become increasingly popular as it has the potential to create incentives to improve care, coordination, and control costs and may have some flexibility to address social determinants of health based on some of the broader flexibilities for MCOs. Some states try to leverage their public transit systems as part of their NEMT programs. Again, this is a smaller number of states. And while using public transit infrastructure may reduce costs and administrative effort, patients may have limited access to public transit due to geographic location or health care needs.

Finally we have the most common model which is the brokerage model. Under this model states can contract with private companies or in some cases state agencies to manage NEMT services. Brokers instead of the state Medicaid agencies are typically responsible for confirming eligibility of transportation providers, and beneficiaries, as well as sort of authorizing and arranging the trips.

Many states are switching to this model because they believe it will allow them to better manage costs, because they are paying on a more capitated basis rather than on a per-ride basis. And it allows them to partially delegate responsibility to monitor NEMT programs for fraud and abuse.

So despite advances in these different ways of being able to deliver NEMT, states continue to face certain challenges in administering their NEMT programs. Some of the challenges states face include customer service challenges. So some NEMT beneficiaries report issues related to poor customer service and lack of flexibility. So you see some of these challenges listed here on the slide. Some of the frequently cited challenges include scheduling. Beneficiaries often have to schedule rides significantly in advance of appointments. Thus, transportation providers may be incapable of adjusting to last-minute changes in pickup times or locations or responding to events that can't be scheduled in advance.

Additionally there are access challenges. In some regions there simply are not enough NEMT providers to really meet the needs of local beneficiaries. This something we hear a lot about when thinking about rural areas in particular. There are also driver quality challenges. So beneficiaries may face long wait times, no shows, poor driver behavior or drivers who lack the expertise on how to work with patients with certain conditions.

Then finally, program restrictions. So we also hear raised in this context the idea that things may happen like beneficiaries with mobility limitations may miss appointments because drivers may not be able to meet patients at doors or assist in leaving the home. Also some beneficiaries have reported problems regarding the need for accompaniment to their individual healthcare appointments.

Then the other sort of large area of challenge that we hear a lot about is fraud and abuse. So NEMT programs may struggle to address problems related to fraud and abuse. These are the types of stories that you hear in the news where things happen like we have an example from Indiana. The owner of an NEMT company was found guilty of fraud after billing Indiana Medicaid program for over \$1 million in rides that never occurred.

And so we do hear these types of reports. There are other challenges that sort of fall within the fraud and abuse area. So data collection challenges. So being able to track what is really happening to know whether or not services are being delivered.

All states require basic service data like date and time of service, total mileage traveled, et cetera, to be tracked. But no federal requirement, there are no real strong federal requirements that these reports are supported by outside data or recorded electronically or use GPS. So all of these sort of technological advances that could be leveraged to help with data and oversight, there aren't strict requirements around them.

Additionally, there is more general oversight challenges. State oversight systems may be inefficient. They might lack transparency. Or they might leave NEMT programs susceptible to fraud or waste.

So how are states really responding to these challenges? States can and have reacted to these challenges in sort of two distinct ways. As we'll discuss in detail later in the webinar, some states are really exploring innovative new approaches to NEMT as well as other creative ways to

overcome transportation barriers. And these have the potential to improve program efficiency and reduce utility says of high cost services.

However, some other states are taking a much more restrictive approach. Faced with some of the challenges, as well as political and budgetary pressures, some states are looking to reduce or eliminate access to NEMT services for certain populations. As suggested by the title of today's webinar, I would really like to spend the majority of the webinar focused on these more positive innovative approaches to addressing transportation barriers. What are the exciting things happening in this space?

However, before we do, I do want to take a brief look at some of these more restrictive approaches and how individuals on the ground can respond to them.

For those of you that would like a deeper dive into this issue of sort of threats to NEMT, you can listen to the recording of our previous webinar that focused solely on this topic. What are these threats and how can you respond to them? We'll cover them just briefly here today.

So one way the states are restricting access to NEMT and to Medicaid more broadly is through the use of Medicaid section 1115 demonstration waivers. So what is an 1115 waiver? If a state wants to make a change to the structure of its Medicaid program, that would sort of violate the broad federal Medicaid requirement such as reducing or eliminating a mandatory benefit like NEMT. The state must apply for a waiver.

1115 waivers are the most flexible type of waiver available and they are the most likely to be involved in changes to an NEMT benefit.

Historically, states have used 1115 waivers to expand access to Medicaid by providing coverage to additional populations, for example adult populations that are otherwise not covered, people living with HIV, all of these things have been covered under 1115 waivers in the past.

However, more recently we sort of have seen a change in this trend. Instead of looking to expand Medicaid coverage, some states are developing a more restrictive approach to 1115 waivers. As I'm sure a lot of you have heard in the news over the last year or so, some states have applied for 1115 waivers that would reduce overall eligibility for the Medicaid program by establishing things like work requirements, block out periods, et cetera, as well as applying for some waivers that could limit or eliminate access to NEMT services for certain populations. Currently three states have been approved in limiting access to NEMT services: Indiana, Iowa, and Kentucky. And the current administration has also shown interest generally in approving and encouraging these types of waivers.

Additionally we should note that the Trump Administration has also shown interest in making a broader change at the federal level that would give states even greater flexibility to restrict or eliminate access to NEMT. Until now, as we discussed earlier, NEMT services have really been designated as a mandatory Medicaid benefit. Thus, states are required to seek a waiver to eliminate or restrict NEMT.

However, the Trump Administration has previously indicated both in its 2019 and 2020 budget proposals and in a regulatory document known as the unified agenda it would like to introduce regulation that would change the benefit from a mandatory to optional Medicaid benefit. This change would make it far easier for states to eliminate the NEMT benefit across their entire Medicaid population as they would no longer need a waiver to apply to do so.

They could instead eliminate through a transparent -- less transparent process known as the state plan amendment process.

We discussed this previously in our webinar and how to respond to them there. I am not going into that in detail, but let me summarily say first, don't panic. First, remember that state efforts

to limit access to NEMT have been fairly rare up to this point. Only three states have approved waivers. And those waivers only limit access for certain populations. Additionally, the Trump Administration discussion of this idea of moving it from a mandatory to an optional benefit has sort of changed over time. So recently, just over the last month or so, the Trump Administration has pushed back the timeline for that proposed rule change to 2021. Previously it has said it was planning to make a rule regarding that change actually this month. So it has really pushed it back not by months but by years suggesting that the administration may be losing interest in this change, particularly as 2021 would be after the election and the administration may not even be in power at that point.

Additionally, there are opportunities for you as a stakeholder to publicly push back against both of these types of changes if they are occurring in your state. So both federal law and regulations establish as a transparency requirements that must be met before an 1115 waiver can be approved or before a regulation can be finalized. These requirements allow for stakeholder opportunities to respond and place public pressure on policymakers to change or eliminate potentially harmful proposals. In particular, federal laws and regulations create opportunities for stakeholders to respond to proposals either in person or at hearings or in writing via a public comment process.

Stakeholders can leverage both of these opportunities to highlight why NEMT benefits are so crucial to Medicaid beneficiaries and urge -- state and federal policymakers against implementing any restrictions to these benefits.

To construct a response, you can again look at part 3 of our resource series or listen to the recording of our previous webinar. Both give an overview of the transparency requirements and provide tips, tricks, talking points, et cetera, for responding to restrictions proposals.

I don't want to focus there today. Instead we want to focus on innovation. For the remainder of this webinar we are going to shift our focus, as I said, to the other way take states can respond to challenges to NEMT through innovation. Specifically, we are going to look at the question of what can states do to improve their NEMT programs and even go beyond NEMT when thinking about how to address transportation barriers that prevent recipients from having the access that they need to improve and thrive. States are currently striving to improve the NEMT programs and think about the broader needs of their populations than Medicaid and NEMT services can certainly address.

First let's look at what can be done within NEMT programs to address ongoing challenges such as oversight and service availability.

On the slide we've identified three categories of potential innovation. First NEMT policies; second, collaboration with transportation network companies; and third, the use of state coordinating councils.

First, some analysts highlighted steps that states can take in establishing the structure of their NEMT program to improve quality. So one such strategy that has been highlighted in the literature is the use of capitated payment models. The capitated arrangement generally used in a managed care organization or brokerage model places much of the financial risk on MCOs and brokers. Creating incentives for these organizations to control costs and monitor services for signs of fraud.

So thus building in an additional layer of monitoring in their program. Ideally.

However, it is also important to recognize that delegating to MCOs or brokers takes away a degree of state control and state oversight is needed to ensure that these entities are keeping costs

down by eliminating fraud and abuse and implementing innovative approaches, not just by failing to deliver services.

How do we think about that problem? One way to establish oversight is through creative and effective contract design. So when states are delegating to an MCO or broker they are entering into a contract with that entity. States can include provisions in their contracts that address some of the issues by doing things like addressing data collection, customer service, and requiring reporting, electronic tracking, training, and scheduling. Sort of covering a wide area of things that can create problems within NEMT.

So for example, states can use electronic tracking provisions to require contractors to use realtime GPS trip monitoring to assure timeliness in pickup, eliminate frapped and provide data in general. This is recently added to New Jersey's NEMT contracts. So thinking about the ways that you can contractually require NEMT providers to do a better job of tracking and reporting on what they are doing.

And utilizing these types of contract provisions, states will also want to think a bit about enforcement. So the contract provisions are only as good as the work done to actually ensure that they are being enforced. So is the Medicaid agency or another body doing sort of checks on the broker or MCO? For example in a recent report, a D.C. official conducting random checks of his brokers and NEMT documents such as provider enrollee documents to ensure it was maintaining appropriate records and complying with contractual requirements.

Again, thinking creatively about contract design, also remembering to place emesis on enforcement.

Additionally, one other way that states can innovate within their NEMT programs to make sure that they are addressing some of the challenges is to expand driver networks. One of the big problems tends to be in particularly for rural areas the actual access to drivers. And what does the network look like?

So states can also consider creative approaches to expanding their pool of NEMT drivers to improve areas where drivers may be scarce. So, for example, NEMT programs can reimburse sort of other individuals, family members or friends of beneficiaries, for using personal vehicles. States can also re-examine what their current NEMT driver rites are to see if there is any way to adjust them to create a broader driver pool while still maintaining quality of service.

Second, one of the largest areas of innovation in NEMT right now is this idea of transportation network companies. So increasingly, states are looking to partner with TNCs to provide access to care. TNCs are companies such as Uber or Lyft characterized by on demand hailing capabilities and easy to use mobile applications.

This allows TNCs to address flexibility and scheduling concerns typically associated with TNC programs and create electronic automatic ride records that can be used to provide moreover sight.

To give you examples you may have heard about, we know that Lyft significantly has significant partnerships with transportation brokers to deliver NEMT and continuing to expand. Lyft has a three year contract with logistic care to provide rides in 286 cities and 31 states and D.C. Uber recently announced a new electronic platform called Uber health to try to streamline use of Uber for NEMT purposes.

And while research is somewhat mixed studies do indicate that these types of partnerships can improve user experience and help control costs. For example, one study has found that while traditional NEMT is cost effective, it projects that using modern NEMT methods such as Lyft or Uber has the potential to yield greater cost savings and improve the overall patient experience.

In comparison using modern NEMT was estimated to save roughly \$268 per expected user and roughly 537 million annually when scaled nationally.

However, when implementing these types of partnerships, states do have to proactively consider what types of challenges could arise. For example, states will need to consider whether drivers in these TNCs can meet any state credential link or training requirements and whether the TNC has all the needed accessibility options across the targeted service areas.

And then finally we have one additional option listed here on the slide. The idea of using coordinating councils to try to streamline delivery of transportation services. Some states tried to coordinate and consolidate transportation services used by similar populations. This is stepping back and saying what are all the ways that transportation is being provided in my state? Can we coordinate them to create efficiencies across these programs? State coordinating councils are often made up of state officials, consumers and other stakeholder who oversee services, look at barriers and look for increased coordination.

Many states have these coordinating councils and they range in terms of how formal they are. Some may be more formal, being covered by statute, having dedicated funding and being able to steer research.

There are also councils more informal, more volunteer-based and do things like perform assessments, develop strategies, things like that.

So exam wills here are -- examples here are for example Kentucky and Maine have active state coordinating councils established by statute. This is an interesting option to think more broadly, but again how helpful they are may be depending on how structured they are, how formal they are.

As I said earlier we also want to think about not only what types of things can be done within an NEMT program but what type of innovation sort of goes above and beyond them to address some of the barriers and populations that NEMT can't really address on its own.

This is because NEMT services are subject to restrictions and may keep them from meeting the full spectrum of transportation needs in their communities. For example, they only serve Medicaid patients. Additionally they are generally limited to access to medical services. So we often hear a lot of questions come up about things like social determinants of health, other populations like Medicare or privately insured. What are we going to do when we think about those populations?

First this question about the limitations within the Medicaid program. One key limitation of Medicaid NEMT services is that they typically cannot be used to help patients access nonmedical services such as food or housing supports. Even though the services can play a critical role in driving health outcomes. Recently, though, a number of states have begun using Medicaid 1115 waivers to address this gap. I mentioned earlier that Medicaid 1115 waivers are a way to create flexibility within your made program. They can be used to sort of expand what your Medicaid program does or, as I said, more recently we have seen some restrictive approaches with these waivers.

However, this is the flip side of what I was talking about earlier, that threats conversation. This is the way that Medicaid 1115 waivers can be used to innovate. There are a number of states right now that are thinking about transportation within the context of Medicaid 1115 waivers that innovate and expand access. One example is right here in Massachusetts. So Massachusetts is currently implementing an 1115 waiver that created accountable care organizations across its Medicaid program. These accountable care organizations starting next year will have access to a stream of funding for what is called flexible services. These flexible services are really

addressing some of the health-related social needs of their patient populations. They target specifically food and housing needs.

And in some of the materials that are Medicaid programs have put out regarding the flexible services program they indicated that flexible services dollars can be used in sort of a broad range of ways that would encourage access to food and housing, including transportation to access food or transportation to access housing support services.

Similarly, an exciting new waiver is coming out of North Carolina that was recently approved that is going to have what are called healthy opportunities pilots that again are going to be going after the health related social needs, including things like transportation and security. There is some innovation happening in state Medicaid programs to think beyond the ways that transportation directly connects patients to healthcare. They are thinking about what are the ways that we can use transportation to connect patients to the other types of services that play a role in driving health outcomes, like housing and food.

Additionally, we know that Medicaid NEMT is only available to individuals who are in fact eligible for Medicaid. Many of you earlier in the webinar indicated that you also are interested in broader populations like Medicare populations and the privately insured. What does transportation look like for those populations?

First, let's look at Medicare. Medicare has historically provided more limited access to non-emergency medical transportation than Medicaid. Coverage of transportation in Medicare Part D is generally very limited and focused on ambulance services.

However, in some parts of Medicare there is broader access to transportation, specifically we are seeing a broadening of access in Medicare Advantage. So Medicare Advantage is Medicare that is delivered through a private insurer. Also known as Medicare part C. So about one-third of Medicare recipients receive their insurance through a Medicare Advantage plan.

Within those plans, the plans themselves can offer a broader spectrum of transportation services. They do have to provide that basic transportation via ambulance services for Medicare part B, but they can also provide what are called supplemental benefits that can include non-emergency medical transportation.

Additionally we are seeing similar to those Medicaid 1115 waivers a move within Medicare to think more broadly about the types of services that people need to improve their health outcomes. Particularly within Medicare Advantage, there are recent changes that are going to be going into effect for the 2020 plans that will allow the Medicare Advantage plans to give a broader spectrum of supplemental benefits, particularly to individuals who are chronically ill.

For those individuals, they can not only provide non-emergency medical transportation, but they can also provide transportation to address social determinants of health. Again, things like food or housing, with the idea that those types of things can also help improve health outcomes.

Additionally, we have a third category here where we see innovation. We have innovation in Medicaid and Medicare and a third way that individuals can access transportation is through, directly through healthcare providers. So regardless of your insurance status.

So healthcare providers, large hospital systems, individual physicians, things like that, they have historically been cautious about providing transportation due to federal laws such as the anti-kickback statute and beneficiary statute. These laws are trying to limit the use of free offerings and services to induce a patient to choose a particular healthcare provider or to use Medicare or Medicaid services.

And in the past they have had implications for providing free transportation. However, just in the last few years the OID, the federal government has introduced new regulations to allow

certain free transportation services from healthcare providers under certain conditions. So specifically, the services have to be geographically limited, have to be modest. They can't be ambulance level. They cannot be advertised. And they can only be offered to established patients.

Additionally -- oh, they must also be for the purpose of accessing medically necessary services. Providers may also establish a local shuttle service that anyone, not just established patients can use. Again these are ways that we are seeing greater flexibility being built into federal law to allow access for transportation. That was specifically through safe harbors created in those compliance laws.

Finally, we see one final option that can be very helpful regardless of insurance coverage. That is the volunteer transportation network. So these transportation networks can vary. They can be small and informal. Or they may be larger and more structured. One example we've given here is the A Breath of Hope Foundation. And their ambassador program. So A Breath of Hope Foundation is a Minnesota based organization for people with lung cancer. They established a volunteer transportation network in response to transportation barriers, especially for low income and elderly populations.

This program pairs individuals living with lung cancer with volunteer drivers. These volunteers are trained and have experienced cancer within their immediate families. This program provided roughly 350 to 400 rides for 50 lung cancer patients in 2017.

We know, though, that even these extra transportation options may not really be enough to overcome all of the transportation barriers that patients can face, especially in regions where transportation providers may be scarce. So for the last part of this webinar we want to look beyond direct transportation, so beyond NEMT, beyond Medicare, beyond the volunteer networks, beyond all those direct transportation, to think about what are the other types of policies that can be put in place to create a comprehensive response to transportation barriers. So this first slide discusses an approach called health in all policies. This is an approach that takes a broad look at policies that are being put in place either by local or state policymakers and asking: How do those policies directly impact health?

So health in all policies is defined as a collaborative approach to improving the mental health of all people by incorporating health decisions into health policy areas. As you can imagine state and local governments make a number of decisions that can address or exacerbate health-related transportation barriers. For example, do city bus routes include stops at or near key healthcare positions, or are sidewalks provided to provide walkable access to community health centers. These are not strictly speaking a healthcare decision, not part of a Medicare program or necessarily a public health program, but they do have an impact on the ability to access healthcare.

By encouraging these decision makers to commit to using a health in all policies approach you can be sure that these questions are raised during that decision making process. T during that process to decide where public transportation stops will be. In that process, thinking about walkability of different parts of a city or town. So that is a broad approach that can bring transportation into the decision making process.

State policymakers can also go beyond, above and beyond to address transportation barriers by adopting innovative strategies that bring healthcare to the patients. So one strategy that is currently very popular and growing is the use of tele-health strategies. Tele-health is broadly defined as communication and information technologies used to provide or support long distance

clinical healthcare, patient and professional health-related education, public health and health administration.

Really, tele-health can be used to bring more primary care and specialist services to patients in their home communities which reduces the need for patients traveling long distances.

Tele-health can be used to increase the capacity of local providers by allowing them to consult electronically with distant medical professionals.

There's remote patient monitoring and E-consultations and other services. These things prompt strategies to reduce travel burdens and increase aspects of care -- access to care. We have to keep in mind that they face legal, administrative, technological and cultural barriers that could prevent providers and patients from taking full advantage of them. If you are interested in expanding tele-health in your region or state, think about things like broad health insurance coverage for services provided via tele-health. Funding for healthcare providers to access tele-health equipment and training and increase investment in broadband especially in rural areas as Internet access is often a prerequisite to using these technologies.

On this slide we see an example where this is happening at the University of Hawaii. And this is thinking about the use of tele-health to reach rural or remote populations.

So in island regions many individuals have limited access to healthcare services, sometimes needing to travel by plane to access the care they need. Researchers at the University of Hawaii started a three-year initiative that will use tele-health to improve the ability of healthcare providers to connect patients to cancer care. The initiative plans to assess current infrastructure available to providers of tele-health and expand the use of tele-health strategies over time to provide expert consultations and direct cancer care in target regions.

Another big strategy for bringing care to people in the communities is the use of community health workers. They are defined as trained front line staff who bridge the communication and cultural gaps common between low income, underserved and often high cost patients and clinical staff. What does this mean? Community health workers are really members of the communities they serve and have a unique knowledge of the language, cultures and pressures on the patients they serve. They often help patients overcome transportation barriers. Community health workers work with patients in their homes and communities and bring care to the patients. Community health workers can help patients navigate health and Social Services which can provide transportation and thinking about access to things like Medicaid and Medicare and the ways that they might provide transportation to and from medical appointments.

And by helping patients really overcome some of these barriers, both social and cultural and in addition to just transportation, studies have shown that they improve healthcare outcomes and reduce costs.

Like tele-health, these studies can face legal and logistical barriers that prevent full integration into the healthcare systems. Again if you are interested in promoting the use of community health workers in your state or region, you have to keep in mind things like funding and workflows and really the ways that those things need to change to really integrate them into care. So anyone that is promoting use of CHWs want to promote policies that will leverage current opportunities to promote sustainable use of these services and second, they might want to consider promoting new payment models to emphasize team-based care.

And like tele-health, CHWs as I said earlier are important strategies for improving care in rural regions. And one great example of this is currently operating out of Marshall University in the Appalachian region. This program operates out of rural health centers in rural Kentucky and Ohio. Patients identified as high users of healthcare are connected to a care coordination team

that utilizes community health workers. They work one-on-one with patients in their home. During these visits, the community health workers help patients address health management, and adherens to health management and connection to services.

I want to highlight one new and interesting way to bring care to patients in their communities. That is through the use of what is called mobile health clinics. They are broadly defined as customized vehicles that travel to urban and rural community and provide prevention and health services where people live, work, play. There are 2,000 mobile clinics across the nation providing a variety of healthcare services. Mobile health clinics are on able to connect patients to a wider variety of services and get at the social determinants of health that we are increasingly seeing interest in our healthcare systems.

They can also help target vulnerable populations such as low income, uninsured and marginal communities.

I want to turn this over to Darcy Doege to discuss this strategy in use in North Carolina.

>> Darcy Doege: Was that my cue?

>> Katie Garfield: Sorry, next slide.

>> Darcy Doege: No, you're fine.

>> Katie Garfield: Darcy is a registered nurse program coordinator for the Lung B.A.S.E.S 4 Life the first mobile lung cancer screening program. She has 15 years of nursing experience including medical, surgical, ICU and intervention am radiology. She has been specializing in oncology, program cured facial, and she tapped the University of Kansas and received Bachelor's degree in nursing from Washburn university in Topeka, Kansas.

>> Darcy Doege: Hi, all. Katie, thank you so much for the introduction. Thank you for the opportunity to get on and kind of speak a little bit about our program and kind of the, as Katie was saying, the innovative ways that all of us are trying to reach the vulnerable populations and the communities that we serve.

I have been with the Levine Cancer Institute now for about eight years. Since the conception of it. But the Levine Cancer Institute is located in Charlotte, North Carolina, through the Atrium Health. Previously Caroline's healthcare system.

So our reach is we have about 30 cancer sites throughout north and South Carolina and the idea of the Levine Cancer Institute has always been to offer equal access to care, despite the zip code that our patients have. And making sure that they each have the accessibility to the same services, regardless of where they live.

So Melissa Wheeler, my director, created the idea of the Lung B.A.S.E.S 4 Life. It is the concept of bringing awareness, screening and treatment for vulnerable populations. We target the underserved population of uninsured and Medicaid through the state of North Carolina and soon to be South Carolina. This is true community baffled education with the screening, navigation and intervention all kind of combined into one program.

So with the idea of this kind of coming, what was it, 2016, early 2016, the truck hadn't been built or none of the programs had been established. So it was kind of a blank slate as far as we were concerned. But the mobile unit was created to just travel and offer the screenings out into the community, where the patients are already seeking their care. That was the biggest part is once we decided to grow in a community, we did network, we did education. We connected the dots between various free clinics, FQHCs, clinics and primary care offices throughout, that served Atrium and non-Atrium facilities, making sure everyone was aware that this service was offered. So it allowed the barriers to be broken down for these folks that were not seeking their care at a bringing and mortar site. They were not getting the screening offered because of stigma or other

rennes why. Many of them couldn't afford to get the screening paid for. And through the Squibb foundation we are still able to screen patients for free on the mobile unit.

About 60 percent of the patients that we do screen right now are uninsured. About 40 percent are insured.

And so as we move forward were our program we will never be screening patients that have insurance due to some of the state legal issues that we have with our CON.

With that being said we truly are able to meet the patients where they need to be met. As we've moved forward with our screenings, we have layered in some other things such as head and neck screenings. We are doing free screenings for the patient, on site tobacco cessation counseling. More and more ways we are touching the vulnerable populations has allowed the patients to come back and seek care. They are more likely to seek their care.

I feel as though that's part of the NEMT. As Katie was saying with some of the people, the access of drivers in the rural areas, if they know those people are going to be accountable enough to come pick them up for the appointments they are more likely to go. Reaching the Medicaid populations is very similar to reaching the uninsured populations. As you are with saying, it is alarming how many people are on Medicaid, but as quickly as they are on Medicaid, they are off of it and considered uninsured again. We need to look at that population as very much the same in the way that we reach out to them needs to be similar.

And so that's why when we go into the communities and we are parking in the parking lot of the locations where they are already comfortable with getting, if it's a food bank, a clothing bank, a homeless shelter, wherever they are already getting that care, they are more likely to show up for that point and come back for the next point.

With that being said we are covering 12 Counties at this point, moving into South Carolina as I mentioned very soon. But the amount of people that we can touch in that community while we are there is very overwhelmingly incredible.

We have a lot of people that show interest. We have a lot of walk-ups that we are able to accommodate now. And people get excited that the mobile unit is rolling into their community. And not just because we are screening patients for cancer, but because it is a certain population of patients that are eager to get care that they have been lacking for quite some time.

So as we move forward in our program we will be obtaining a second mobile unit that we will be targeting more research to younger populations, to firefighters, and doing a lot of research just to continue going on this direction that we are really reaching as many patients as possible through our mobile program.

This is much more accommodating for not just the uninsured but for employed individuals. I know up in Chattanooga they have a program that they do a lot of on-site screening for the insured populations of, like at a plant where there are a lot of heavy smokers and what not. But this really does allow the transportation barriers to be broken down for many of our patients. Medicaid transport does not bring patients to the mobile unit, but we have really been able to park in multiple areas in a day. Well, at least two to three areas in a day and offer screenings throughout that entire day at different areas to accommodate more for other people and offer gas cards through granted funding, through ACS that we received. And just being able to try to connect the people as much as they can.

The free nicotine replacement is incentive for the patients as well if the patients are interested in quitting smoking. That is another layer of service that we offer for the patients as well.

Katie, is there any other things you wanted me to touch on?

>> Katie Garfield: I think that covers it, especially since they would be great if we could try to reserve here the last 20 minutes or so to get questions from anyone in the audience who has questions, either for you, Darcy, or more broadly about the rest of the webinar.

So I wanted to just encourage everyone again to use the question and answer feature that is available as part of your sort of control bar for the webinar.

I am just going to jump into the Q&A. People can continue to submit questions. And so one of the things I wanted to address, because it came up so often in the questions that were submitted ahead of time for the webinar, was returning to this idea of social determinants of health. We received a number of questions that say how can transportation be arranged to get the things like food, housing, et cetera? Because they can have such a big impact on health. I tried to capture those throughout the webinar today but I wanted to end with a brief reminder on that point since there was so much interest in it.

As I mentioned earlier, there are ways that social determinants of health transportation are being worked into both the Medicaid and Medicare systems. First in the Medicaid system while NEMT specifically, so non-emergency medical transportation must be used to access healthcare services. There are ways that we're seeing introduction of broader transportation. So through 1115 waivers we are seeing some states creating funding for transportation that would get people to health-related social need services, things like food and housing. Again examples if someone is looking for sort of case studies of that, upcoming would be Massachusetts will be implementing a program called flexible services that will provide that type of transportation or at least give accountable care organizations the opportunity if they would like to provide that sort of transportation starting in 2020.

Additionally, North Carolina in its waiver that has recently been approved will also moving forward be creating sort of grants that will focus on health-related social needs that will create transportation insecurity.

Also managed care organizations inherently have some flexibility to provide services that go a bit above and beyond standard Medicaid services due to flexibilities within their contracts. If you are interested in exploring the way Medicaid managed care organizations can sort of provide broader services, I would recommend there is a great issue brief out there from the Commonwealth fund on addressing social determinants through Medicaid managed care. It highlights the opportunities for flexibility through things like value-added care or in lieu of services. And it takes a deep dive into that.

As I mentioned before, social determinants are also an issue that is coming up in Medicare. Mostly within the Medicare Advantage population. Again, we are seeing new flexibility particularly for the chronically ill populations that receive Medicare through Medicare Advantage to receive supplemental benefits that could include transportation to address social determinants needs.

Finally I would just highlight that there are also sort of local and state funded initiatives that are considering the issue that aren't necessarily Medicaid programs. They are broader sort of transportation programs. Thinking about the way that they are being addressed there.

Let's see. I have a number of other questions that came in ahead of time. Let me check the ones online as well.

One of the other big areas that we received a lot of questions about was access to care in rural areas. Again we tried to highlight that a bit throughout the webinar, but to take a step back and highlight it here, rural access to transportation is a particularly intractable problem. But there are some options to try to address it.

One of those options is to expand the network of drivers. This can be done through using TNCs like Lyft or Uber partnerships. I know that even those services may not have U.S. drivers in rural areas. Or may not be able to meet some of the specific needs of individuals in those areas. Again another way to get at this is to allow sort of reimbursement for transportation provided by others like parents or others in your community as part of the NEMT program.

Another way to get at this is, as we said there is more flexibility to provide NEMT through healthcare providers than there was in the past under that new safe harbor, under some of the key compliance and anti-kickback statutes and beneficiary inducement steps.

And then finally, again, thinking about broader ways to address transportation barriers that go beyond NEMT. Again, these can be really helpful in a rural area. Things like tele-health and community health workers or more mobile units as Darcy was talking about, can be a way to reach those areas that NEMT programs simply cannot.

Let's see.

And then we had a number of questions I've seen coming in about links for any of the examples we referenced. The one thing to know about that is that again this webinar is really launching a series of written resources. So you will be able to find all of the resources themselves on our website, www.CHLPI.org. Those resources will be posted after this web forum.

I see a question about that.

And then we've also gotten a number of questions about ensuring quality of programs. So really, for example, if a State has used a brokerage program or MCO, how do you assure that they are delivering a high quality of service? What this comes down to is the need for robust monitoring, strong contract language, and enforcement. So we've got some good examples out there of things like this. A good example of government monitoring comes out of Texas. Texas has a centralized NEMT office where staff really just monitor NEMT contractors. That's a way to have dedicated staff that are specifically doing this. It is a good way to ensure enforcement.

Another good example can be thinking about how advocates on the ground can try to get engaged in monitoring. We have seen an example of this coming out of New Jersey. In New Jersey, there was some concern regarding their NEMT provider, lodge particulars care and the quality of services being provided. Local advocates got heavily involved in this process. They leveraged a government report that looked at the New Jersey program and they also gathered other sources of data. They did a survey of people who received NEMT to identify places where the program could be stronger and advocated for change in the contract language to address some of those issues. In fact, some of those recommendations were included in the updated contract. So things like requiring GPS tracking in the large majority of vehicles in the NEMT program. Having a more standardized complaint and resolution system and having a lot of Complaint -- log of complaints being submitted to the state and limiting the wait time and making sure that drivers are contacting participants, the NEMT drivers are contacting the participants ahead of time to remind them of their scheduled transportation.

All of those things through the work of the broader public and sort of advocates on the ground are ultimately incorporated into the contracting process. That is an example of people on the ground being engaged in enforcement.

If you want to go to an even more extreme example, currently just earlier this year in Connecticut, the Connecticut legal services organization actually filed suit against its Medicaid program based on concern regarding the provision of NEMT services. So there is an even more extreme example of advocates getting involved.

So I think those are some of the ways we can think about enforcing quality. Making sure that there are mechanisms built into the government side of things for monitoring and enforcement and inclusion of strong contract language and encouraging advocates on the ground to think about how they can also place public pressure and scrutiny on the program to make sure it is meeting the needs of the populations that they serve.

I just want to make sure that I'm getting all of these. So we have a question -- sorry. Oh, we have a question, Darcy. This is a question for you asking how the program, the mobile program is funded.

>> Darcy Doege: Yes, so we had a grant that was written. Like I said, Melissa wrote it specifically through the Bristol-Myers Squibb foundation. The actual truck itself cost us -- it was the first time the design had ever been built. They custom built the truck around the CT scanner. It was about 1.2 million. So the total grant was 1.6 million. That includes us paying for all the tobacco cessation, all the scans, the salaries for the tech and the driver and our rent that we pay for where we park our mobile unit.

If there is any other -- there's a ton of people that reach out to us on a monthly basis wanting to start a similar program. You guys can always feel free. Katie can give you my contact information and you can feel free to reach out to me if you have specific questions about all this madness.

>> Katie Garfield: Excellent, thank you, Darcy. And then we've also had a couple of questions submitted in advance about broader programs that we didn't touch on so much during the webinar today. We did have, for example, one question regarding transportation in the V.A. program. So just to give you a brief overview of that. The Department of veterans affairs does provide some access to information within the V.A. program. So things like mileage reimbursement and NEMT for travel to healthcare and rehabilitation appointments for disabled veterans, meeting certain criteria. That is something we have not -- it is not a sort of core part of this issue brief. We don't go into it in detail there. There is information out there on ways that individuals in the V.A. program can also access transportation.

Other questions?

(Pause.) okay. And then I'm trying to see if we have any other ones that we can answer broadly. I think we have had some people asking a little bit more about the healthcare provider option, that flexibility that I mentioned earlier. If you would like a citation to that, certainly let us know. I provided that to at least one person via the Q&A there. But again like I said, that is an important new opportunity for healthcare providers to directly provide transportation services, but you must keep in mind if you are interested in that the sort of restrictions that were placed around that safe harbor. As a reminder, the new regulation, the new safe harbor allows certain free transportation services to be provided, but the travel has to be modest and geographically limited. So to remember geographically limited means in this context, I believe it is 25 miles in urban areas and 50 miles in rural areas.

It also cannot be advertised. And it must also only be offered to established patients for medically necessary services. There is also an option to provide broader transportation from individual healthcare providers by doing things like establishing a local shuttle service to anyone, not just established patients to use.

I am trying to see if we have any other sort of broad questions.

Most of the other questions look like, a lot of people are asking about access to the slides. Laura, do you want to talk about that?

>> Laura Burr: Yes, thank you. Good question. The slides and the recording of this event and the transcript will be available by next week at Dialogue4Health.org. On the page for this event. Participants today will get an email regarding that as well.

>> Katie Garfield: Excellent. So I think that's all I have today, Laura. I know you have a couple of final housekeeping things.

>> Laura Burr: Yes, thank you so much.

Okay. So thank you all for joining us. I would like to thank Katie, Maureen, and Darcy for your presentations today. And many thanks to the Center for Health Law and Policy Innovation of Harvard Law School, the Go2 Foundation for Lung Cancer, and the Bristol-Myers Squibb foundation for sponsoring today's event.

And of course, thank you to you, our audience. We appreciate your participation today. And as I said, a recording of this presentation and the slides will be available to you next week at Dialogue4Health.org. You will receive an email from us that will have a link to a brief survey. Please take our survey. We would like to hear from you.

The survey will include instructions for requesting a certificate of completion for this event if you would like one. Thanks so much for being with us and that concludes today's web forum. Have a great day.

(The web forum concluded at 2:30 p.m. EDT.)