



Safe Harbor Regulation and Non-Emergency Medical Transportation

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Note: This transcript of this webinar is in no way intended to be construed as legal advice. Individuals interested in this issue as it applies to their locality are encouraged to seek legal advice.

Sheryl Gross-Glaser (SGG): Good morning transportation folks. Our webinar today is Safe Harbor Regulation and NEMT or Non-Emergency Medical Transportation. We are sponsored by two organizations this morning. The National Center for Mobility Management (NCMM) and the Community Transportation Association of America (CTAA). NCMM is a partnership of CTAA, APTA (the American Public Transit Association) and Easterseals. And here's just a little bit of what NCMM does, or you can go to [nc4mm.org](#) and there's lots of materials there. We are also cosponsored today by CTAA and we have our Executive Director, Scott Bogren with us. Scott?

Scott Bogren: Good morning everyone. Thanks for joining us today and after a, for many of us, a holiday weekend, getting back in the swing of things here on a Tuesday, I'd like to give you just a little bit of information about CTAA. I think many of you looking at the names are probably well aware of who we are, but we're a national non-profit association of organizations and individuals who move people, and they move – we move people to work, to education, to retail, to social and human services, and yes, to healthcare. One of our fastest growing membership categories is the non-emergency medical transportation or NEMT categories. And I would also note that our rural transit members, our urban transit members and our specialized transportation members also do a lot of trips and provide a lot of access to healthcare. CTAA provides our members with resources, advocacy, training, networking opportunities, our annual expo conference is coming up in Detroit in June. Some of those resources that we provided are really the focus of today's webinar. In December we covered the Safe Harbor ruling that we will be discussing today. Also in November we had some coverage on an HHS OIG ruling and just to set the stage, both of those rulings are starting to move the needle in the direction of allowing healthcare providers of all types to support, in a number of different ways, transit. Transportation and even in some cases things like transportation coordinators, which I think has a good overlap with our concept of mobility managers and mobility management. So before I turn it back to Sheryl, I just like to thank those of you who are members for being members of CTAA. If you're not, we'd sure love to have you as a member and they'll be – go to our website. It's [CTAA.org](#) and you can get plenty of information on who we are and what we

do, and mostly thanks for joining us this morning and we hope that you find this both – this to be a time well spent for you. Sheryl?

SGG: Thanks Scott. I'm going to go back to just the NCMM slide there for a moment so you can see a little bit – take a moment to see what we do in terms of trainings, technical assistance and other kinds of supports and resources. We have a really interesting webinar for you this morning. I think Scott is right, that there are a lot of possibilities that the Office of the Inspector General of OIG at the Department of Health and Human Services is doing for us with the rule that came out in December. There's also a whole history of advisory opinions, what Scott was describing as rulings, that show great support for the idea at least of healthcare participation with transportation. But as those of us in transportation know, the reality is a lot more complicated and slow moving. So I will introduce our speakers and we can get into those details and move forward. Our first speaker today is Susanne E. Crysler. She is a healthcare attorney. She deals with regulatory, legal and compliance issues, and she provides general council services to hospitals and other healthcare entities, including healthcare physician relationships, patient care and consent issues, risk fraud and abuse and Stark issues, and she drafts independent contractor and vendor agreements. Susanne is also a former healthcare provider. She was a nurse, so I think she will have a really in-depth perspective that we're going to discuss. And then on the transportation side of the aisle we actually have CTAA's President on with us this morning, and not because he's the President but because William McDonald has decades of experience in non-emergency medical transportation. He was the Executive Director of Medical Motor Service in Rochester for 33 years, and he grew that from a 26 vehicle fleet to 50,000 rides per month. Bill also is involved with a bunch of non-profits in his area of New York State, including United Way, Rochester Regional Health, the Monroe County Department of Human Services and more, and I happen to know that Bill is involved with mobility managers and other involved in NEMT throughout upstate New York. So he really has a great deal of experience and knowledge in this area. Sue?

(07:00) Susanne Crysler (SC): Perfect. Well, good morning everybody. This is particularly a timely topic. As Sheryl points out, we have a new rule that went into effect this past January 6, 2017, which effectively commits hospitals now, service providers, and we'll walk through terms here as we go along, but it's a broad overview to provide patient transportation services in really one of two ways.

SC: I will tell you that as being outside counsel and looking at these issues, we have been approached and we've actually negotiated a lot of contracts right now with health systems that are looking to actually provide this type of service. So this really is a hot topic. I think for purposes for this conference, this webinar, it's important to understand the issues, the dynamics that face these healthcare providers when they're trying to negotiate because there are a lot of regulatory constraints, which are on their side that they have to fit these programs into. In other words, not to violate the law. So when we negotiate, and I've seen this on both sides, sometimes people might get a little dug in. But the understanding is that we need to get to something that's going to be legally acceptable to the government when these services are being provided.

SC: But I will tell you right now that there's a lot of outreach and a lot of interest right now for transportation for patients. So with that in mind, I'm gonna give you a brief background of the law. I know that there was some information provided with respect to – Sheryl did a very nice job of the overview and actually gave you some good details. I'm gonna walk through it a little bit more in-depth, and then we're gonna walk through how we can do certain things, and then go through some dos and don'ts. Certainly I'm sure there's gonna be time for question and answers. So with that, I'm gonna just jump right in here on the brief background of the law.

SC: As you're aware, there was a new Safe Harbor that was implemented and it was a Safe Harbor to the anti-kickback statute. Additionally, we have to look at under those anti-kickback statute it – there's another statute called the beneficiary inducement statute. Both of these are important because when healthcare providers are providing services and those services have to be framed in a way, otherwise it might look like we're trying to induce a patient to utilize services for purposes of payment for the patient coming back and payment being made by the government, specifically Medicare, Medicaid. And that's a problem from the government's perspective because they believe that that drives up the cost.

SC: So this Safe Harbor that came out, which is called the Transportation Safe Harbor protects the provision of free or discounted local transportation by eligible entities – I'll define that term shortly – to Medicare or Medicaid beneficiaries provided certain conditions are met. And that is going to be a requirement and that is absolute. In order to fit within this Safe Harbor and get absolute protection, all requirements of the Safe Harbor have to be met on the healthcare provider's side. (10:00) While I say that I will then go on to qualify that with, while non-compliance with the Safe Harbor does not necessarily mean a transportation arrangement will violate the anti-kickback statute and providers are charged with insuring that transportation Safe Harbor requirements are met, and to assess whether there are any of their existing transportation arrangement should be restructured. So in other words, you try to line up, you want to get it in exactly. At the end of the day for some reason if it didn't fit in 100 percent, then we need to look at facts and circumstances to see what is going on with the arrangement, how closely can we align to it, and most importantly right now, we have providers that are actually taking a look at their existing policies and arrangements and seeing how they can best structure to avail themselves of this Safe Harbor.

SC: Why is this important to fit within the Safe Harbor? Because anti-kickback statute provides criminal penalties for individuals or entities that knowingly or willingly offer to pay, solicit, or receive remuneration in order to induce or reward the referral business on your federal healthcare program. We talked about that. That's Medicare, that would be Medicaid. There's TRICARE. All those insurance programs that fall under that federal healthcare program. The offense for violating the anti-kickback statutes is classified as a felony and is punishable by a fine of up to \$25,000 per incident and imprisonment up to five years. So it's very imperative that we align the structure of the program with the Safe Harbor. Types of remuneration for purposes, and when we look at this definition I think, for example, kickbacks are bribes. Kickbacks being, you do something for me, I'll do

something for you. That's a problem from the government's perspective, whether those are made directly or indirectly.

SC: Historically there has been, and this was mentioned earlier, there has been no Safe Harbor for the provision of transportation to patient. What has occurred is that we've had advisory opinions put out by the Office of Inspector General in whereby health systems wanted to provide transportation to their patients and they laid out the structure of that transportation program to the Office of Inspector General, and they either deemed it as being passing with very low risk to the program. Meaning the federal healthcare program where there'd be an incident of inducement for patients of coming back. Or they've outright denied it. We have lots of opinions that have been approved. We also have what's called the proposed Safe Harbor back in 2014, which took literally the last two and a half years to get passed, the one that just passed right now. So what folks did was, they tried to align themselves, the programs, as closely as possible with the advisory opinions and the proposed Safe Harbor to mitigate risk in terms of violating the anti-kickback statute. Interesting point about the advisory opinions, when we get them, is they're only unique to the requester. In other words, we can't rely on that for anybody else cannot rely on that in terms of approval for their own program. So this is especially important and timely that the new Safe Harbor has come out because all healthcare providers can avail themselves now of this Safe Harbor and structure their program appropriately and get the needed – get patients the needed transportation that – well, I should say, get the transportation that patients need to get the healthcare services that are needed.

SGG: I just want to jump in for a moment on two points. And we'll get into this a little more later, which is the limits of this new Safe Harbor rule and outside those limits, particularly regarding geography, they – cause there's mileage limitations put in, that those old advisory opinions will still apply. So those same factors that they would list, still apply to folks outside the geographic limits of the new rule.

SC: Exactly. If, under the new rule, we don't meet those requirements folks now, they can't structure their program, will have to request an advisory opinion to make sure and let the government take a look at the program to either get their blessing and sign off on it, or in some cases have to modify it or in other cases, they've been told no. But yes, you're right. Those advisory opinions will always still be there in the event you can't structure to align with the current Safe Harbor.

SGG: Right. And just one more point before you go on. Those – in the last few years – those advisory opinions have been very friendly to transportation.

SC: Yes. Absolutely, yes. So, because of the broad reach, and we've talked about this, because of the broad reach of the kickback statute, safe harbors were developed to protect various types of payment of business practices that would otherwise be treated as criminal offenses under the anti-kickback statute. The concern here is that these payment and business practices may potentially be capable of inducing referrals of business under federal healthcare programs, which drives up the cost to the government.

SC: So safe harbors were developed so all the requirements are met under a particular safe harbor, and today we're only talking about one, and it's the Transportation Safe Harbor, the arrangements are protected under the anti-kickback statute. However, it's very important to know – and I go through all these things because this decides if the healthcare provider's going to look at when they're determining whether they're going to implement a program or not – to help you folks understand where the logic and thinking is coming from the healthcare side. Compliance with the Safe Harbor only insulates an individual or an entity from liability under the kickback statute only. There is still a requirement to comply with all the laws and regulations and guidance that applies to the business at hand. So there might be other ones that we need to look at as well. We're not gonna get into those today, but this is only one small piece of it, but this is a big piece of it.

SGG: Sue, we have a question. Could-and since we're still on your presentation and it's pertinent to it, we have a question, which is, could you please just explain exactly what a safe harbor is a little bit more.

SC: A safe harbor – if the government's come out and said, you – and I'll put this real plainly – you can do this arrangement, provided you structure your arrangement a certain way.

SGG: So when you say safe you mean OK, you're not going – there will be no criminal or civil penalties. You're – get out of jail free card basically.

SC: Right. It's not – it does not rise to a level they'd have a criminal activity, no. That being said, cause the lawyer in me says, put this out there, you can structure your program – Let's just say for example or give a couple, it has to be less than 25 miles. I'm just gonna – for ease of conversation. Let's say I'm an established patient, and to the extent that you can't be a luxury vehicle. You all those things correctly and you structure your program. But if there's intent, meaning some type of intent along the way to induce referrals along the way for those patients, because we all know that Medicare, Medicaid is paid by the government. So if we're trying to induce somebody and we're setting this up – we set the arrangements correctly, but the arrangement with perhaps the vendor is not setup correctly, in other words, we have an arrangement that says, we structured this correctly but then the arrangement between the healthcare provider and the vendor, the healthcare provider says, you're not going to charge us. And for not charging us to do this, we will give you all our referrals. That's a problem and that will likely negate the Safe Harbor completely because the intent behind the program was in a lot of ways, criminal. So, again, and I'm trying to keep this very simple, that the bottom line is if hospitals provide – I'm going to use hospitals – is they provide the program structured within the Safe Harbor and they do everything that they're supposed to do, technically you're protected, unless there's some other type of intent there that the government looks at and says, even though you set this up you really intended to do nothing else. Hopefully that makes sense.

Bill McDonald (BM): To me, when I looked at the regulations, it became – just to support what you said – it comes down to transportation cannot be used as a recruiting tool for patients, and we had this situation a while back with the kickback statute where some non-

profit agencies, or even for-profits, wanted to be both the broker of transportation and the provider. And except in those cases where it was waived, and they regulations talk briefly they'll waiver programs such as the PACE programs operated by healthcare systems, (20:00) generally speaking they ruled against providers also being brokers. So there had to be this separation. But it's a very narrow – to me, it's a very narrow kind of opportunity because they define who can provide it and who cannot. So a good example of where this conflict was in the regs was a pharmaceutical company could not provide transportation to a doctor on the premise of the patient, on the premise that this would be free transportation to the doctor, allowing the doctor to gain access to the patient and therefore, reimbursement, providing that the abuse concern was that they would then prescribe higher cost drugs that they have been made by that pharmaceutical company. But what is allowed is a hospital, which I found kind of ironic, a hospital could with their established patients, provide transportation to their pharmacy to get drugs. One of the key hoops, and Sue's probably going to talk about this, is whether you are a current patient of the provider or not and they define that rather liberally. You could have signed up to be a patient, but not been there yet and that would still qualify you. So they're trying to make these distinctions where you can only use transportation, you can't use it for any exchange of referrals, but unfortunately, they still take a very limited view in terms of you can't provide transportation to other social determinative health type of destinations, except maybe through the shuttle because there's two kinds. But I think it was just really – they're trying to keep these agencies from using it as a recruiting referral opportunity, which is kind of a thin line to me because we're trying to provide access to patients to healthcare so that will increase participation, but they – and access – but they want to make sure that the patients are already affiliated with that provider, right? Either by the fact that they've received care in the past or they've made the choice – it all comes down to patient choice – except in – they want to protect that, except in waived programs, like managed care operations or case programs.

SGG: This is Sheryl. I – we'll go back to Sue in a moment. The established patient part of the rule is as you said, very liberal. And I think this is a good example of why people get scared about regulations because the term, established patient, sounds to a normal person like someone who has an ongoing relationship with the healthcare provider. When the rule actually defines it as someone who's basically made the first appointment and hasn't even walked out the door necessarily to go to that appointment, and I'll let Sue take it from there.

SC: No, you both are spot on on this, and in terms of what the government was trying to get to and in some ways, you're – Bill, you're right. They really have narrowed – they've kept it fairly narrow under the individual transportation. They've broadened it under the shuttle service somewhat, but yes, they've kept it fairly narrow under the individual, which is what I will tell you that I am seeing a lot of, the requests for health systems in terms of providing the patient transportation and how hospitals can actually do that in terms of opening up new avenues that currently weren't available to them that they now are going to take a look at. So, certainly that we'll get to here.

SC: So as we said, the Safe Harbor requirements when followed will mitigate the risk and appropriately balance any risk against the benefit of the properly structured program. It's important to remember that nothing in the Safe Harbor exempts contracts between entities and transportation vendors, and I already talked about this, from complying with all other applicable fraud and abuse laws for the term of the arrangement that are not protected by the Safe Harbor. So, you will – we will usually see this when we're looking at it that all areas are covered off when there's negotiations going on. And as I gave that example earlier, an eligible entity – we'll use – we'll pick on a hospital, we'll use that term – may not require an ambulance company to provide – they talked about free or discounted transportation to its patients as a condition of receiving referrals. This is a no-no, cannot occur. Please keep in mind that when we discuss the Safe Harbor, the Safe Harbor in itself does not create liabilities for the parties at all. Rather, it protects the transportation arrangement that would otherwise be prohibited under the anti-kickback statute. So it's a good thing that we have it.

SC: So when we look at this everybody's saying, so what is the new Transportation Safe Harbor? What are the pieces of the puzzle we put them together right now. (25:00) And Sheryl mentioned eligible entities. This is key as we start. Who can avail themselves under the Safe Harbor? Eligible entities are defined to include all entities and individuals, including physicians, hospitals, physical therapists, dialysis facilities, homecare agencies and entities that do not provide healthcare services to patients, such as a managed care organization. They all may provide transportation to patients, provided they fit within – they structure the program within the Safe Harbor.

SC: The key here to be protected is that the provision of the transportation must be medically necessary. And when I say that I'm going to put the caveat in here is that there's two ways to do the transportation. We've talked about the individual transportation and we'll get to – we'll talk about that in-depth in a moment, and the shuttle transportation. For purposes of the individual transportation, the transportation has to be tied to being medically necessary to get the patient somewhere. That is very key here to be protected.

SC: Suppliers of items generally do not play a role in insuring that patients have access to providers. And I what I mean by that is what Bill also raises. For example, durable medical equipment suppliers, and these are folks that provide things like walkers, wheelchairs, oxygen tanks, and pharmacies are actually excluded from this Safe Harbor. Thus any transportation that would be done for those folks would not be protected under the Safe Harbor. So, it's a defined group of folks.

SC: When we get – we talked about the eligible entities, and we also have to talk about the established patients that go with these eligible entities. And the whole concept of limiting local transportation offers to establish patients, is to offer flexibility to improve patient care. That's the key here. While limiting the risk of the transportation being used so much as a recruiting tool or to bring patients in for unnecessary services, which in the end drives up the cost to the government. And that is what is to be avoided.

SC: And then I have, what does an established patient mean and why is it important? Established patient encompasses any patient who has made an initial appointment with the provider or supplier. This means when a patient makes an appointment, including rescheduling an appointment with an eligible entity, that eligible entity may offer transportation regardless of whether the patient has received services from an eligible entity in the past. So it's a very loose definition. You simply have to reach out and schedule an appointment. At that point you could be eligible for transportation services. This established patient concept is not applied to the shuttle service concept, which we'll also talk about separately. That is a little broader in terms of what can be done.

BM: So, the concept of the patient, isn't it correct that it is the patient or the entity on behalf of the patient? So it could be a family member or a caregiver –

SC: Yes.

BM: Would call a healthcare provider to make an appointment and then at that point they could ask, is transportation provided? If the answer is yes, then they could enroll the person. But a health provider could not reach out – and this is the part I think I'm correct in this, and it's an important point – a health provider cannot reach out to a mobility manager or care manager or health home and say oh, we're offering transportation to your client if you refer them to us. Is that a correct statement?

SC: Yes. You are spot on, yes, that is exactly – They cannot do that. Yes.

BM: But the problem I see with that, and we can talk about this later, is just that we would want – the challenge for mobility managers on the other side of the aisle or street is become aware of these health providers who are offering this service but not be solicited by them. That's the tricky part.

SC: Correct. And I will say that – we'll also get into this in a little bit as well, but – and I'll use the term hospital because it's just easier conceptually when we're talking about providers. But, hospitals also have – must have policies in place to address when transportation can be provided. (30:00) So to the extent that they have a policy in place it also has to be consistently applied and enforced with respect to transportation services.

SC: The government doesn't say how you determine who is eligible for the transportation, and a matter of fact, they give you some examples of specifically – A lot of hospitals will use financial need, that is a big one. Other hospitals will in fact look at service area or they will look at if – and the government gives this as an example as well – that if a patient is calling to schedule a surgery and they know that the patient is not going to have the ability to drive after surgery because they were put under (anesthesia), then at that point, if their policy allows, they can reach out and offer that individual a ride home. Or for example, another could be if you have a patient that has a history of missing appointments, that might be a part of the hospital's policy that says that we can extend an offer of transportation to those individuals. So, the hospital really has control over that in terms of the individual patient transportation and how that occurs and how they identify.

SC: What you can't do though, however, for purposes of looking at these established patients determining who gets them is, you can't specifically point to insurance and say, we're only gonna offer this to Medicare and Medicaid. That's a major no-no. Now, to the extent that you say that you have individuals that are financially needy and however that might be defined in your policy, if that group happens to make up a proportionate share of perhaps Medicaid, but your policy is crafted in a way that meets the financial need, then that's just kind of incidental to, but that doesn't rise to the level of you're targeting certain types of insurances that for purposes of looking to get those services for referrals coming back to your facility. The government says that you can't do that. They're – and again, they have not delved into how you do your policy. They've given some examples. But I will tell you that lots of health systems, set their policy for transportation around charity care and financial need. More often than that, 99 percent of the time I have seen or when we're reviewing or when we're looking at these, most of these are built around charity care and financial need for patients to be availing of these rides.

SGG: This is Sheryl. I just want to stay on this a moment longer so everybody's clear. What the rule does is create possibilities. So, what Sue is saying is exactly right. A hospital can avail itself or another healthcare provider can avail itself of the full range of possibilities that the rule allows for. But it can also only choose a subset such as people with a certain condition, or people right after surgery, or people above a certain age, or with certain disabilities, but it – Or it can say every patient. Now, is that correct Sue?

SC: Yep. You just have to be consistent in how you apply your policy.

BM: But I think as Sue said, you couldn't – if I – as I understand it – you couldn't discriminate based on the insurance types. So you may have these other criteria. You couldn't say, we're only going to provide this to Medicaid or Medicare beneficiaries and not to other health insurers, correct?

SC: That's absolutely correct. As a matter of fact, they even give an example of that in the preamble language, specifically speaking. And then they go on too, as we discussed, to say however, if your financial needy policy – let's just say 200 percent above poverty is what you look to to determine charity care and to fit within their policy for transportation – if the majority of those folks happen to be Medicaid it would be incidental to but it wouldn't be targeting that specific insurance.

SGG: And I think for the – somebody who's not a lawyer, it translates a little bit as being a little disingenuous. It's not being real because you can say, OK, all of these people who come below the poverty line, right? Most of them are getting their medical care through Medicaid. Why not just say, all Medicaid patients? (35:00)

BM: Well, you wouldn't want to say that because one of the issues for a lot of people that are just above the Medicaid eligibility have a transportation barrier. And I think the positive thing about that is the transportation's not a covered benefit for a lot of other health insurance plans, but this could open up, as I understand it, access to those people provided

they fell within the other criteria to get transportation. So, yeah, it might be a little disingenuous because – but their area of focus is solely on the population anyway, federally funded healthcare programs like Medicare and Medicaid.

SC: Correct. For purposes of preventing the fraud and abuse, right, in terms of this program, yeah. Because a lot of times we will see the financial needy policies really apply to those folks who are not even insured. They haven't even gone out to get, from a Medicaid standpoint, they just have no ability and so they're not even underinsured, they're just not insured period. I truly have not seen policies any other way with respect to this. We might see more of them now, but up until this point because we haven't had the Safe Harbor and we just try to remind to what the previous – what the government has previously said in advisory opinions, they have just really fallen back on charity care policies.

SGG: If I could make one analogy, and cause I'm imagining people sitting there listening to this webinar or listening in the future once it's archived, to say, oh my gosh, this is just so detailed and confusing and what do I do? I would compare it to a recipe. It's very simply – you say, oh, it's so easy to make this cake. You just add these three ingredients and you're good to go. But we all know that once you get into making that cake there's actually 10 different things you have to do and there's certain – you're gonna use flour, but what kind of flour? And it's the same thing when you're talking about anything legal. You're talking about, what are the exact definitions and what do you actually have to do once you get into it? So, the details just become important and actually it's a good thing if you have an hour and you're involved in non-emergency medical transportation to actually look at this rule because there's a lot of really good information in there that goes into details about what you can and cannot do. And it's written in pretty accessible language for a lay person.

SC: You know, Sheryl, that's a – it's a perfect analogy in terms of there are just five or six steps here that need to be followed, and I will tell you that even if you were to, from a transportation provider, to approach a healthcare system to say hey, we can provide X, Y, and Z for you in terms of transportation, I guarantee you the health system is going to be very up on what needs to be done and how to structure the program in a way that meets the requirements. So in reality it's both sides working together to make sure the program that they're putting into place and that the transportation that is occurring is compliant under the terms of the Safe Harbor, and it is not very onerous. Actually they've relied pretty much on what they've historically said in the past, and have just put pen to paper to formalize it.

BM: Sue, what – would you say that the focus of this change is more on Medicare beneficiaries than Medicaid? I know it applies to both, but – So for example, in New York and other states there's a generous transportation benefit already for Medicaid beneficiaries so that in theory at least, and really in practice, there's not – there's no reason to consider transportation as a barrier for Medicaid recipients in this state, and medically – to what they define as the appropriate definition of medical necessity. So, why – if that's the case, and I believe it to be – why would a healthcare provider want to construct a transportation program for Medicaid people?

SC: Well, they wouldn't necessarily want to construct for Medicaid because again, that would go back to – Do you mean from a hospital side or just from a transportation side?

BM: Well, from both. But let's say a transportation provider who is may be a Medicaid providers of transportation. (40:00) So they're getting Medicaid business provided that the passengers are choosing them or whatever the rules are around conflict of interest and kickback on that. But if you are a hospital, why would you want to invest in transportation for Medicaid beneficiaries when there's already a source of payment for it?

SC: Well, you wouldn't necessarily be investing in the Medicaid. Again, it would go to the scope of your policy as to who's eligible for the transportation. So you might be scooping some folks in that are actually Medicaid. But conversely it could be folks that are – again, however their policy is set up – to fold in individuals into . . . to provide that particular type of transportation for them. And given the way healthcare is going nowadays in terms of the changes and with ACOs and taking more control of patient care, you want to really – you want to net those people that are least likely to do follow-ups with their own care or have the ability to actually do any follow-up with their care, or even initially get to the hospital. But again, I wish I could give you a better answer – it could be driven by policy by the hospital in terms of who really is gonna be able to avail themselves of that.

BM: No, that's a very good point because in the discharge process at the hospital, they may feel that it's too complicated now to go through the broker for Medicaid transportation to set that trip up with the follow-up physician or the pharmacist, which are some of the key ingredients for conditions in care. So, that there, you did answer that. That did make sense. What was disappointing to me was the fact that they say in the future they'll consider whether you can provide transportation to non-medical services that are part of coordinated care which aren't covered now. I think that's an opportunity we need to watch. You talked about value based statements down the line in healthcare, those other destinations, like to get food, like you get discharged from the hospital but you don't have any food. Getting food is kind of important for your health.

SC: Oh no, exactly. Now, that doesn't prohibit from when we get to the discussion about the shuttle piece. It just doesn't allow it to do it under this one prong, which I call the one-on-one, the individual transportation of that person, and it did carve out family members. Interestingly enough, in the proposed rule that floundered for two and a half years, at the time they actually added some language in there that did allow family members as part of that, but then they took that completely out on the final rule and just basically said it's the patient, and if there's anything else, that they might subsequently look at that, but then in the language, in the document that we've talked about here, they've alluded to the fact that the shuttle would certainly be an acceptable mechanism.

BM: Yes. They are taking this very narrow, I think, interpretation of allowable transportation on the one to one, but a broader one with regard to the shuttle

SGG: Sue, can you talk about now that the two types of transportation that the rule discusses. One, the patient only type of transportation, and then the – what the shuttle rule is exactly.

SC: I can. So the two big ones here that came out of this rule is two things. We have individual transportation and we have . . . I'll call it individual versus shuttle services. The Safe Harbor said that eligible entities can provide free or discounted transportation services under two separate scenarios. The distinction is important because as you've heard as we've been discussing this, there are various things that you can do under one that you can't do under the other.

SC: So for the first scenario is gonna protect the free or discounted transportation of an individual by an eligible entity to a healthcare provider or supplier provided that all the following requirements are met. Now, I'm gonna go over these in larger picture detail in terms of what the requirements are underneath this, because when we get to the shuttle service you'll see how different it is.

SC: Specifically, for this individual transportation, the healthcare provider has to have the transportation set forth in a policy that is applied uniformly and consistently. We've talked about that. (45:00) Meaning those healthcare providers have to have a policy in place. The government declined to mandate any specific parameters on the policy in the final rule, other than it had to comply with the distance requirements which we'll talk about in a minute. And it prohibited transporting patients only to referral sources.

SC: In addition, the government said for under this particular one, and we said this as well, the government said that the policy should not include criteria that bases the transportation eligibility on whether the patient is a Medicare or Medicaid beneficiary. They talked about that actually quite a bit within the Federal Register language. The transportation is – cannot be air, luxury, or ambulance level transportation. Now I know Sheryl you pointed out in your update that you had sent out when this first all came out and you put a very nice piece together in terms of all the broad highlights in this, you specifically pointed out, while this says you can't use ambulance, or air, or luxury, there might be instances – and we'll use Alaska, cause I think you did as well on that, and it was also from the government – there might be communities where the only transportation is air or perhaps ambulance. In those specific cases, if we can't align – which we wouldn't be able to align under this particular prong of the Safe Harbor, then the recommendation would be, if it was a client of mine to say, let's go to the government and get an advisory opinion and get sign off for the program that you want to put in place so we don't have any worry in terms of what you're doing for purposes of your patients.

SGG: Exactly. And that's a good point to make, that when you go beyond the geography envisioned in this rule, or if you have a special case like a town in Alaska where the only service to a hospital would be air transportation, that this rule doesn't allow for that, but it doesn't prohibit it.

SC: Correct. Absolutely correct, yes.

SGG: So there are things you can do if you're not within the parameters of this rule.

SC: Which is reaching out and getting an opinion. And we have done that plenty of times on other things with the government and – in fact, they encourage that because they want these things to work for health systems and patients.

SC: The other piece of this for this individual transportation is that the transportation under this particular mode cannot be publically advertised. It means no marketing of any healthcare item for services can occur during the course of transportation or at any time by drivers who provide the transportation, and importantly, drivers or others arranging for the transportation are not paid on a per beneficiary transported basis. In other words, you can't pay on a per person basis. You pay in mileage, like a taxi, that's fine. You just can't say I'm going to pay per head going into the vehicle. The government says that's not allowed.

SC: You can include signage designating the source of the transportation on the vehicle. They said this is OK, even though somebody might say, well, it's marketing. I'm slapping a sign on there that says, for example, Human Healthcare System. Well, isn't that marketing? Well, they said, this is really done because for purposes of safety and that that's OK to put that on in terms of signage, but they don't consider that to be marketing for purposes of being prohibited under this particular prong of the Safe Harbor.

SC: But going one step further, other than that for purposes of letting folks know who's doing the transportation in terms of a safety perspective, we cannot – hospital, I'll use hospitals again because it's just easy – they can't on their website promote this type of transportation, not can they do this in printed material. And you can't distribute this to patients. You can have a policy in place within the hospital setting and you can ask patients if they need transportation if you're doing discharge. For example, a patient arrives by ambulance in an emergency department and you're aware that they're gonna need a ride home, you can ask patients if they need a ride home. And certainly you can give them that ride, but you can't put that out there as marketing in terms of "hey, look at us, we can provide free transportation or discounted" because that's – government sees that as possibly inducing those individuals to come to the hospital facility to get services of which the government would pay for. And that's inducement.

SGG: Let's stay on this topic just one moment longer. (50:00) So hospital or dialysis center or doctor's office cannot put something on their website saying, there is transportation help if you need it and this is exactly what it is?

SC: Correct.

SGG: But if you have three patients who happen to know that there is transportation and they say to their friends, well, the doctor's office won't mention it to you but they'll ask you this question or that question or they can't put it on their website, but we happen to know that if you ask there is a service. That kind of thing is allowed because the healthcare provider is not controlling it. They're not putting that word of mouth.

SC: They're not marketing it. Yep. No, you're spot on.

BM: And the problem with that rule is that from an access standpoint, how would a mobility manager in a community know that by word-of-mouth. So on the one hand we're trying to provide access to healthcare and then on the other hand this rule is saying, well, you can provide it but you can't tell anybody that you're providing it.

SC: I know. It doesn't necessarily make sense, does it?

SGG: That would need a change in the actual statute, would it not? To be able to do that kind of thing.

SC: Correct, because it's even gone as far as to say, if hospitals want to put some type of marketing to say that we have a charity care policy in place and they want to put this in a big magazine or some type of national press, you run the risk, even though you don't specifically say perhaps that it's free or discounted, but you might be offering a program, you run that risk that the government could construe that as marketing. Even though realistically, let's just say, you put that article saying that "hey, we've looked at this, there's a new Safe Harbor, we can provide these within certain parameters" and they put this in – I'll use *Modern Healthcare*, it's a big healthcare magazine – it's conceivable that the government can see that as marketing for purposes of your program and you would then have to make your argument to the government that you were actually weren't marketing this program. Now I might make the argument back that realistically folks that are in need of this transportation, let's just say the underinsured or the non-insured who are living day-by-day, are they really going to pick up a *Modern Healthcare* subscription that costs a lot of money and see this in here really as an inducement. So you are right, it just seems like it's a sliding scale here of OK, you can do this over here and you can talk about it generically in public, folks between each other, but the hospital can't do certain things like put patient brochures on a vehicle, put that their transportation policy on a website and say hey, we can do these things. A little bit of smoking mirrors, but the government just says you can't market it.

SGG: Right. And the government, when we say the government we mean the Office of the Inspector General at the Department of Health and Human Services, and they are limited when it comes to the regulations they issue as to whatever statute they're operating under says. So if there is a limitation in the statute they can't go beyond that. They have to work within those restrictions.

SC: Correct. And then they would enforce within those parameters. And so in a lot of cases what we do is we counsel on erring on the side of caution. What health systems can do in terms of, because they're very vested in making sure that patients get the care that they need and if they don't have the mechanisms of getting there, then they want to set this up. But again, not wanting to raise scrutiny from the government by doing something that might run afoul of the Safe Harbor.

BM: And so Sue, before this regulation change, if you were a healthcare provider, hospital, and you were concerned about follow-up care and provided transportation to people to get to the follow-up appointment who were already patients of yours, that would not have been allowable?

SC: Well, let me think about how I want to answer this. Because there was the proposed rule and because there were advisory opinions and these advisory opinions and the proposed rule previously talked about established patients, (55:00) hospitals would align their programs up with what the advisory opinions – even though they couldn't necessarily rely on that opinion if – saying the government signed off on our program. What the reliance was on is if we set it up like this, that the government previously approved that program, and the proposed rule, here's what the government's thinking that is going to be acceptable, if we can align as closely, if not spot on, then we're gonna go ahead and do this. And that's what they have done. This now this bright line section that says, now I'm gonna fit it in and here's all the things that I can do and not do, which means they might also have to tailor some of their local – or some of their transportation policies right now.

SGG: So, Sue, before we digress here, you were talking about the individual transportation for what is called an established patient.

SC: Yes. So, we've talked about you can't advertise. You can't use air, luxury, or ambulance level of transportation. So healthcare providers must have a policy in place that says who is going to be able to utilize the local transportation service. Some other highlights are for the purposes of this particular prong of the Safe Harbor, which is the individual local, transportation under this piece is only provided – can only be provided 25 miles of the healthcare provider or supplier to or from which the individual's being transported. So that's the mile radius. Or 50 miles if the individual resides in a rural area. Understand, and Sheryl, you brought this up when you sent your analysis, this 25 miles or this 50 miles, it's as the crow flies, it's a straight line. There are programs, Sheryl, you did reference this, there are programs, Google's one of them, that will allow you to plug that in. That doesn't mean . . . because we say 25 miles as the crow flies, that in reality it might be a 35 mile winding drive, but that's acceptable as long as it meets the 25 miles for urban or the 50 miles for rural.

SGG: Right. And the urban and rural designations, people should know on this call, are not Department of Transportation definitions. The designations that they use are metropolitan statistical area, which is a Census designation. Or New England County Metropolitan areas. And those – the New England thing is the Executive Office of Management and Budget, the others are Census designations. So they have these urban definitions and basically rural is defined as anything not urban.

SC: Which is just completely clear as mud. But yes. When – and I had to smile when they said rural is not urban. So it's everything but when they give you the definition for what urban is. Although the government does say now that this is a bright line test, so it's easy to apply. I know if you look at – if you read through the analysis of what the government did to get to this 25 miles, this 50 mile radius, they really did go through and there was a lot of

folks that actually – When these rules come out, there's a period of time when folks can make comments and the government will respond and if you read through the actual – which was attached to the federal register discussing this rule, you will see the actual comments that folks asked. And a lot of them were looking for increased limits, things along this line. And how the government actually settled on the 25 and the 50 were provided in that bright line. So it's actually interesting how they got there.

SGG: Yes. And I believe their designations they said include 95 percent of the American population.

BM: Was this do you think tied to their definitions for Medicaid transportation in common medical marketing areas? Do you think that – was that the rationale behind limiting this? Or defining what the mileage or area had to be? (1:00:00) So you couldn't just willy-nilly go across state lines or something farther away where the cost of the service might also be higher? They have that requirement on common medical marketing area in Medicaid currently anyway. In other words, you can't pick a specialty doctor that's 75 miles away if there is such a doctor providing that service in your own community.

SC: Oh, for purposes of the transportation?

BM: Yes.

SC: I didn't see anything in here specifically that the government used some type of the – But there were a lot of folks that came out with a lot of different – if you look through all the comments in there wanting to do things differently in terms of that mileage and they were just set on the 25 miles and the 50, which Sheryl points out, really got to the heart of grabbing everybody into that – I'm going to call it a safety net – for purposes of seeing if it could capture as many folks in terms of who could avail themselves to laws, that's the transportation.

SC: Now, interested to note, thought, for the modes of transportation, even though we said it excludes air, luxury, ambulance for this, vehicles equipped for wheelchairs and third party transportation, including public transportation, for example, a bus, are OK. So they did point that out and again, we talked about in the individual cases or communities that might justify something different would have to go to get the advisory opinion.

SC: Again, for the local the big piece of this is and most important to remember is the transportation's provided only for the purposes of obtaining medically necessary items and services. You can't use this type of transportation for any other purpose and they give a specific example. For example, of counseling or to get food, go to food banks or the food stores and that's when they get into this whole issue of perhaps using the shuttle. In addition, government was very clear that stating that the transportation could not be contingent on the patient choosing a particular provider. And for example, they actually gave a pretty good example in here, so I'm going to use it. If a hospital offers to transport a cancer patient who need to see a follow-up visit with an oncologist, the hospital needs to provide that transportation to the oncologist of the patient's choice. In other words, the

hospital can't direct which oncologist the patient's going to see for purposes of providing that transportation. And so you can't just direct them to your referral sources back to your hospital. So that was a big piece of this. If the patient that gets – it's their choice in terms of where they want to go if they're providing this service.

SC: Most important, the eligible entities that provide this transportation. The government's very clear, they have to bear the cost of the transportation and they cannot shift these costs onto any federal healthcare program, other payors or individuals. Now, how they bear that cost is up to them and there's a lot of discussion in here about– if you're looking for a grant or foundations or balance sharing with another health system to share the cost – that's between these healthcare providers to determine how they're going to stretch dollars to do this. They just can't shift it to anybody else.

SGG: So the rule is set up so you can have this one-on-one patient transportation, and I think an important limitation on that is it does not cover any caregivers or visitors in this part of the rule. (1:05:00)

SC: Yes, you are correct.

SGG: And some of the advisory opinions do allow for that kind of thing, but that would be beyond what this rule looks at.

SC: Correct.

SC: So for the second scenario, which is the Safe Harbor says, you can provide free or discounted shuttle services, an eligible entity I should say can provide that, which means that the shuttle should run or needs to run at a set route and schedule. So let me walk through what this means, cause this is a much broader concept and it allows the health system or the hospital some flexibility.

SC: Specifically the requirements for a shuttle service incorporates some of the same requirements for individual transportation arrangements, including a restriction on air, luxury, or ambulance level of transportation, and marketing – except that the shuttle's schedule and stops can be publically disclosed by the eligible entity. So that's the little unique piece of this. They can post those. The same thing goes with the restrictions on the driver payments and we'll talk about that shortly in the cost shifting. Again, you can't shift the cost of the shuttle service to a federal healthcare payor, other payors, or individuals. The shuttle service has to run on a set route and a schedule. It may be only provided within the eligible entity's local area, meaning that there be may be no more than 25 miles from any stop on the route to a stop or healthcare items are provided when measured directly. They sometimes have to think about this in terms of spanning out. So if you have healthcare items, if you're doing a shuttle – and I'll go through this in a minute. Let me just finish this up. Unless one of the stops is within a rural area which commits the distance between the stop and all providers to be 50 miles. And I'm going to give you an example right now, cause I had to stop and read it about four times myself. Government doesn't usually write anything real user-friendly.

SC: For example, if a health system runs a shuttle and it stops at a hospital, a public transportation stop, which would be a bus stop, which happens to be in a rural area, meaning the bus stop is, a grocery store and an urgent care clinic. That's your route. We've got a hospital, a bus stop, a grocery store, and an urgent care clinic. All stops, other than the bus stop, must be within 25 miles of the hospital and the clinic. And that's measured directly as the crow flies. Without regard to any intervening stops.

SGG: And the bus stop, could you clarify that, cause I'm not sure I heard you correctly about that. You seem to make an exception for the bus stop.

SC: Well, because the bus stop is gonna be in the rural area, so if you're now and you're coming into a rural area on this little route that you have, which is the hospital, the bus stop, the grocery store and the urgent clinic, if – the urban is going to be within 25 miles. And then it's measured directly, and the hospital and the clinic must be within 50 miles of the bus stop in the rural area. So you get additional mileage for rural and then we have this 50 mile rule from the bus stop in terms of the hospital and the clinic.

SGG: So, let me just clarify to make sure I understand it. So, whatever the healthcare provider is, in a rural area you have to be within 50 miles. So whether it's a bus stop or two blocks from where the patient lives, or whether it's a stop by a grocery store, or stop by the urgent care clinic or the pharmacy – whatever stops you have on the shuttle route, if it's rural it's 50 miles? And if it's an urban area, however that's defined in the rule, it's 25 miles?

SC: Correct. There is no established patient requirement for the shuttle service, so this makes it a little bit easier. And the shuttle service routes can include – we just talked about non-healthcare locations. So we can move them along to a spa if we have to. To like I said, the grocery store. You can have various different spots on a set route.

SGG: (1:10:00) And in terms of who can get on a shuttle, the healthcare provider has arranged options. So it could be the general public. It could be only patients in attendance. It can be a subset. Is that true?

SC: Yes. It can be family members of patients. It can be employees of the eligible entity. It can make the shuttle – you can keep it a closed loop, which would be family members of patients or employees only, or you can also open this up, the shuttle, to open it up to the general public in terms of who can avail themselves of that shuttle.

BM: So is it also correct that when you're – when the provider is establishing the shuttle and the stops, that if they're in an urban area and there are multiple healthcare providers within this range of mileage they're not obligated to stop at other healthcare providers, but they can have a stop that's only for their own healthcare provider, like a satellite office or whatever?

SC: Yes, it can be within their system.

BM: So, I find that ironic that you can provide transportation limited only to your own affiliated healthcare on a shuttle, for people to just get on the bus that you had no relationship with, but in the individual transportation you have to be more careful about that.

SC: I would suspect that for folks that if they're – hospitals are really going to do a shuttle, I don't necessarily know. And this will be interesting to see how this spans out in terms if this really actually gets opened up to the general public, or they have some subset of folks that they're actually targeting for purposes of this shuttle. Because when we think about this, and I know Sheryl you reference this in your summary analysis about there's no requirement for the ADA. There isn't specifically within the rule.

SGG: But the ADA still applies even though –

SC: Yes, because anything that's going to be general public would have to apply. So to the extent that now you're opening up or for people that need assistance that are perhaps wheelchair bound or cannot get up steps. There's a bunch of logistics. So it will be interesting, and I can tell you right now, I have not seen anything in terms of the shuttle, but what I am seeing is in terms of health systems availing themselves of how do they add more opportunities to provide under the individual and adding another mechanism or another way to provide transportation directly to their patients.

SGG: Sue, I'm gonna go to a few of the questions that I know are pressing. Dialysis transportation specifically is a very big issue. Is the limitation on where the funding comes from sort of the big obstacle to that? Because I get questions all of the time about dialysis centers are not willing to help fund transportation. So, is the limitation on using Medicare and Medicaid dollars a really big obstacle when it comes to dialysis centers contributing money for transportation?

SC: Well, interestingly enough the government does address – because there was exactly that type of chatter in the preamble language about dialysis centers, the extent that they could concern with respect to these providers and that well funded dialysis providers may increase their volume by mutually providing transportation hurting smaller providers. The government declined at any point to exclude other than what we talked about, for example, DME [durable medical equipment] providers or pharmacies from this. In terms of dialysis providers, certainly can provide that. But I guess I'm not sure Sheryl, in terms of when you're saying funding, are we saying –

SGG: So the rule says, you cannot use Medicare or Medicaid dollars.

SC: You can't shift the cost, correct.

SGG: (1:15:00) You can't shift that cost. Now in my understanding, and you probably know this better than me, most dialysis dollars, they're getting their money from Medicare and Medicaid. So what dollars do they even have left to use to fund transportation? So

does that become that limitation on the dollars they can use, does that become really a very significant practical obstacle to them helping to fund some kind of transportation?

SC: Well, they might have to look for other ways to get those dollars in terms of funding that to the extent that you can't shift any of these costs over to the government or any other individual or payor if – to the extent now that they've been doing that in some form or fashion, then they are going to have to look for other ways to fund this, or it might conceivably shut this down in terms of how they transport their patients back and forth. Did that answer your question?

SGG: Let me clarify. Right now I get the complaint basically that the dialysis centers aren't willing to play. They're not willing to get into this at all. They tell our folks that the OIG rules are a complete ban. That they can't get involved at all. So, I guess what I'm asking is, does that still apply? Does a dialysis center, because they're getting most of their dollars or all of their dollars from Medicare or Medicaid, are they still gonna come to the table or not? Or refuse to come to the table because of the limitations that are still upon them?

SC: But I don't know if I actually have the answer for you to that in terms of whether they're gonna – their behavior. Because I think really what you're asking is, is their behavior going to change?

SGG: Right. Is there any – right. Is there an opening for them to change their behavior?

SC: It could be. I think it's gonna be – cause this is gonna limit them somewhat in terms of – So they might be willing to look at this differently and be more open in terms of transportation. But I have not – personally, I will tell you this. From a pure dialysis point of view, I have not worked on anything that would even – that resembles the dialysis in terms of transportation. So I can't give you an absolute answer on that. I think there's some mechanism for perhaps them changing and coming to the table. But whether that occurs or not, I do not know. The government certainly has said, and they were very specific about dialysis, that they said the prohibition on the advertisement and the mileage, some of this to some degree limits the cost of the transportation. So that in itself is a checks and balance with respect to even these individuals. But they've also gone on to say that in addition – this is some exact language – we believe that Safe Harbor will save healthcare program monies in the very populations cited by this individual. Dialysis patients are a population that have been identified to contributing to the increasing costs of non-emergency ambulance transportation, and the benefit from local transportation furnished by providers. So very well might be that this opens the door for other providers to provide that service.

SGG: I think what you're saying is that it opens the possibility but it won't necessarily bring those dialysis center willingly to the table.

BM: Well, the statute doesn't require anyone.

SC: No, absolutely. It's all voluntary. It's absolutely voluntary. Whether you choose to want to do this, meaning the health system, the hospital, a provider is totally up to them. If you choose to do it, you've got to do it within the constraints of the Safe Harbor.

SGG: We have a few more pressing questions that I'd like to get in. These two questions are related so I don't know if you can handle them together. One was brought up earlier, which is, can mobility managers list what healthcare transportation is available? And similarly, one of our – the people on the webinar brought up that they've seen Uber advertising non-emergency medical transportation services. So are these folks, like Uber, like mobility managers, are they limited by this rule? Can they put out the information that there are transportation services available?

SC: (1:20:00) Well here's the interesting part about Uber. Uber doesn't bill itself to be a transportation provider. Uber bills itself to say that I'm a middleman and I can provide the hookup between the health system and the patient to get the transportation, but all I am is a middleman that provides an app or some type of kiosk that allows the health system to access the Uber app to connect patients to drivers.

SGG: I will just say this. Although there have been various lawsuits that where the plaintiffs have said, we think Uber is a transportation provider, none of those lawsuits thus far have ended in any judicial determination. They've all be settled and so Uber has been able to avoid any kind of judicial decision on that question.

BM: The ride hailing companies Lyft and Uber are developing what they're calling concierge services where they will contract with the – Lyft is doing this now in some markets – contracting with the healthcare provider for transportation through Lyft where people if they don't have the app on their phone it can be arranged by the healthcare provider for them to use Lyft. And that's not Medicaid and Medicare yet, but – well, it wouldn't be Medicare anyway, but I think they're moving in that direction for –

SGG: Well, they're willing to put out that service, but they do not concede that they are a transportation provider. I think that's what Sue was saying and that's an important distinction.

SC: And I can tell you this because I have looked at these at the national level for clients. These types of arrangements raise a whole host of different sets of issues that have to be heavily looked at by healthcare systems in terms of liability issues, HIPPA, to state-specific insurance laws, in terms of apps and protected health information, which is information like a patient's name or date of birth, her address, that goes into this app and for purposes of HIPPA and the business associates agreement. There's all kinds of issues right now that are not insurmountable, but it brings up a whole set of other challenges for this type of transportation, which is different for, for example, taxis, who employ, who cover their employee drivers from an insurance standpoint. There's contractual, what we call privity, between the rider and the driver because it's done through the employment arrangement that makes things much easier versus the folks like Uber and Lyft right now, which are challenging.

SGG: I have a few questions that I will ask rather quickly. And I will say that we've had a few requests for some kind of follow-up because this is a huge issue for mobility managers and transportation providers and people at all different levels of government that deal with transportation. So let me ask very quickly, this rule, does it – it applies beyond Medicare and Medicaid patients, is that true?

SC: Well, the anti-kickback statute applies to everybody, but specifically with this rule, this rule goes to – because there's two rules here that we look at that go in conjunction with this. There is what we call the anti-kickback statute, which it is for Medicare and Medicaid beneficiaries. Yes. If you provide those types to those arrangements, which are federal government programs, then yes, this rule applies. The civil monetary penalties statute, which is also called beneficiary inducement statute, only is applicable to Medicare. So, we have two sets of rules that get us to Medicare and Medicaid beneficiaries. Now, when – but to the extent that – and maybe I should back this up. I'm sorry. Anti-kickback says federal healthcare program. So most people think of federal healthcare programs, they think of what? They think of Medicare. But there's other healthcare programs that fall underneath. TRICARE is one of them that I would say out there. There's some other ones. Anything that is going to be reimbursable by the federal government is likely going to get caught up in the anti-kickback statute with this Safe Harbor.

SGG: (1:25:00) But if I have Blue Cross/Blue Shield and somehow – and I'm in an area where a hospital says, I'm willing to give individual patient transportation to people with X, Y, Z transportation problems, these rules would still apply to that transportation that they're providing to me. Is that correct?

SC: Well, there's a whole another area – and hospitals can provide transportation to everybody if they theoretically wanted to, but they couldn't cost report it, they couldn't write off bad debt. There's a whole bunch of things that they couldn't do if they wanted – So it gets us into a whole another prong and that gets back to their policy. So, at the end of the day, some of this gets into a billing rule and what you can do on cross reporting and things along those lines that we can certainly address. But at the end of the day, this policy, this particular rule was governed really from a federal – we'll use Medicare, Medicaid beneficiaries inducement to those individuals because that's where the government believes the fraud abuse would be.

SGG: Another few quick questions. For either the shuttle or the patient-specific transportation. It could be set up in a way that the patient would pay part of the cost of the transportation. So let's say they would be charged \$1 when they get on the shuttle or \$1 when they get that patient-specific transportation, unless they're Medicaid. That's a whole different things. But would that be allowed to say, OK, our riders need to X amount?

SC: Well, again, it's likely going to be – and I only use this in the context – cause we've only seen this really with charity care and financial need. Most of those patients that are gonna get the transportation right now for current hospitals that we see, that we've been negotiating, are for those folks that don't have the ability to pay. And the hospital's going to

be paying directly. There's going to be a mechanism in the contractual arrangement that allows for invoicing or tracking for purposes of paying those transportation costs. To the extent that the patient was paying part of it, I guess I would have to go back and take a look because I've not seen anything per se under a hospital policy where more often than not it's just free care, it's free transportation, or discounted in some form. So I guess the question is, is the patient able to pay for part of it and then who are they going to collect from the rest of, it is the health system, is the eligible entity? Is that the question?

SGG: Right. Or on the shuttle, would you have – just like you go onto a public bus and you either pay money or you have your card that pays. Would you be able to charge someone getting on that shuttle or not?

SC: Well, likely if it – you're gonna charge for somebody getting on the shuttle. The patient that's probably riding the shuttle is going to have a voucher that they're gonna give you anyway for those folks. Or in some cases if there's going to be a cash reimbursement to patients, it's gonna have to pay and then get some type of receipt to show payment to get reimbursed from the hospital setting if that reimbursement falls within the hospital's reimbursement policy. A lot of times I've seen hospitals for cabs and for buses and even for taxis, I've seen it two ways. I've seen it where the cabs have actually reimbursed – get reimbursed by the hospital on a monthly basis for transportation of patients. So there's no dollars exchanged between patients and cab driver. And I've also seen it where even where I – for 17 years in mental health services as a nurse, we would often have vouchers for patients, even for buses. So we pre-paid them and then gave them vouchers.

SGG: Very quickly since we have one minute, partnerships. So if you had a bunch of healthcare providers who got together and said, let's create a transportation service together that we all put money into, is that allowable?

SC: So we would probably have to look at this and peel this back and know some more facts because they specifically got into this whole issue about integrated health systems and what large integrated health systems couldn't do in terms of transportation. If you had a physician office in the integrated health system, they purposely went on to say that you couldn't do certain things on large integrated. So again, I would have to know specific facts to say what the government – cause the government came out and said ACOs, accountable care organizations could do certain things cause they're not a service provider. (1:30:00) But integrated health networks could not do certain things in terms of transportation. So and again, we also have a radius limit. So that might be prohibitive in terms of healthcare providers getting together because we've got the 25 mile and the 50 mile radius as well, which should be prohibitive stopping some of those arrangements.

We have come to the end of our time, so I am going to thank Bill McDonald and Sue Chrysler, and I'm going to promise all of those of you who are still with us, cause I see a lot of you are, that we will follow-up with more information and with something structured around all these questions. Because it's really like any other law. You get into the weeds and boy, it just raises more and more questions. And I know that our transportation folks want bright lines to know, what can we do and not do? And who can we play with in this

very, very important sandbox? So, thank you today to our speakers and Anthony Frederick, who did our technical work on the webinar today. This is not the last word. We will be following up.