December 31, 2019

Office of the Inspector General
U.S. Department of Health and Human Services
Attention: OIG–0936–AA10–P, Room 5521, Cohen Building
330 Independence Avenue SW
Washington, DC 20201

Re: Medicare and State Healthcare Programs: Fraud and Abuse; Revisions To Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, OIG–0936–AA10–P

To Whom it May Concern:

The Medical Transportation Access Coalition (MTAC) (www.mtaccoalition.org) was formed in 2017 to educate federal and state policymakers and other stakeholders about the benefits of medical transportation and the need for policies that support continued access to these services. The coalition’s founding and allied members include a diverse set of transportation brokers and providers, managed care organizations and trade associations, and patient advocacy groups. MTAC writes in response to the existing safe harbor regarding local transportation (42 C.F.R. §1001.952(bb)).

As a general matter, we support this existing safe harbor’s role in removing barriers to care and facilitating more coordination within the nation’s health care system by facilitating access to non-emergency medical transportation (NEMT) for beneficiaries. As health care providers increasingly adopt value-based care arrangements, NEMT has been increasingly adopted as a means of closing care gaps and avoiding hospitalizations.

We support the proposed rule’s proposal to modify the existing safe harbor to expand the distance which residents of rural areas may be transported, as well as the proposal to remove the mileage limit on transportation of a patient from a healthcare facility from which the patient has been discharged to the patient’s residence. These modifications are needed to address health disparities experienced by rural patients. An MTAC-commissioned study of 977 Medicaid beneficiaries with common chronic conditions who use NEMT to make their appointments in three diverse states, Louisiana, Michigan, and New Jersey, found:

- Two-thirds (66.7%) of rural respondents would not be able to attend any appointments without NEMT services, compared to 60.7% of all respondents;
• 85.7% of rural patients would be required to pay more out-of-pocket without access to transportation, compared to 81.6% of all respondents; and
• Without transportation, rural patients would be able to attend only 2.45 appointments per month on average (as compared to 11.56 appointments per month with NEMT).¹

Further, the Medicaid NEMT program demonstrates for many individuals in rural areas, the appropriate provider or treatment facility is not available locally. One study found the percentage of hospitals that offer substance use treatment services is substantially lower in rural areas (11% vs. 27% in urban areas) and there is less federal funding in rural areas for substance use services. Further, there may be more stigma associated with seeking substance use treatment in rural areas, the authors suggest, supporting the need to remove barriers to care as much as possible.²

Another study found Medicaid beneficiaries who use NEMT services are significantly more likely to make the recommended number of annual visits for the management of chronic conditions than those who do not use NEMT. For example, of the Medicaid beneficiaries with congestive heart failure in rural areas, 70.77% of those who employed NEMT services completed the 10 visits per year whereas only 27.03% of those who did not use NEMT services made the 10 visits.³

In 2015, Wisconsin audited its Medicaid NEMT program and found that many of the most costly users of NEMT services were being transported to receive substance use disorder (SUD) treatment at methadone clinics. Besides underscoring the need for more local treatment options, the audit highlighted the reality that clinically effective treatment options for patients are often halfway across the state in many cases. This is true even for common conditions like SUD and is undoubtedly truer for rarer conditions. According to the report, the Wisconsin Medicaid agency “found that 87.2 percent of trips for drug rehabilitation provided through [MTM, the NEMT broker] from August 2013 through June 2014 were to methadone clinics for the treatment of opioid addiction. Individuals receiving treatment for opioid addiction may require daily trips to specialized clinics that are primarily located in the State’s urban areas. Based on data maintained by DHS, the northernmost clinic specializing in opioid treatment is currently located in Wausau [a city 233 miles south of Superior, in northern Wisconsin].”⁴

We do not think it is necessary to condition the current safe harbor on a showing of need, nor do we think the proposed modifications should be conditioned on financial, medical, or transportation need. The implementation of the Medicaid NEMT benefit, a mandatory benefit for Medicaid beneficiaries—by definition, a financially needy population—demonstrates that NEMT is initiated and utilized by a relatively small percentage of patients without a reliable means of transportation. Data from MTAC founding members, three NEMT brokers, find that less than 10% of all Medicaid beneficiaries entitled to the benefit use the benefit, and other studies have estimated that outlays for Medicaid NEMT services constitute less than 1% of total Medicaid spending—a figure that does not take into account downstream cost savings to the system.  

Finally, MTAC is encouraged by the increasing use of non-medical interventions that have a reasonable expectation of improving or maintaining the health or overall function of a beneficiary, such as the additional flexibility to offer tailored supplemental benefits to Medicare Advantage members with chronic conditions pursuant to the Bipartisan Budget Act of 2018. Accordingly, we support OIG’s consideration of non-medical purposes in the final safe harbor and ask for this clarification to be reflected in rule text. As health care providers increasingly tackle the social determinants of health that influence a beneficiary’s ability to maintain an independent, healthy, and fulfilling life, this safe harbor’s expansion to include non-medical trip purposes is ripe and can be appropriately managed through existing parameters under the rule. Given the incentives to providers brought by value-based care and managed care arrangements, it is likely that the most frequent recipients of transportation services for non-medical purposes would be individuals recently discharged from a facility or those with chronic conditions (i.e., those with the highest risks of hospitalization and preventable costly episodes of care). However, we believe a permissible approach should be taken to give providers and health systems the discretion to invest in preventive, upstream measures like transportation to a food store or bank for a pre-diabetic patient or for an expectant mother living in a food desert. We believe fostering prevention through greater investments in transportation (and other supports) will lead to long-term health care cost savings and better health outcomes.

We appreciate your consideration of this letter.

Sincerely,

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Advisor to Medical Transportation Access Coalition

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