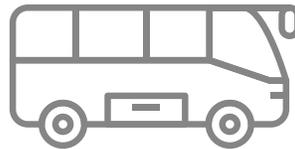
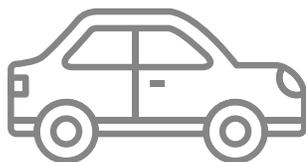


ISSUE BRIEF

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Non-Emergency Medical Transportation:

PAST, PRESENT, AND FUTURE OF A CRITICAL SERVICE



PART IV: TRANSPORTATION AND THE BROADER POLICY LANDSCAPE

About the Authors:

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality health care and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective health care and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

Lung Cancer Alliance serves and listens to those living with and at risk for lung cancer to reduce stigma, improve quality of life and increase survival. Lung Cancer Alliance empowers its community by helping people navigate the paths of early detection, diagnosis and treatment. Insights allow Lung Cancer Alliance to improve care, amplify awareness, drive advocacy and lead research with the vision of tripling the number of survivors in the next decade.



I. Introduction

Each year, millions of Americans encounter transportation barriers that prevent them from accessing the medical services they need to heal and thrive. As a result, these individuals may struggle to prevent or manage serious health conditions, resulting in worsening health outcomes and rising health care costs. As discussed in **Parts I – III** of this series, Non-Emergency Medical Transportation (NEMT) plays a critical role in addressing these transportation barriers. NEMT is a required Medicaid benefit that serves as a bridge to care by ensuring that low-income, vulnerable populations can get to and from their medical appointments.

However, Medicaid NEMT is only one strategy for overcoming transportation barriers. Health care providers, payers, and nonprofits across the United States are currently investigating a variety of approaches to better connect patients to care. These strategies can be paired with NEMT as part of a comprehensive plan to address state and local transportation barriers. Therefore, this final resource, **Part IV** in our NEMT series, will examine the broader landscape of transportation-related services and their impact on access to care.

II. Additional Options for Providing Transportation

While Medicaid NEMT services are a valuable resource for many low-income individuals, they are subject to certain restrictions that may prevent them from meeting the full spectrum of transportation needs in a given community. For example, Medicaid NEMT services are not available to individuals who do not qualify for Medicaid coverage. Additionally, NEMT services are only available to access medical care. They therefore cannot be used to address other needs that may ultimately impact health outcomes (e.g., nutrition, housing, etc.).

Luckily, there are a variety of other programs that can begin to fill these gaps. This section provides an overview of several of these additional transportation options, including: **(1) Medicare NEMT; (2) health care provider NEMT; and (3) volunteer transportation networks.**

- 1. NEMT Coverage in Medicare:** Many Americans receive their insurance coverage through our nation's other large public insurance program: **Medicare**. Medicare provides health insurance for individuals who are **65 and older** as well as for younger individuals with **certain disabilities** or **End Stage Renal Disease (ESRD)**.¹ Medicare enrollees either receive their coverage directly through the federal government, through Medicare Parts A (Hospital Insurance) and B (Medical Insurance), or through private health insurers that have contracted with the federal government to provide Medicare coverage (a/k/a Medicare Advantage plans). Medicare has historically provided more limited access to NEMT than Medicaid. However, recent policy reforms may create new opportunities to access transportation in the Medicare program moving forward.

- **Medicare Part B Coverage of NEMT:** Medicare Part B has historically covered *some* forms of non-emergency medical transportation. These services have generally been limited to **ambulance services** “where the use of other methods of transportation is contraindicated by the individual’s condition.”² Federal regulations restrict use of these services to situations in which “the beneficiary is bed-confined, and it is documented that the beneficiary’s condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.”³
- **Medicare Advantage Coverage of NEMT:** Medicare Advantage plans must provide, as a baseline, the same services provided in Medicare Parts A and B. However, in the case of NEMT, Medicare Advantage plans can also go beyond the limitations of Medicare Part B and more broadly provide NEMT to enrollees as a **supplemental benefit**.⁴ Like Medicaid programs, though, Medicare Advantage plans have historically only been able to provide these services to address enrollees’ health care needs. The plans cannot currently provide transportation to address broader, social determinant needs, such as accessing food or social services.⁵
 - **Recent Reforms under the Bipartisan Budget Act of 2018:** Beginning in 2020, though, Medicare Advantage plans will have new flexibility to provide **chronically ill enrollees** with a broader spectrum of supplemental benefits, provided that the new benefits “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.”⁶ Unlike supplemental benefits for other enrollees, these new Special Supplemental Benefits for the Chronically Ill (SSBCI) will not need to be “primarily health related.”⁷ In its recent Call Letter the Centers for Medicare and Medicaid Services (CMS) provided additional guidance on the SSBCI program. This guidance specifically stated that SSBCI may include “**transportation for non-medical needs**.”⁸

2. NEMT Coverage via Health Care Providers: Some health care providers also choose to directly provide transportation to their patients. Doing so can both improve patient health and benefit the health care provider by reducing no-shows and/or other scheduling issues. However, health care providers have historically had to be cautious when offering free transportation services. Federal laws, including the **Anti-Kickback Statute**⁹ and the **beneficiary inducement statute**,¹⁰ limited the ability to offer free services, such as transportation, when the service could induce a patient to use a particular provider. Under an advisory opinion process, some providers were able to get specific review and approval¹¹ of their non-emergency transportation arrangements, but this process took time and was very fact-specific.

- **Increased Flexibility Under 2016 Regulations:** In 2016, however, the Department of Health and Human Services, Office of the Inspector General (OIG) introduced a new regulation to allow certain free transportation services, as long as they operate within established boundaries and according to applicable compliance policies. For door-to-door transportation to be protected, the travel must be geographically limited (to trips within 25 or 50 miles depending on the area), modest (and cannot be air or ambulance level), must not be advertised, and can only be offered to established patients for purposes of accessing medically necessary items and services.¹² Another option for providers is to establish a local shuttle service that anyone, not just established patients, can use.¹³

3. Volunteer Transportation Networks: Volunteer transportation networks can play an important role in connecting individuals to care who may not qualify for or have access to other transportation programs. Eligibility and enrollment vary by program, and so some programs may be small and informal (e.g., programs operated by faith-based organizations), while others may be much larger and more structured.

Example: A Breath of Hope Lung Foundation – Ambassador Program: A Breath of Hope (ABOH) is a Minnesota-based non-profit organization serving individuals who have been impacted by lung cancer. When developing its support programs, ABOH reached out to patients and caregivers to learn more about the barriers that prevent access to lung cancer care. Transportation barriers emerged as a key theme in these conversations, especially for low-income and/or elderly populations. As a result, ABOH developed a volunteer transportation network as part of its Ambassador Program. This network provides supplementary driving services, building upon existing transportation options to better meet patient needs.

Geographic Scope: Twin Cities region of Minnesota.

Target Population: Individuals diagnosed with lung cancer who are ambulatory and receiving care from one of eight current partner hospitals in the Twin Cities region.

Program Description: ABOH’s Ambassador Program works to address persistent transportation barriers in the Twin Cities region by pairing individuals living with lung cancer with volunteer drivers (Ambassadors). All Ambassadors are vetted, insured, and trained (e.g., on patient privacy laws) by ABOH and have experienced cancer within their immediate families. Because Ambassadors all have personal experience with cancer, they may also provide companionship services to program participants.

To qualify for Ambassador services, patients must contact ABOH. While patients must personally request services, the eight participating hospitals help to identify and connect patients to the program. Once connected with the program, patients are generally eligible to receive 10-15 rides per year or per diagnosis. ABOH also provides participants with information regarding other transportation options that can help to meet their needs.

Impact and Future of the Program: In 2017, the Ambassador Program provided between 350 – 400 rides to roughly 50 lung cancer patients. The program continues to grow and is particularly working to expand its reach in low-income, minority communities in the Twin Cities region.¹⁴



III. Innovative Strategies for Bringing Care to the Patient

Health care providers, payers, and other stakeholders can also employ a variety of strategies *beyond* providing transportation to better connect patients to care. Many of these innovative strategies involve finding ways to meet the patient where they are, bringing care into homes and communities to reach patients that might otherwise struggle to access care in more traditional settings. This section provides an overview of three such strategies—**(1) telehealth services; (2) Community Health Workers (CHWs); and (3) Mobile Health Clinics (MHC)**—and some of the steps that interested stakeholders can take to encourage adoption of these strategies in their states and local communities.

1. Telehealth: Telehealth is “**communication and information technologies [used] to provide or support long-distance clinical health care, patient and professional health-related education, public health, and health administration.**”¹⁵ According to the Center for Connected Health Policy, common forms of telehealth include:

- **Video Conferencing:** Live, two-way interaction between a patient and a provider using audiovisual telecommunications technology.
- **Store-and-Forward:** Transmission of medical information, such as digital images, documents, and pre-recorded videos, through an electronic communications system to a provider who uses the information to evaluate the case or render a service outside of real-time or live interaction.
- **Remote Patient Monitoring:** Electronic transmission of personal health and medical data collection from a patient in one location to a provider in a different location for use in care and related support.
- **Mobile Health (mHealth):** Clinical and public health services and education supported by mobile communications devices such as cell phones and tablet computers.
- **eConsult:** A primary care provider consults with a specialist via live video conferencing or store-and-forward.¹⁶

Telehealth technologies can be used to bring more primary care and specialist services to patients in their home communities, reducing the need for patients to travel long distances to access necessary care. For example, health care providers can use video conferencing to visit with patients living in distant towns, or use store-and-forward technology to transmit images or documents to distant specialists for evaluation. Additionally, telehealth can be used to increase the capacity of local primary care providers to deliver more complex care by allowing them to consult electronically with specialists.

While telehealth technologies present promising strategies to reduce travel burdens and increase access to care, a number of **legal, administrative, technological** and **cultural barriers** often prevent patients and providers from taking full advantage of advances in health technology.¹⁷ Therefore, stakeholders interested in increasing the use of telehealth technologies in their communities should look for opportunities to encourage health care providers, payers, and policymakers to address these barriers, such as by:

- **Supporting legislation and regulation at the federal and state level that expands public and private health insurance coverage for care provided via telehealth;**
- **Increasing funds for health care providers to access telehealth equipment, technical assistance, and training; and**
- **Increasing investment in expanding access to broadband—often a prerequisite for using telehealth technologies—especially in rural areas.**¹⁸



Example: University of Hawai‘i – Increasing Receipt of Cancer-Related Services in Vulnerable Indigenous Pacific Populations: In island regions, such as Hawai‘i and the U.S. territories, transportation can be an enormous barrier to care. Many smaller or outer islands, in particular, have very limited access to health care services and may lack access to specialty services entirely. Patients in these regions may therefore need to travel by plane to access the care they need—a process that is not only time-consuming, but also prohibitively expensive. In recognition of these unique challenges, researchers at the University of Hawai‘i have recently kicked off a three-year initiative that will explore the use of a variety of technology-based strategies—including telehealth services—to increase access to cancer-related services for Pacific populations.

Geographic Scope: Hawai‘i Island, Guam, Commonwealth of Northern Mariana Islands (CNMI), and American Samoa.

Target Population: Indigenous Pacific Islanders, including those living with cancer. In particular, the initiative will focus on the Marshallese population on Hawai‘i Island and the entire population of Guam, CNMI, and American Samoa.

Program Description: The initiative will use technology to improve the ability of health care providers in the target regions to deliver or connect patients to cancer care. The initiative will proceed in three phases.

- **Phase One:** The first phase of the initiative will focus on assessing the current infrastructure—including policies, staffing, and technology—available to provide or support the use of telehealth strategies in the target regions. This phase will also involve an assessment and community engagement in the rural setting to ensure this initiative is meaningful and practical for the community.
- **Phase Two:** The second phase of the initiative will then leverage technology to increase local capacity to deliver cancer care. Specifically, project leaders will use the Project ECHO model to connect local oncologists, surgeons, primary care providers, nurses and community health workers with cancer education and case management support. Under this model, expert teams will use video-conferencing technology to conduct virtual clinics with community providers. Topics covered in these sessions will cut across the spectrum of cancer control continuum, ranging from cancer prevention and screening to treatment and palliative care.
- **Phase Three:** Finally, the third stage of the initiative will look to expand the use of telehealth strategies to provide expert consultation and direct cancer care in the target regions.

Impact and Future of the Program: The initiative was launched in July 2018 and will be implemented over the next three years.¹⁹

2. **Community Health Workers:** Community Health Workers (CHWs), also known as *promotores de salud*, community health advisors, or community health educators, are “**trained frontline staff who bridge the communication and cultural gaps common between low-income, underserved, often high-cost patients and clinical staff.**”²⁰ CHWs are often members of the communities they serve, giving them unique knowledge of the language, culture, and socio-economic pressures impacting the patients they assist.

CHWs can play an important role in helping patients to overcome transportation challenges. First, CHWs often work with patients in their **homes and communities**, bringing an element of care directly to the patient rather than requiring them to appear at a hospital or physician’s office. Second, part of the CHW role is often to help patients sign up for and/or navigate **health and social services.**²¹ These services include programs like Medicaid or Medicare that can provide coverage for transportation to and from medical appointments.

By connecting patients to care and helping them to overcome other social and cultural barriers, CHWs allow patients to better manage their health, resulting in improved health outcomes and reductions in health care costs.²² Studies have shown CHW services to be effective in helping patients to address a variety of conditions, including diabetes,²³ hypertension,²⁴ and tobacco use.²⁵ As a result, patients who receive CHW services often have less need to access high-cost services (e.g., Emergency Department visits, hospitalizations, and hospital readmissions), resulting in cost savings.²⁶

Despite the compelling evidence regarding the impact of their services, CHW programs have historically been grant-funded, limiting their availability and long-term sustainability. Therefore, stakeholders interested in promoting the use of CHW services in their communities should look for opportunities to encourage health care providers, payers, and policymakers to:

- **Leverage current opportunities to establish sustainable funding for CHWs (e.g., via payer or provider operating budgets or managed care contracts);**
- **Adopt payment models that have greater emphasis on team-based care and flexibility to fund CHW services (e.g., shared-savings models, bundled payments, etc.).**

Example: Marshall University Care Coordination Model for High Risk Patients: In the Appalachian Region, transportation issues combine with low income levels, limited resources, and lack of readily available specialty services to make it difficult for many individuals to access care. These challenges can be particularly daunting for individuals living with serious chronic health conditions. In 2011, experts at Marshall University and Williamson Health and Wellness Center therefore established a pilot program that used CHWs as part of a care coordination team to better address the needs of high-risk patients. A growing number of health centers across the Appalachian Region have since adopted this model to improve care for their complex patients.

Geographic Scope: 17 Federally-Qualified Health Centers (FQHCs) and Rural Health Centers in Ohio, Kentucky, and West Virginia.

Target Population: High utilizers of health care services (e.g., high-risk patients living with diabetes, cardiovascular disease, etc.) living in rural counties in the Appalachian Region.

Program Description: Under this model, each participating health center establishes an intensive care coordination team. The team consists of a mid-level health care provider, a nurse, and CHWs. Patients identified as high-utilizers of health care services are referred to the care coordination team for assessment and enrollment in the program. Once a patient is enrolled, the care coordination team works with the patient’s primary care provider to develop a care plan and then follows up with the patient on a regular basis.

As part of this follow-up, the team’s nurse manages clinical care for the patient (e.g., making referrals, setting up clinical appointments, etc.) while CHWs work one-on-one with patients in their homes. During these home sessions, CHWs help patients to address a variety of issues, including chronic disease self-management, medication adherence, healthy eating, and connection to social services.

Impact and Future of the Program: Approximately 350 patients are currently enrolled in this intensive care coordination model across the 17 participating FQHCs and Rural Health Centers. Up to this point, the model has been grant-funded. However, the model developers and participating health centers are currently working with local health plans to develop more sustainable funding models that reflect the cost savings resulting from the model and cover program costs.²⁷

3. Mobile Health Clinics: Mobile Health Clinics (MHCs) are “**customized vehicles that travel to the heart of communities, both urban and rural, and provide prevention and healthcare services where people work, live, and play.**”²⁸ According to the Mobile Health Map—a collaborative research initiative working to gather data on the current provision of mobile health services—there are currently an estimated 2,000 mobile clinics located across the United States.²⁹ These clinics provide a variety of health care services, including:

- **Primary care,**
- **Preventive screening,**
- **Disease management,**
- **Behavioral health,**
- **Dental care,**
- **Pre-natal care, and**
- **Pediatric care.**³⁰

MHCs are also often able to connect patients to a wider network of resources and social services to address not only patients’ medical needs but also social determinants of health that can impact health outcomes.³¹ In delivering all of these services, MHCs typically target vulnerable populations, such as communities that are largely uninsured or publicly insured, low-income, rural, homeless, minorities, and/or migrants.³²

Like telehealth and CHW programs, MHCs allow health care providers to bring care more directly to patients. In doing so, they help to overcome barriers related to transportation, as well as money, time, and trust, that can interfere with access to care.³³ As a result, studies have shown MHCs to be effective in increasing screening for infectious and chronic illnesses, initiating preventive care, and improving chronic disease management.³⁴ Additionally, initial estimates indicate that MHCs reduce overall health care costs by reducing the need for expensive services such as unnecessary Emergency Department (ED) visits.³⁵

Like CHW programs, MHCs have historically received much of their funding from philanthropy, and therefore may struggle to maintain financial sustainability in the long-term.³⁶ Therefore, stakeholders interested in expanding the use of MHC services in their communities should look for opportunities to encourage health care providers, payers, and policymakers to:

- **Leverage current opportunities to establish sustainable funding for MHCs and MHC services (e.g., via payer or provider operating budgets and flexibilities within managed care contracts);**
- **Identify and address existing policies that may create barriers to funding or delivering mobile care (e.g., state Certificate of Need policies, insurance restrictions based on location of care, etc.); and**

- **Adopt new payment models that incentivize health care payers and providers to address population health and control costs (e.g., Accountable Care Organizations, shared savings models, etc.).**



The first ever Mobile Lung Cancer Screening unit based out of Charlotte, North Carolina with Atrium Health and the Levine Cancer Institute. The Lung BASES 4 Life Program, funded by the Bristol Myers-Squibb Foundation, offers uninsured and underinsured individuals who qualify free low dose CT scans, tobacco cessation therapy, nicotine replacement, navigation and connection to local resources.

Example: Levine Cancer Institute – Mobile Lung Computed Tomography (CT) Unit: Early screening plays a vital role in the successful diagnosis and treatment of many cancers. However, low-income communities may struggle to access screening due to lack of transportation or insurance coverage. In 2017 the Levine Cancer Institute established its Mobile Lung Unit to respond to these barriers, bringing free lung cancer screenings and education into communities in and around the Charlotte, NC Metro Area.

Geographic Scope: 10 counties in and around the Charlotte, NC Metro Area.

Target Population: Individuals who are uninsured or insured by Medicaid³⁷ that meet the following criteria: (1) age 55-77; (2) current smoker or quit within the last 15 years; (3) with a smoking history of at least 30 pack years (i.e., average one pack per day for 30 years).

Program Description: The goal of the Mobile Lung Unit is to help overcome barriers to lung cancer care by making lung cancer screening more available and accessible to North Carolina communities. To bring care to its patients, the Unit parks and provides care in locations chosen based on their accessibility. Typically, these locations are near health care clinics and other community resources (e.g., food banks) and, if possible, accessible by public transportation. The Unit visits each of its chosen sites once every three months.

The Levine Cancer Institute has worked with local health care providers in its target communities to raise awareness of the Mobile Lung Unit. These providers refer eligible patients to the Mobile Lung Unit for screening. Once referred, Unit staff perform a pre-navigation assessment to address barriers that could prevent the patient from accessing the Unit and schedule the patient for screening. When the patient visits the Unit they receive both screening and education regarding lung health and tobacco cessation. Finally, Unit staff then work with patients to provide them with their screening results and navigate them to any other necessary services (e.g., follow-up care for positive screens).

Impact and Future of the Program: The Mobile Lung Unit has provided education regarding lung cancer screening to over 1000 health care providers and screened over 350 individual patients.³⁸

IV. Broader System Approaches – Health in All Policies

Finally, to develop a truly comprehensive approach to overcoming transportation barriers, stakeholders can examine the ways that broader policies directly or indirectly impact the ability of individuals in their community to access health care services. This broader approach is known as **“Health in All Policies.”** Health in all Policies (HiAP) is generally defined as “a collaborative approach to improving the health of all people by incorporating health considerations into decision-making sectors and policy areas.”³⁹ While HiAP can take many forms, the American Public Health Association (APHA) and the Public Health Institute suggest that there are five key elements to this approach:

- **“Promote health, equity, and sustainability:”** Incorporating these three concepts into specific policies and into government decision-making processes.
- **“Support intersectoral collaboration:”** Bringing together actors and agencies from various issue and policy areas to collaboratively promote health and equity.
- **“Benefit multiple partners:”** Identifying ways to simultaneously achieve the goals of multiple partners or agencies.
- **“Engage stakeholders:”** Working with a variety of stakeholders to gather necessary information and better understand the needs of the community.
- **“Create structural or procedural change:”** Creating and maintaining structures that ensure cross-sector collaboration and embed health and equity considerations into governmental decision-making.⁴⁰



Stakeholders interested in addressing the impact of transportation on access to care can encourage their state and local governments to adopt a HiAP approach when designing and implementing transportation policies. Under a HiAP approach, policymakers could create formal or informal partnerships between health and transportation agencies and establish mechanisms to identify and address instances in which transportation policies could impact access to care. For example stakeholders could encourage policymakers (e.g., legislators and agency officials) to adopt a HiAP approach by:

- **Assessing and prioritizing access to health care services when establishing public transportation routes;**
- **Promoting policies to establish safe streets (e.g., wide sidewalks, proper lighting, etc.) in areas surrounding health care facilities; and**
- **Creating a state coordinating council or task force on transportation issues that includes government officials involved in administering both transportation and health care services.**

By ensuring that health care access is taken into consideration in the development of these and other transportation policies, stakeholders can help to maximize available transportation options, thereby limiting the overall need for NEMT.

V. Conclusion

NEMT plays a crucial role in connecting low-income, vulnerable populations to necessary health care services. However, Medicaid NEMT cannot, on its own, address the full spectrum of transportation needs currently experienced by patients across the United States. As discussed in this issue brief, NEMT can be paired with an array of additional innovative strategies to address transportation barriers. These strategies can include both connecting patients to alternative sources of transportation and adopting approaches that bring care directly to patients in their homes and communities. By encouraging policymakers, payers, and health care providers to support both NEMT and these innovative strategies, stakeholders can promote more widespread, equitable access to care across their states and throughout the country as a whole.

Endnotes

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- ⁶ The Bipartisan Budget Act of 2018 (“Budget Act”), Pub. L. No. 115–123 § 50322 (2018).
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- ⁸ *Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, Ctrs. for Medicare and Medicaid Svcs., 189 (Apr. 1, 2019).
- ⁹ 42 U.S.C. § 1320a–7b.
- ¹⁰ 42 U.S.C. § 1320a–7a(a)(5).
- ¹¹ See e.g., [OIG Adv. Op. 15-13](#) (Oct. 14, 2015).
- ¹² See 42 C.F.R. § 1001.952(bb). Note: OIG defines an “established patient” as anyone who has selected a provider and initiated contact to schedule an appointment or who has previously attended an appointment with the provider. Under this definition, transportation can be offered to any patient with a scheduled appointment, regardless of whether it is the first visit or a subsequent appointment. For additional guidance, see Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Safe Harbors Under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 81 Fed. Reg. 88375-90 (Dec. 7, 2016), available at <https://www.govinfo.gov/content/pkg/FR-2016-12-07/pdf/2016-28297.pdf>.
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- ³¹ See Stephanie W. Y. Yu et al., *The Scope and Impact of Mobile Health Clinics in the United States: A Literature Review*, 16 *Internat'l J. for Equity in Health* 178 (2017).
- ³² *Impact Report*, Mobile Health Map, <https://www.mobilehealthmap.org/impact-report> (last visited Sept. 11, 2018).
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- ³⁵ Stephanie W. Y. Yu et al., *The Scope and Impact of Mobile Health Clinics in the United States: A Literature Review*, 16 *Internat'l J. for Equity in Health* 178 (2017).
- ³⁶ See Caterina F. Hill et al., *Mobile Health Clinics in the Era of Reform*, 20(3) *Amer. J. of Managed Care* 261, 262 (2014).
- ³⁷ All screenings are covered via grant funding. North Carolina's Medicaid program does not currently provide coverage for low-dose CT screening for lung cancer.
- ³⁸ Telephone interview between Katie Garfield, Staff Attorney, Center for Health Law and Policy Innovation, and Darcy Doege, RN, BSN, Program Coordinator, Lung B.A.S.E.S. 4 Life Program (Sept. 6, 2018) (notes on file with authors).
- ³⁹ Linda Rudolph et al., *Health in All Policies: A Guide for State and Local Governments*, *Amer. Public Health Ass'n & Public Health Inst.* 6 (2013), available at <http://www.phi.org/uploads/application/files/udt4vq0y712qpb1o4p62dexjlgxlnogpq15gr8pti3y7ckzysi.pdf>.
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