



The Ground Has Just Shifted: Time to Talk to Healthcare Providers About Transportation

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The US Department of Health and Human Services, Office of Inspector General (OIG) has granted certainty and lots of [possibilities with its final rule](#) regarding financial contributions to and provision of non-emergency medical transportation (NEMT). The rule effectively creates a new safe harbor for two types of local transportation: (1) Transportation that is provided for patients; and (2) Shuttle services for patients or others – along a fixed route with a set schedule. This fact sheet is a summary of a detailed rule.

The rule makes clear that healthcare providers are allowed to contribute to or provide transportation services within certain parameters. These parameters offer great leeway on the part of healthcare entities in terms of who may receive NEMT and to which services and providers. Plus, healthcare and unrelated businesses may now contribute to NEMT or shuttle services.

What changes?

The new rule permits healthcare providers – including hospitals, clinics, physician's offices, dialysis clinics, medical laboratories, physical therapists, and the like to **choose to fund** by themselves, or in combination with others, local (1) NEMT or (2) shuttle services that may go way beyond NEMT.

Local transportation equals up to 25 miles for urban areas or up to 50 miles for rural areas from the healthcare provider. Only consider where the patient resides for determining urban or rural. The rule deems a patient is rural even if the healthcare provider is located in the middle of a big city. The 25 and 50 miles are maximums and transportation may be provided within shorter distances from a healthcare provider.

How do you measure distance? NOT by vehicle miles traveled. Distance will be measured “as the crow flies” – as a straight line within a 25-mile-urban or 50-mile-rural radius of the healthcare provider. A two-second Google search comes up with websites that will calculate the “crow fly” distance. [Click here](#) for one of these direct distance calculators. This will help in any area where there are winding roads or indirect routes used.

Wheelchair-accessible transportation, third-party transportation, and public transportation may all fit within the new rules if the other conditions of the rule are met. Indeed the OIG’s main concern is that healthcare referrals not be required or induced.

In keeping with previous OIG opinions, the following will NOT be permitted:

- Luxury, air, or ambulance transportation
- Marketing or advertising of transportation services by the healthcare provider
- Shifting of costs onto federal healthcare programs
- Decisions about transportation based on “anticipated volume or value of federal health care program business”
- Requirement that a patient use a particular healthcare provider (This is one issue with details to be careful about.)

For those living in very sparsely populated rural areas that do not fall within the mileage limits of the new rule (discussed below), the situation remains the same as it did before. The OIG will consider a request to review any NEMT service to ensure its legality. However, we currently have an OIG that has approved various NEMT arrangements and funding agreements, with an understanding that transportation means access to healthcare. As long as its guidelines are respected, transportation is being looked upon favorably. The same goes for NEMT air travel in places like rural Alaska. This situation is not covered by this new rule, but it very likely would be approved if set up in keeping with guidelines laid out in past OIG opinions.

Who is urban and who is rural?

The OIG rule does NOT use same definitions as the US Department of Transportation!

Rural = anyone not residing in an urban area

Urban = anyone residing in a [Metropolitan Statistical Area](#) (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. Census.gov keeps a list of these areas.

And Urban = Residing in particular counties in New England. These are listed in the rule on page 110.

Transportation payment details

Payment to private providers of transportation must be made on a mileage or “other fixed-rate basis.” Payment may be made per-trip based on distance. For transit or taxis, payment may be made via vouchers, transit fares, or reimbursement for transit or taxi trips. Drivers or anyone arranging for the transportation may NOT be paid on a “per-beneficiary-transportation basis.” The rule does not mention volunteer driver services or funding for such service, but there is nothing to prevent such an arrangement as long as the other conditions are met.

Local NEMT Allowed for Established Patients

Beware that it helps to go to law school before reading these rules. Why? Some of the definitions used are contrary to common usage, particularly for the words *established* and *local*. This part of the rule only applies to local transportation for established patients.

Established patient = Any patient who has even made the first appointment, including those who have not yet gone to the first appointment. Translation: This definition means that transportation may be provided to a first appointment, between healthcare providers, to a skilled nursing facility from a hospital, or home from an emergency room visit.

However, this part of the rule does NOT apply to transportation provided to caretakers, family members, or visitors. Services that transport these types of individuals may be allowable by the OIG and have been approved in the past (and there is a process in place to review transportation services), but just not under this part of the new rule.

What established patients may receive free or discounted transportation?

There is no set procedure or template for how to determine who may receive transportation or who is asked about transportation need. Individualized determinations of who receives transportation are permitted as long as the determinations are:

- Uniform and consistent
- NOT based on type of insurance

What kind of transportation?

Again, tons of leeway. Transportation can be door-to-door from a patient’s home, between healthcare facilities, such as a hospital and a skilled nursing facility, or only to particular facilities – but with limitations not covered in this summary. Transportation by home health agencies is permitted. There is no requirement for advance reservations or anything regarding that issue.

This part of the rule does not pick providers or modes. Transportation can be taxis, Uber and other ride hailing providers, transit on buses or rail, faith-based or community organizations with vans or volunteers driving their own cars.

Local Shuttles

This part of the rule opens up a ton of possibilities. The shuttle may use buses, vans, or other vehicles for transportation:

- Along a fixed route
- With a set schedule

There is no limit in terms of how few or many stops are on of the shuttle route. Nor are stops required for all healthcare services along the route.

It would be perfectly legal, for example, for a shuttle to travel a route with stops in a residential area, at a grocery store, a strip mall, a pharmacy, or other destination as long as there is a healthcare provider along the route and that provider is within 25 miles of a stop in an urban area or 50 miles of a stop for a rural area. The “as the crow flies” distance applies here as well.

A shuttle can be funded by a sole healthcare provider or jointly by healthcare providers or by healthcare and non-healthcare partners. There is no limitation on what entities may or may not actually provide the transportation.

Who may ride the shuttle?

Shuttle ridership may be as broad as the general public, as narrow as “established” patients of a particular healthcare facility or provider, or lots of possibilities in between. Shuttles could be designed to serve healthcare employees, or visitors and caretakers of patients.

Shuttles are NOT ...

Shuttles are NOT demand-response transportation, such as any door-to-door service or request-based transportation, including taxis, ride hailing, or app-based micro-transit. There is NO requirement in the rule that anything like ADA-type complementary paratransit service be provided for anyone eligible to ride, but unable to ride, fixed-route shuttles.

Information Sharing

Beware of the ban on marketing and advertising. Information about the transportation services should come from healthcare providers and NOT from transportation providers insofar as transportation should not be used as a sales tool to induce people to use

particular healthcare providers. The OIG is fine with simply telling a patient that transportation is available, but not with information on websites or in printed materials. Nor can a healthcare provider's sponsorship be acknowledged, though that does not apply to those non-healthcare-related donors or contributors. Route and schedule information about shuttles may be provided.

Signage on a vehicle is not considered to be marketing, whereas a driver recommending particular physicians or handing out pamphlets with healthcare provider information would be totally out of the question. Shuttle information may be posted with schedules and stops.

Though the rule for NEMT and shuttles prohibits the marketing or advertising of transportation services, and this topic can be complex, there is nothing to prevent others from talking about or sharing information on social media or any other media. It is okay if patients gab to each other that a particular doctor's office provides transportation. It is also perfectly fine for a member of the public to share on Facebook, Twitter, or Instagram, as examples, that one hospital is located on a shuttle route that permits caretakers or visitors to ride, while other hospitals lack similar service. If a coffee shop blog has a post about a shuttle available to the general public, that is fine as well.