

Submitter : Ms. Coletta Corioso
Organization : Area Transportation Authority of N. Central PA
Category : Local Government

Date: 09/17/2007

Issue Areas/Comments

GENERAL

GENERAL

Comment 1: Entitlement Issues

ATA provides medical assistance non-emergency transportation on behalf of several counties in north central Pennsylvania. There has always been concern about local areas having to foot costs for federal entitlement programs above what is granted to the local area despite the demand for services. Local areas have not had the option to deny services due to lack of funding. We have seen enrollments significantly increase during the past seven years. The consumer may choose to go to a provider that is not the closest and this has increased the cost of services radically. These two items have contributed to major cost increases. In the past, the state has covered all of these related costs since it has recognized that the current program is an entitlement. Future guarantees of covering the costs for an entitlement program would be essential. If the provision of eligible medical services for eligible clients is an entitlement, then the cost of related transportation should also be considered an entitlement and funded at a level such that there is no risk for state/local governments for bearing this cost.

Comment 2: Coordination of Non-Emergency Medical Transportation by Public Transportation Authorities

Public transportation systems operating as brokers have the best opportunity and means to "coordinate" transportation need with available resources for benefit of the public. As public transportation authorities are invested in the transportation systems already funded with taxpayer sources. Non public transportation authorities do not necessarily engage FTA funded systems services, especially in rural areas. This is to the detriment of the HHS funded programs since it may end up paying more for services than necessary.

Having said that, "regional" systems have the best opportunity to coordinate services most effectively. Establishing regions that are most viable should be left to the States to determine. This should be directed to the State's Department of Transportation and not Health/Human Services.

Submitter : Mr. Larry Worth

Date: 09/18/2007

Organization : Northeastern Colorado Association of Local Governm

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Mr. Larry Worth

Date: 09/18/2007

Organization : Northeastern Colorado Association of Local Govern

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2234-P-3-Attach-1.DOC

#3

NORTHEASTERN COLORADO ASSOCIATION OF LOCAL GOVERNMENTS
231 Main Street, Suite 211
Fort Morgan, Colorado 80701

September 19th, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2244-P
Post Office Box 8017
Baltimore, Maryland 21244-8017

Re: Comments to Docket Number CMS-2234-P ((CMS) HHS Proposed Rules for
Implementing Changes in Medical Transportation

Administrator McClellan:

The Northeastern Transportation Authority/Northeastern Colorado Association of Local governments (DBA County Express) was created in 1978 to provide public transportation for residents of a 9,600 square mile service area extending from Morgan County on the West to the Nebraska and Kansas borders on the East.

Since transportation is a barrier to maximizing health for underserved populations, the Board of Directors for County Express has defined trips for dialysis treatment, radiation, chemotherapy and other medical appointments as a major priority of the public transportation system. Over the last eight years, NECALG has developed partnerships with Health and Human Services for Reimbursement of Non-Emergent Medical Transportation, Federal Transit Administration, and Other Federal Agencies, Colorado Department of Transportation, Colorado Department of Local Affairs, and Local Counties and Municipalities to provide part of the cost of non-emergent medical transportation through support of public transportation. County Express was able to leverage these State and Federal resources with the Banner Health System, Caring for Colorado Foundation, El Pomar Foundation, and other private resources to provide access to medical facilities that were unavailable in the smaller communities of the Region.

From January to August 2007, County Express has provided 73,718 trips for residents of Northeastern Colorado. Of the total number of trips provided by County Express, 7,647 trips (or approximately 10.5% of all trips provided by County Express) were for non-emergent medical transportation. Currently, the average for each medical trip is 77 miles per one-way trip. Based on the FTA defined cost for miles, hours, and trips, the cost for

non-emergent medical transportation exceeds 37% of the total operating budget for County Express.

Comments to Docket Number CMS-2234-P

Page 2

In the proposed rule, CMS announces that no one can pay or be charged for service more than what the general public is charged. Even with the rate increase approved in 2007, Medicaid does not pay the actual cost of service. When NECALG became the Medicaid Broker for Northeastern Colorado, the agency deducted the revenue and expenses for Medicaid trips, and then calculated the cost of providing transportation to residents of Northeastern Colorado.

The rate established for Medicaid is the same fare charged to the general public (less subsidies provided by State and Federal Governments.) It appears that the proposed rules from CMS simply shift the cost of providing non-emergent medical transportation from Health and Human Services to the Federal Transit Administration and to Local Governments.

The rule that there would be no shared or fully allocated costs would penalize the rural communities of Northeastern Colorado. Because of the distance and cost of non-emergent medical trips, NECALG has coordinated trips for kidney dialysis treatment with the scheduling staff of the Sterling Regional Medical Center. This coordination not only insures that there is a treatment facility available when the client arrives in Sterling, but also insures that the "shared or fully allocated costs" equals the total cost of the trip. Without the participation of multiple partners, non-emergent medical transportation may not be available in the rural areas of the Region.

In an article that appeared in the Fort Morgan Times, Dr. Scott Faulkner noted, "the only dialysis facilities in the region requires a 90 mile round trip three days a week. You are exhausted when you are done. It is a huge burden not only on the patient, but also on family members."

A client traveling 90 miles a day, three days a week for dialysis treatment would travel a minimum of 15,120 miles in year. Since the actual cost of transportation is as high as \$1.50 per mile, the client would pay \$22,680 per year or \$1,890 per month for non-emergent medical transportation. This cost would be in addition to medical treatment and prescription drugs. In 2006, there was a \$10.00 per trip co-pay established for individuals who were not eligible for Medicaid Transportation. For some clients this co-pay was unaffordable and added the additional stress of worrying about the availability and cost of transportation to the individual and family members.

In July, NECALG hosted the National Association of Area Agencies on Aging Advisory Committee. After the site visit, the National Advisory Committee sent a video team to film a non-emergent medical trip from Fort Morgan to dialysis center in Sterling. The Executive Director presented the preliminary draft of the video on September 13th.

The saddest part of this entire discussion is that two of the three clients who participated in the filming on non-emergent medical transportation to the dialysis center passed away before the film was finally edited and presented. I fear that the needs of the client have been sacrificed under the pretense of budget reduction.

In 2004, to coordinate resources and manage the ballooning cost of non-emergent medical transportation, the six Counties of Northeastern Colorado contracted with NECALG to serve as the Broker for Non-Emergent Medical Transportation in the respective Counties of the Region. The responsibilities as the "Broker" for Northeastern Colorado were in addition to serving as the only transit provider in most the geographical area.

The language of the proposed rules (that would make it impossible for a transit agency or a mobility management agency to be a broker unless it has no shared relationship with a transportation agency or transportation provider) is a disaster in the rural communities served by NECALG. While the "Broker" for Northeastern Colorado is an employee of NECALG, she is responsible for complying with the rules and regulations of non-emergent medical transportation reimbursed by Medicaid. For every authorized trip, the broker is required to obtain prior approval for non-emergent medical transportation. The following checklist is used to determine eligibility of clients: (1) medical necessity of the trip; (2) determine if there is an automobile in the household and if the Medicaid client would be able to drive himself or herself to the appointment (3) if family, friends, or a Community Based Organization can provide the trip for a mileage re-imbusement, (4) the least cost option for non-emergent medical transportation reimbursed by Medicaid.

Through cooperative arrangements between Federal, State, and Local Governments, Private Business, and Private Foundations, NECALG is able to combine medical trips to insure access to medical facilities and services in the Region. The coordination of public and private resources eliminates duplication of service, maximizes the existing resources, and integrates transportation as a component of medical care.

CMS has proposed that no "Broker" can be a service provider regardless of whether they are a public or a non-profit agency and utilizes the example of a physician referring clients to their own pharmacy as example of a conflict of interest to justify the proposed rules.

In a rural community, a narrow definition of "conflict of interest" is totally inappropriate and borders on the absurd. In some rural communities, a City Council member may be only medical provider in the community. Any conflict of interest is announced to the public and placed in the public record. The City Council member refrains from voting on

any issue that is perceived as a conflict of interest by the citizens of the community or the funding sources, but continues to provide the services of his or her profession.

Comments to Docket Number CMS-2234-P

Page 4

NECALG is the only public transit system in Northeastern Colorado, and as the "Broker" for non-emergent medical transportation reimbursed by Medicaid, NECALG must contract for transit services with its subordinate component, County Express.

Following are some of the issues faced by staff in attempting to broker a non-emergent medical trips in the small rural communities: (1) The reimbursement from Medicaid does not cover the cost of the service, especially if there is a deadhead trip to an urban hospital to return a client to Northeastern Colorado; (2) County Express is the only transit system with vehicles that have either a wheelchair or ramp for handicapped clients in every Community or County in the Region. Other transit providers would generally not travel several miles out of the community to pick up a Medicaid client because there would be no re-imbursement for the return trip. (3) The distance to medical facilities limits the number of transit providers and the options for transportation that are available in rural areas. (4) the transit system is dependent on part time drivers to provide non-emergent medical transportation, especially for trips that depart for Sterling prior to 4:30 A.M. It is difficult enough to provide the service when the agency has the dual role of broker and provider.

These issues will remain the reality of a rural transit system regardless of how CMS structures the broker system. However, in rural communities, the unintended consequences of rigid enforcement of conflict interest definitions or eliminating the transit provider as the broker may be the reduction of non-emergent medical transportation and other transit services in rural communities.

With the ballooning costs for medical services and an aging population requiring more medical service for a longer period of time, it is important that CMS review cost containment and budget reduction alternatives. **But I don't believe the answer is to disrupt partnerships that are currently providing non-emergent medical transportation to Medicaid clients, or to implement a policy that no "Broker" can be a service provider regardless of whether they are a public or nonprofit agency, or to rigidly define conflict of interest.**

It appears that a more balanced approach to the issue of conflict of interest would be the documentation of authorized trips to insure justification when the "Broker" authorizes trips to their own transit system.

NECALG concurs with the published comments of the American Public Transportation Association regarding Docket Number CMS-2234-P and would welcome an opportunity to participate in further discussion on implementation of the proposed rules.

NECALG appreciates the opportunity to assist CMS in implementation of the Deficit Reduction Act of 2005. For additional information, please do not hesitate to contact me at (970) 867-9409, Extension 233 or my email address lworth@necalg.com
Sincerely,

Larry Worth
Executive Director

CC: Senator Wayne Allard
Senator Ken Salazar
Representative Marilyn Musgrave
Community Transportation Association of America
Colorado Association of Transit Agencies

Submitter : Mr. Ed Haas

Date: 09/19/2007

Organization : Arkansas Association of Area Agencies on Aging

Category : Health Care Provider/Association

Issue Areas/Comments

General

General

The Arkansas Association of Area Agencies on Aging, Inc. opposes the rule which prohibits Medicaid Non Emergency Transportation Brokers from being a Provider of Transportation services.

CMS-2234-P-4-Attach-1.DOC

ARKANSAS ASSOCIATION OF AREA AGENCIES ON AGING, INC. (5A)

P.O. Box 2637

Batesville, Arkansas 72501

Contact: Ed Haas (870-612-3029_

Re: File Code CMS-2234-P

Via: Electronic Submission

PROVISIONS OF THE PROPOSED REGULATIONS

1. The plan to give states the option to “establish a non-emergency medical transportation program” (1902(a)(70)), rather than to require states to apply for a waiver to include a transportation program in the Medicaid state plan is excellent. The 5A supports this proposed regulation.
2. By the language in the proposed federal regulations, we are compelled to ask whether those who drafted this proposal considered best practices already in place. It appears this important step was omitted. We base this judgment on the fact that Arkansas’ experience seems to have been overlooked.

For example, we believe that the terms “broker and brokerage” are misnomers. The terminology needs to refer to “a transportation program” or “transportation services.” “Broker” and “brokerage” should be an option available to the states in designing effective and efficient medical non-emergency transportation rather than to be mandated by the regulations.

Further, the idea of safeguards should be expanded to address conflicts of interest and the issues related to self referrals and “steering,” when applicable.

In Arkansas’ program, the reimbursement rate is capitated which negates any opportunity for a provider to gain financially from self referrals. This is accomplished in several ways. Particularly, the state of Arkansas establishes rules for Medicaid eligibility and who may qualify for medical non-emergency transportation. In addition, the Arkansas Foundation for Medical Care (AFMC), an independent agency, monitors the quality and quantity of Medicaid non-emergency transportation services provided under contract with the state of Arkansas.

After almost ten years of implementation under the option for a waiver, the Arkansas transportation program operates efficiently. Arkansas has encountered problems in areas where the “broker” concept is actually in place--particularly in the greater metropolitan area where the third “brokerage” is now operating.

A transportation provider has infinitely more control over contract compliance, including drivers, vehicles, and client complaints than a “broker”. A “broker” who is not involved in direct service must work through a third party to problem solve, which is generally much less productive.

3. The Medicaid Program is traditionally a federal and state financial partnership with the federal government having the role of establishing a framework giving states options to develop programs that are responsive to local needs, constraints, and opportunities. States need the flexibility to select the options believed to be best for all its stakeholders. The transportation program should build on what is already in place in each state. It should have safeguards and take into account best practices.

In the process of review and approval, the federal government has the obligation to address any issues which threaten the integrity of a medical non-emergency transportation program.

In light of these concerns, the 5A strongly urges that the proposed federal regulations promulgated as 440.170 paragraphs (a)(2) and (a)(4) be totally rewritten to protect the interests of all stakeholders, especially transportation disadvantaged Medicaid clients.

Submitter : Mr. Dale Marsico
Organization : Community Transportation Association of America
Category : Other Association

Date: 09/19/2007

Issue Areas/Comments

GENERAL

GENERAL

our comment is in an attachment

General

General

our comment is an an attachment

CMS-2234-P-5-Attach-1.PDF

September 19, 2007

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

**Re: Medicaid Program: State Option to Establish
Non-Emergency Medical Transportation Program**

By electronic submittal: www.cms.hhs.gov/eRulemaking

The Community Transportation Association is a national nonprofit membership organization with over 4,000 members, providing important community and public transportation services across the United States. For more than 30 years the Association has been engaged in supporting the continued development of local mobility systems that improve access to health care — with special emphasis on those participating in the Medicaid program. In these three decades, we have provided extensive development on best practices in medical transportation, worked closely with state and federal agencies to develop cooperative efforts to provide cost-effective medical transportation, and done extensive research on how non-emergency transportation can provide not just excellent patient care and patient management, but lower the cost of health care by supporting more outpatient strategies and methodologies. Medicaid plays a vital role in assuring basic health care for many of our most vulnerable citizens and non-emergency medical transportation is essential to making this care accessible and available.

We agree with the clear affirmation and vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and delineated on page 48605 of the August 24 edition of the *Federal Register* where they acknowledge that, "**the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.**" The history of the last 20 years is replete with examples that reinforce this concept, and it is vital that we maintain approaches that enhance the benefits of flexible design that have served us well. We also share with CMS the important conclusion found in the same area of the proposed regulation that it must provide States with the flexibility granted by the Deficit Reduction Act of 2006.

A good example of flexibility as we think Congress was seeking can be found in the CMS interpretation on page 48605 of the August 24 *Federal Register*, where it stated that the Deficit Reduction Act gives the Secretary of HHS powers to include, "other forms of transportation" not yet included in the statutory language under this scope of the rule.

Letter to CMS, Page 2.

We support the CMS determination to not specify these other forms of transportation until and unless identified by the states. Allowing states to make these requests when they submit their plans, or in amendments, simplifies the approach for alternative kinds of service. It is another example of the flexibility that recognizes that all states may have unique transportation needs beyond those established in the statute. Certainly, CMS's example of the needs for air service in non-emergency medical transportation is the kind of issue that meets both the intent of Congress to recognize that the statute does include every kind of service that might be needed, and that in adding these kind of services, an easy-to-administer process by the Secretary as outlined here, is an appropriate course of action.

In other respects the proposed regulation includes recognition of important lessons learned over the history of the Medicaid non-emergency transportation service and we support requirements that non-emergency transportation services must be provided through staff that are qualified, competent, and courteous. We also share the commitment of CMS that all of its programs should ensure quality and adequacy. Those in need of these services require no less.

As the last two decades have seen improvement and enhancement in the networks of providers and operators delivering non-emergency medical transportation, there have been other developments, expansions, and improvements of other mobility services with both a strong federal financial investment and interest.

In an effort to more closely align these efforts, President Bush signed an Executive Order (Executive Order 13330, dated February 24, 2004) that stresses the importance of coordination at the federal level to encourage coordination at the state and local level. Additionally, Congress has recently enhanced development of cooperative activities in the reauthorization of transportation legislation in SAFETEA-LU (P.L. 109-59), which calls for closer collaboration between programs like non-emergency medical transportation and public transportation. We believe Congress, through its own efforts, has seen many useful ways that these mobility programs can and do work together — especially in our rural areas. The continuing development of rural public transportation under the U.S. Department of Transportation's efforts with the states reflects a parallel — and very often a fully coordinated — approach to service delivery for Medicaid clients as well as the general public. In SAFETEA-LU, Congress and the President expanded the opportunities for these efforts to include more fully coordinated transportation in urban areas. States, and local communities working with the states, have created many of the flexible institutional arrangements this regulation should support and uphold. We believe that the Congressional commitment to furthering these trends in urban areas as well as rural is outlined in the support and creation of mobility management activities that seek to develop a more coordinated approach to federally subsidized transportation activities.

Letter to CMS: Page 3.

As an aside, we note that the term "rural area" used in the CMS regulation is different than the term "non-urbanized" as used in federal transit laws. The difference in definitions may or may not be necessary, but will cause some confusion as states turn to their transit partners for the development of transportation brokerages under this rule.

When rules are finalized, we hope that CMS will emphasize that these transportation requirements apply only to transportation brokerages that states choose to adopt under the flexibility established at Section 6083 of the Deficit Reduction Act. States and other stakeholders may need a reminder that these rules do not necessarily apply to the many other mechanisms under which states may, and often do, choose to assure transportation access to Medicaid services.

The proposed regulation creates issues that can impair further cooperative development and that are not in the best interests of the Medicaid program. Toward that end we believe that Medicaid's Section 1877 conflict of interest language is being too broadly applied. We understand and recognize that the Deficit Reduction Act does require brokers to comply with restrictions concerning referrals and conflicts of interest based on the Section 1877 restrictions, but the proposed rule's approach does not apply these principles in a way that is meaningful or useful by the states.

We believe that with their vast experience in non-emergency medical transportation the states are capable of designing systems to prevent the kind of abusive conflicts of interests that might arise when a broker is involved in the direct delivery of service. Additionally, the broad application of this rule might have the unintended consequences of actually reducing the number of potential businesses and organizations that could compete to provide these services. We think that the states should develop procedures — after a broker is selected — to ensure that they do not unfairly reward themselves as opposed to excluding them beforehand. Again, as CMS clearly states, there are differing interpretations on how 1877 is applied.

We believe that multi-purpose, community-based organizations, as well as public transportation agencies, should be part of the solution that guarantees mobility for Medicaid users. We also think that states, based upon their individual experiences and needs, can determine post-selection conflict of interest procedures that provide the safeguards sought by CMS. There will be occasions that such organizations are the best and most cost-effective way to deliver services, but states are better positioned to create protections to prevent possible abuses. As we mentioned earlier, states have broad authority under current federal programs to coordinate — which assumes that they can create structures that accommodate multiple federal agency requirements. We should not restrict those possibilities for states.

Letter to CMS: Page 4.

We are particularly concerned about certain aspects of pricing in the proposed rule as they relate to public transit and, "charges to the general public." Experience has shown that state Medicaid agencies, and existing brokers, have made excellent use of purchasing fare cards for those who can use traditional forms of public transit. This has worked well for both Medicaid recipients and states by reducing paperwork as well as providing cost-effective transportation services. We think Congress mentions bus passes in the statute because they recognize that bus passes are a unique tool to create mobility for Medicaid patients.

There has been an ongoing difference of opinion about the non-traditional forms of transit delivery, particularly ADA services, offered by public transit and the cost structures and reimbursement rates for Medicaid recipients. We believe these services and costs should be examined more closely by CMS before making the "general public charge," applicable to all public providers, especially public transit. Additionally, we think CMS should work with the federal interagency Coordinating Council on Access and Mobility (CCAM), which was mandated under E.O. 13330 to investigate such issues, and of which the Department of Health and Human Services is a signatory member, to convene a committee to research the best way in which costs for specialized services should be paid so that rational guidelines can be developed for states to follow.

In many cases, public transit services under the ADA are providing parallel services to existing fixed routes. Going off-route is not the same service and therefore may require a more flexible kind of review.

This proposal has significant interest and impact across the nation. We think that CMS needs to provide greater research and discussion of the rule before it is finalized. There should be public hearings on the rule so that recipients themselves might have an opportunity to participate in ways that are easier for them, since we doubt many Medicaid recipients have the resources to submit their comments as provided for in the rule. Earlier we said we endorsed the CMS idea of customer service, and we believe that there must be room for customers to be heard in the design of a service that in many ways can be a life or death link to them for vital services.

According to the dates published in the regulation, the test of the proposed rule was prepared and approved by CMS on August 30, 2006, and approved for public comment by the Secretary of Health and Human Services on May 10, 2007, and was submitted to the *Federal Register* on August 13, 2007.

In short, the federal government allowed a year to go by from the time these rules were promulgated until they were made available for comment, and then gave the public 30 days to comment on the proposal. Under these circumstances a further delay for public involvement would not seem an unreasonable delay in light of these actions.

Letter to CMS: Page 5.

We believe that by working together we can continue to improve on these vital services to the American people. But, we can only do that by working together as envisioned by President Bush in his executive order on coordination, giving states the greatest flexibility possible to meet their needs.

Dale J. Marsico, CCTM
Executive Director
Community Transportation Association of America
1341 G. Street, NW
10th Floor
Washington, DC 20005
Phone: 202-628-1480
Email: Marsico@ctaa.org
Fax: 202-737-9197
Web: www.ctaa.org

Submitter : Mr. Hank Braaksma
Organization : Denver Regional Mobility and Access Council
Category : Other Association

Date: 09/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2234-P-6-Attach-1.DOC

September 19, 2007

RE: file code CMS-2234-P

On behalf of the Denver Regional Mobility and Access Council (DRMAC), I am writing to provide comment on the proposed rule change regarding Non-Emergency Medical Transportation under 42 CFR Part 440.

There are two primary areas of concern for members of DRMAC (a regional coordinating council established to promote the coordination of human services and public transportation as well as funders).

First, proposed section 440.170(a)(4)(ii)(B)(4)(iii) setting a rate of no more than a rate being charged to the general public does not take into account that some public fares may be free or low cost since some service is being subsidized by other sources. In Colorado, these sources often involve local or other federal program dollars. In a sense, a rule change restricting fares charged to Medicaid can create "client dumping" or cost shifting by passing the fully allocated costs of rides to other pay sources. This does little to comply with true deficit reduction. The change may limit a NEMT ride to local public transit systems without any provision for specialized transportation services needed by frail and elderly as well as persons with disabilities who may not meet ADA criteria for public transit services.

Second, excluding a Medicaid broker from being a transportation provider could create serious service provision issues in some areas where either a local non profit acts as a broker provider or in rural areas where it is cost effective to house both provider and broker sides under the same administration. This would further restrict a Medicaid recipient's ability to secure transportation and may end up resulting in higher trip costs. This

part of the rules change runs counter to the idea of service coordination promoted by the federal United We Ride initiative.

Sincerely,

Hank Braaksma, Vice President

Denver Regional Mobility and Access Council

Submitter : Mr. Beecher Hudson
Organization : Kentucky Public Transit Association
Category : Health Care Professional or Association

Date: 09/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

General

General

These comments are being submitted by the Kentucky Public Transit Association.

CMS-2234-P-7-Attach-1.WPD

Comments FROM The Kentucky Public Transit Association

Reference File Code-CMS-2234-P

42CFR Part 440

Medicaid Program: State Option To Establish Non-Emergency Medical Transportation Program

August 31, 2007

I am writing you on behalf of the members of the Kentucky Public Transit Association who are Brokers for the Sate of Kentucky's Medicaid Transportation program.

I am commenting on the proposed rules that came from the Department of Health and Human Service, Centers for Medicare and Medicaid Services, 42 CFR Part 440, Medicaid Program; State Option to establish non-emergency medical Transportation Program.

Specifically I would like to comment on page 48606, Sixth paragraph, "Based on the prohibitions in section 1877 of the Act, we proposed that the broker be an independent entity, in that the broker may not itself provide transportation under the contract with the Sate and that the broker may refer or subcontract to a transportation service provider with which it has certain financial relationships, unless certain exceptions apply. Federal funds may not be used for any prohibited referrals."

The State of Kentucky's Medicaid Brokerage Program was established in 1998 and was granted a wavier. The Human Service Transportation Delivery program established by Kentucky Medicaid and Kentucky Transportation Cabinet was one of the first Brokerages established in the United States. This program has become a model program for other States and it has continued to eliminate fraud and save the State of Kentucky millions of dollars.

On page 48608 there are exceptions indicated where a broker can be a provider but I would like to indicate the following comments so our clients, brokers, providers and the Commonwealth of Kentucky are not hurt by this proposed rule change.

- (1) Since the Commonwealth of Kentucky has had a Medicaid brokerage system for (10) years it may be possible to grand father in some policies that are already in place that would not harm the broker/provider, especially in the urban area.
- (2) If the Commonwealth's Medicaid Program cannot be grandfather in then there needs to be an exception added that States "Transportation is provided in a urban area by a broker when there is no other willing Medicaid provider available, when it causes a financial hardship on the State of Kentucky Medicaid program, or if there are unique circumstances that the State knows about and has no choice but to allow a non-governmental entity to be a broker/provider in the urban area.

The Kentucky Public Transit Association hopes that the proposed rule would allow brokers to be broker/provides in the urban areas. We do not want to see the Commonwealth of Kentucky, Medicaid clients, agencies, brokers or provides be harmed by this proposed rule in the urban area. It's our recommendation that some type of exception or exemption be allowed for a non-government entity to be a broker provider in the urban area.

Sincerely,

Beecher Hudson

Beecher Hudson, President
Kentucky Public Transit Association

Submitter : Mr. Beecher Hudson
Organization : Kentucky Public Transit Association
Category : Other Association

Date: 09/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment- This is the correct version of my comments. I forgot to check spelling.

General

General

These Comments are being submitted on behalf of the Brokers who are members of the Kentucky Public Transit Association.

CMS-2234-P-8-Attach-1.WPD

Comments FROM The Kentucky Public Transit Association

Reference File Code-CMS-2234-P

42CFR Part 440

Medicaid Program: State Option To Establish Non-Emergency Medical Transportation Program

August 31, 2007

I am writing you on behalf of the members of the Kentucky Public Transit Association who are Brokers for the State of Kentucky's Medicaid Transportation program.

I am commenting on the proposed rules that came from the Department of Health and Human Service, Centers for Medicare and Medicaid Services, 42 CFR Part 440, Medicaid Program; State Option to establish non-emergency medical Transportation Program.

Specifically I would like to comment on page 48606, Sixth paragraph, "Based on the prohibitions in section 1877 of the Act, we proposed that the broker be an independent entity, in that the broker may not itself provide transportation under the contract with the State and that the broker may refer or subcontract to a transportation service provider with which it has certain financial relationships, unless certain exceptions apply. Federal funds may not be used for any prohibited referrals."

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On page 48608 there are exceptions indicated where a broker can be a provider but I would like to indicate the following comments so our clients, brokers, providers and the Commonwealth of Kentucky are not hurt by this proposed rule change.

- (1) Since the Commonwealth of Kentucky has had a Medicaid brokerage system for (10) years it may be possible to grandfathered in some policies that are already in place that would not harm the broker/provider, especially in the urban area.
- (2) If the Commonwealth's Medicaid Program cannot be grandfathered in then there needs to be an exception added that States "Transportation is provided in a urban area by a broker/provider when there is no other willing Medicaid provider available, when it causes a financial hardship on the State of Kentucky Medicaid program, or if there are unique circumstances that the State knows about and has no choice but to allow a non-governmental entity to be a broker/provider in the urban area.

The Kentucky Public Transit Association hopes that the proposed rule would allow brokers to be broker/provides in the urban areas. We do not want to see the Commonwealth of Kentucky, Medicaid clients, agencies, broker/provider be harmed by this proposed rule in the urban area. It's our recommendation that some type of exception or exemption be allowed for a non-government entity to be a broker/provider in the urban area.

Sincerely,

Beecher Hudson

Beecher Hudson, President
Kentucky Public Transit Association

Submitter : Ms. Vickie Bourne

Date: 09/19/2007

Organization : KY Transportation Cabinet/Office Transp Delivery

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-2234-P-9-Attach-1.DOC

FROM: Kentucky Transportation Cabinet

September 18, 2007

**Comments to Proposed Rule-Federal Register August 24, 2007
Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Part 440
Medicaid Program: State Option To Establish Non-Emergency Medical
Transportation Program**

Reference File Code- CMS-2234-P

“Provisions of the Proposed Regulation”

Page 48605

Kentucky was under the 1915(b), (a waiver of freedom of choice). After the implementation of the DRA, Kentucky went to the State Plan. Kentucky, by state law, allowed freedom of choice to the disabled population. Kentucky has had a non-emergency medical transportation broker system since June 1998, successful under both the 1915(b) and the State Plan. The Cabinet for Health & Family Services contracts with the Transportation Cabinet. Jointly, both Cabinets bid out the regions through our Kentucky Finance Cabinet’s procurement process.

We agree that a brokerage program is a more cost effective way of providing transportation for various human service programs. The Kentucky brokerage program has proven to be a cost-effective way of providing transportation saving millions of dollars. Moreover, the Kentucky brokerage program has increased the quality of services with recipient and provider accountability, improved safety, and increased mobility. We include escorts for the disabled with special needs, lift equipped type vehicles, bus, van, taxi and bus passes.

We DO NOT include stretcher service within the brokerage program. Stretcher services are provided by the State Department of Medicaid Services through the ambulance program.

Our competitive bidding process is based on the State’s evaluation of the broker’s experience, performance, resources, capacity, and qualifications as prescribed in the proposed rule. Being a capitated payment system, Kentucky has proven success in evaluating broker proposals using technical/performance based criteria rather than cost. Kentucky, KRS 281 and 603 KAR 7:080 requires State oversight and monitoring.

Page 48606

We strongly disagree with “Based on the prohibitions in Section 1877 of the Act, we propose that the broker be an independent entity, in that the broker may not itself provide transportation under the contract with the State..” The majority of our Kentucky brokers are both brokers and providers. Kentucky mass transit brokers already have dispatchers/schedulers/call centers ensuring efficient use of resources in a dual broker/provider role. We require the brokers to guarantee transportation. If the subcontractor refuses or no shows, the broker is required to pick-up the

FROM: Kentucky Transportation Cabinet

Page 2

September 18, 2007

Comments to Proposed Rule-Federal Register August 24, 2007

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 440

**Medicaid Program: State Option To Establish Non-Emergency Medical
Transportation Program**

Reference File Code- CMS-2234-P
.....

client. If you are a broker with operating authority or provider status, this can be accomplished more easily. If you are a pure broker, this can be very difficult.

Under our coordinated brokerage program, many Medicaid clients who are not going to a Medicaid covered trip, but need service to a grocery or drug store, may receive transportation by a broker/provider under the Federal Transit Administration Public Transportation Grant Program; thus enhancing access to all transportation services provided by the Commonwealth.

Kentucky's brokers that are also providers are non-profit agencies. However, our competitive bidding process allows for both the pure broker and the broker/provider-type brokerages.

(Page 48606-third column, states, "Additionally, we are proposing to include a prohibition on a broker accepting any form of remuneration or payment from a transportation provider in exchange for influencing a referral or subcontract for transportation services...")

Such a proposal is acceptable in the Kentucky network. Kentucky subcontractors cannot make referrals. All recipient calls are received through the brokerage. In turn, the broker is obligated to evenly distribute trips to subcontractors while ensuring efficiency and cost effective transportation. As a monitoring tool, the broker is required to submit monthly reports to the State detailing distribution of trips by county, by provider, and includes the freedom of choice classes. All of the information can be submitted electronically to the State. Furthermore, Kentucky brokers have a contractual obligation to pay the subcontractor the established rates set by the State. Therefore, there is no negotiation in rate structure between the broker and subcontractor.

FROM: Kentucky Transportation Cabinet
Page 3
September 18, 2007

Comments to Proposed Rule-Federal Register August 24, 2007
Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Part 440
Medicaid Program: State Option To Establish Non-Emergency Medical
Transportation Program

Reference File Code- CMS-2234-P

“Regulatory Impact Statement”

Page 48607

A broker program, to include broker/provider-type brokers, in general can be cost effective. It has proven to be a very successful network in Kentucky. Kentucky has the added benefits with the improved quality of service, the required safety measures established, and the reduction of fraud and abuse by ensuring recipient and provider accountability. Along with our required statutes and regulations, the added benefits are accomplished by the networking of the public transportation systems either as a broker or as a subcontractor.

In summary, we applaud the broker concept. However, the Proposed Rule will have a negative impact on the successful Kentucky Brokerage Program if a broker is not permitted to be a provider (with continued State oversight of brokerages). The Proposed Rule will not permit and unfortunately prohibit public or non-profit agencies to act in a dual role as a broker and as a provider of transportation services in coordinating transportation among all human service programs (as prescribed in United We Ride, Executive Order 13330, Federal Agencies With Transportation Programs to Coordinate Their Efforts, February 2004). The Proposed Rule will reduce access to transportation that Kentucky’s children, elderly, low-income, and disabled have come accustomed to and depend on daily in efforts to obtain essential, life sustaining medical services.

We appreciate the opportunity to comment on this important Proposed Rule.

Vickie S. Bourne
Executive Director
Office of Transportation Delivery
Non-Emergency Medical Transportation
Kentucky Transportation Cabinet
200 Mero Street
Frankfort, KY 40622
502-564-7433

Submitter : Mrs. Vicki Perkins
Organization : CHRISTUS Santa Rosa Children's Hospital
Category : Hospital

Date: 09/20/2007

Issue Areas/Comments

GENERAL

GENERAL

CMS-2234-P

Medicaid Program; State Option to Establish Non-Emergency Medicaid
Transportation Program

Proposed Rule: August 24, 2007

I am making comment on behalf of CHRISTUS Santa Rosa Children's Hospital in San Antonio, Texas.

In the proposed rule, there is no mention of mileage reimbursement as a non-emergency Medicaid transportation service. We understand that the rule deals with services that would be provided by transportation brokers, but it is unclear whether a broker and/or the state could continue to provide mileage reimbursement as a non-emergency medical

transportation service. The Early and Periodic Screening Diagnostic and Treatment benefit requires states to offer to eligible children necessary assistance with transportation to and from providers. For many families, mileage reimbursement is an essential service that allows them to bring their children in for inpatient and/or outpatient services.

At CHRISTUS Santa Rosa Children's Hospital, we approximate that about 1/3 of our Medicaid clients use the Medicaid mileage reimbursement to assist them in their travel for their inpatient and outpatient visits to our facilities. To receive this reimbursement in Texas is a rather complex process. Since such a significant number of our clients do go through this process, the need for this reimbursement is certainly substantiated. Many of these children whose families are using this reimbursement are children with special health care needs and make regular trips to our facilities for their very specialized care.

We request CMS clarify in the final regulation that states could continue to provide mileage reimbursement for families transporting their children to and from health care providers.

Submitter : Ms. Deborah Lipman
Organization : Washington Metropolitan Area Transit Authority
Category : Other

Date: 09/20/2007

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter.

General

General

See attached comment letter.

CMS-2234-P-11-Attach-1.PDF



September 20, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2244-P
Post Office Box 8017
Baltimore, MD 21244-8017

RE: Docket Number CMS-2234-P

Dear Sir or Madam:

The Washington Metropolitan Area Transit Authority (WMATA) is the largest public transportation provider in the Washington, D.C. metropolitan area, and the second largest subway and fifth largest bus system nationally. On average, we provide 720,000 rail trips, 439,000 bus trips, and 4,400 paratransit trips every weekday. WMATA is pleased to provide the following comments on the proposed rule on "State option to establish non-emergency medical transportation program" published by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) on August 24, 2007 (at 72 FR 48604).

Provisions of the Proposed Regulations

While WMATA appreciates the efforts of Congress (in section 6083 of the *Deficit Reduction Act of 2005*) and of CMS to provide states with the flexibility to design cost-effective transportation programs to modernize Medicaid and make the cost of the program and health care more affordable, we believe that one provision will actually be more burdensome to state and local governments.

As mandated by the *Americans With Disabilities Act* and 49 CFR Part 37, public transportation agencies that operate fixed route bus service must provide complementary paratransit service to persons whose disabilities limit them from using fixed route services. These services must be provided at a cost to the rider of not more than "twice the fare that would be charged to an individual paying full fare (i.e., without regard to discounts) for a trip of similar length, at a similar time of day, on the entity's fixed route system." (See 49 CFR 37.131(c).)

**Washington
Metropolitan Area
Transit Authority**

600 Fifth Street, NW
Washington, DC 20001
202/962-1234

By Metrorail:
Judiciary Square—Red Line
Gallery Place-Chinatown—
Red, Green and
Yellow Lines
By Metrobus:
Routes D1, D3, D6, P6,
70, 71, 80, X2

A District of Columbia,
Maryland and Virginia
Transit Partnership

Metro is a multi-jurisdictional agency, with oversight and funding provided by the District of Columbia, the State of Maryland, and in the Commonwealth of Virginia: Fairfax and Arlington counties and the cities of Fairfax, Falls Church and Alexandria. WMATA's complementary paratransit service—MetroAccess—operates a fleet of over 300 vans and sedans and provides 1.6 million passenger trips annually. The average cost per passenger for MetroAccess service is just over \$39, while the passenger pays an average of just over \$2. It is our local and state government funding partners which cover the remaining operating costs of this service.

Proposed 42 CFR section 440.170(a)(4)(ii)(B)(4)(iii), which addresses requirements applicable when a state or local government creates a transportation brokerage to provide non-emergency medical transportation, would require the government brokerage to document that the "Medicaid program is paying no more than the rate charged to the general public." We agree with the American Public Transportation Association (APTA) that this provision would further burden the state and local governments that fund public transportation—including those jurisdictions that fund WMATA operations—with additional paratransit trips without reimbursement for the fully allocated costs of providing that transportation. We further agree with APTA that this would effectively and unfairly shift the burden from the Medicaid program to those state and local governments and abdicate the CMS role of providing non-emergency transportation services to Medicaid recipients.

Consequently, WMATA concurs with the recommendation of APTA that CMS withdraw the proposed rule and submit the matter the Interagency Transportation Coordinating Council.

Regulatory Impact Statement

As noted above, the proposed section 440.170(a)(4)(ii)(B)(4)(iii) would increase operating costs to the state and local governments that fund public transportation across the country. As APTA accurately notes in its comments, any significant increase in the paratransit load borne by public transportation agencies would also result in substantial capital costs to fund additional vehicles and maintenance facilities. Therefore, we believe that the following statement in this section of the preamble to be inaccurate: "This rule would have no consequential effect on State, local, or tribal governments or on the private sector."

Consequently, WMATA concurs with the recommendation of APTA that before promulgation of any rule, CMS should perform and make publicly available a detailed study of the number of trips likely to be shifted to local responsibility, as well as the financial impact of those trips.

WMATA appreciates the opportunity to provide comments on this proposed rule, which would affect both our agency and our state and local funding partners.

Sincerely,

A handwritten signature in cursive script that reads "Deborah S. Lipman".

Deborah S. Lipman
Director, Office of Policy & Government Relations

Submitter : Mrs. Desiree Painter
Organization : Nature Coast Transit
Category : Health Care Professional or Association

Date: 09/21/2007

Issue Areas/Comments

General

General

In 1979 the Florida State Legislature established the cornerstone for Coordinated Transportation by adopting State Statute 427, concerning the transportation disadvantaged. The goal of the legislature was to coordinate all available resources in each of Florida's communities in order to provide efficient, safe, and the most cost effective transportation programs possible.

This coordination of cost-effective transportation was made possible by establishing qualified community transportation coordinators and/or transportation operators for the transportation disadvantaged which included the integration of all not-for-profit transportation operators. In addition strong local partnerships were made with sponsoring agencies, community leaders, and the Transportation Disadvantaged (TD) population. Since 1979, Florida's TD Program has evolved into the nation's model for cost efficient coordinated transportation.

However, in the last few years, this Model Coordinated Transportation Program has been battling threats of fragmentation of valuable resources & funding challenges. Local Transportation Programs have been divided by budget cuts, and individual agency withdrawal from the Coordinated System. Leaving the most vulnerable citizens of Florida in jeopardy of losing their life sustaining transportation services.

In response to the proposed changes to the TD Program for Florida's Transportation Disadvantaged citizens and all citizens in the United States that depend on transportation for life sustaining medical treatment, I oppose these changes and feel that the federal government should allow the state government to arrange non-emergency transport of these most vulnerable citizens. If the federal government wants to get involved on a state level then implement non-emergency transportation with Medicare dollars instead of forcing the elderly to call an ambulance and tying up the emergency system in order to have a means to their dialysis and other necessary medical.

Submitter :

Date: 09/21/2007

Organization : American Public Human Services Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2234-P-13-Attach-1.DOC



September 20, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-2234-P

Dear Ms. Norwalk:

I am writing on behalf of the American Public Human Services Association (APHSA) and its affiliates, including the National Association of State Medicaid Directors (NASMD), to support and offer comments on the proposed regulations implementing section 6083 of the Deficit Reduction Act of 2005. The proposed regulations will implement the revised section 1902(a) of the Social Security Act (the Act) to allow states to establish and administer non-emergency medical transportation brokerage programs under the authority of a state plan amendment and without regard to comparability, state-wideness, and freedom of choice of providers. Brokerage programs implemented under the authority of such state plan amendments will be matched at the federal medical assistance match rate.

The flexibility to implement non-emergency medical transportation brokerages under the authority of a state plan amendment represents a significant expansion of states' ability to construct cost-effective programs appropriate to the unique needs of each state. As noted in the APHSA publication *Crossroads II- New Directions in Social Policy*, allowing states to implement non-emergency transportation brokerage systems at the federal medical assistance match rate via state plan amendment will relieve the state from arduous and time-consuming waiver applications and bi-annual reapplications.

Part 440- Services: General Provisions

Section 440.170 (a)(4)(i)(B) requires individuals and entities providing non-emergency medical transportation brokerage programs to have "oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous." APHSA urges you to clarify the terms "competent" and "courteous" in the final regulations.

Thank you for the opportunity to comment on this proposed regulation.

Sincerely,

A handwritten signature in black ink, reading "Jerry W. Friedman". The signature is written in a cursive style with a large, stylized initial "J".

Jerry W. Friedman
Executive Director
American Public Human Services Association

Submitter : Marcia Larkin
Organization : Penquis Community Action Program
Category : Other Health Care Provider

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2234-P-14-Attach-1.DOC

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

**Re: Medicaid Program: State Option to Establish
Non-Emergency Medical Transportation Program**

Penquis Community Action Program the designated Regional Transportation Provider for Penobscot and Piscataquis counties is a private non-profit organization incorporated in the State of Maine whose service includes the provision of non-emergency medical transportation to persons residing in our service area.

“State legislation enacted and made effective on June 21, 1979 provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. The approval of each plan by the Department of Transportation with the consent of the Department of Health and Human Services is required by law.

In December of 2004, by Executive Order of the Governor, an Interagency Coordinating Committee was established in response to the Olmstead Decision and a Presidential Executive order requiring demonstrated transportation coordination efforts. MDOT was designated the lead agency for this committee which includes representatives from the policy level of DHHS (including MaineCare and Elder Services) and the Department of Labor. In addition to developing a five year strategic plan, the Committee will review and approve regional plans.” *Maine DOT, Guide to Transportation Management*

As such, since 1979 the State of Maine has been providing Medicaid (MaineCare) non-emergency transportation through a model which has proven to be both cost effective and consumer-responsive. Regional Providers currently contract for wheelchair vans (where available), taxis, bus pass and tickets, air transportation, as well as directly providing van and bus service.

We agree with the vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and stated on page 48605, August 24, 2007 *Federal Register* that, “***the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.***”

Provisions of the proposed regulation would have the opposite impact in the State of Maine:

If the current model for providing non-emergency medical transportation (NEMT) in Maine is defined as a brokerage system, all of the current Regional Providers would have to cease providing the current van and bus trips that represent some of the most cost-effective service in this rural state.

The prohibition on broker self-referrals has taken the issues of fraud and abuse, and kickbacks exhibited by physicians and applied it erroneously to what current practice is in Maine. The designated Regional Transportation Providers are each non-profit organizations. As such, there are no

“owners”, and “employees” do not derive any financial benefit from the direct provision of low cost transportation. (Section 1877) Unless the Secretary created an exception, stating that the Maine model did not pose a risk of program or patient abuse, a statewide system in place for 28 years would have to be torn down. It is highly probable that adding an independent brokerage to a system that is already well coordinated and cost efficient would have the unintended consequence of raising costs as another layer of administration and infrastructure would be created.

It is unclear what is defined as “rural” in the proposed rule, in that “any area that is outside an urban area” begs the question of what definition of “urban area” you use. In a state with a statewide population of 1.4 million, Maine’s four “urban” areas are each under 200,000 populations, with the smallest being around 25,000 (contiguous to the Portsmouth/Dover, N.H. urban area).

The proposed guideline that “the Medicaid program was paying no more than the rate charged to the general public” also begs the question of who is defined as “general public” in a rural state where the majority of transportation available is demand-response, not fixed-route public transportation, and where a majority of rural persons transported are low-income, persons with disabilities, and elderly. In Maine, Regional Transportation Providers contract with various state agencies with a variety of targeted consumers, as well as receiving other county and local funds for specific trip purposes. Who is the “general public” in this current model, where fares and donations received from persons whose trips are not eligible through any state or federal contracts, including Medicaid, have to be kept artificially low in order to make typical long-distance rural trips affordable.

General public transportation funding (FTA Section 5311) represents a small percentage of the total funding available to the coordinated Regional Transportation systems in Maine. In many areas, it is provided as a result of existing alternatively funded services (including Community Services Block Grant, Child Welfare, Developmental Disability, and other human service funding, including Medicaid). General public service fares were never intended to represent the cost of providing that service, but are deeply subsidized by the FTA operating funds. If Medicaid does not want to pay in excess of what the “general public” pays, there would need to be additional funds beyond the “general public fare” to cover the operating costs that FTA recognizes.

The proposed rule does not make allowance for currently existing models for the provision of NEMT that meet the financial, oversight and contractual guidelines proposed.

We would request that further time be allowed for the solicitation of comments, including from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

Marcia Larkin
Penquis Community Action Program
262 Harlow Street, Bangor, Maine 04401
207-973-3691/ mlarkin@penquiscap.org

Submitter : Mr. James Wood
Organization : Kennebec Valley Community Action Program
Category : Other Health Care Professional

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2234-P-15-Attach-1.DOC

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

**Re: Medicaid Program: State Option to Establish
Non-Emergency Medical Transportation Program
CMS-2234-P**

By electronic submittal: www.cms.hhs.gov/eRulemaking

Kennebec Valley Community Action Program, the designated Regional Transportation Provider for Kennebec and Somerset Counties, is a private non-profit organization incorporated in the State of Maine whose service includes the provision of non-emergency medical transportation to persons residing in our service area.

State legislation enacted and made effective on June 21, 1979 provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. The approval of each plan by the Department of Transportation with the consent of the Department of Health and Human Services is required by law.

In December of 2004, by Executive Order of the Governor, an Interagency Coordinating Committee was established in response to the Olmstead Decision and a Presidential Executive order requiring demonstrated transportation coordination efforts. MDOT was designated the lead agency for this committee which includes representatives from the policy level of DHHS (including MaineCare and Elder Services) and the Department of Labor. In addition to developing a five year strategic plan, the Committee will review and approve regional plans. *Maine DOT, Guide to Transportation Management*

As such, since 1979 the State of Maine has been providing Medicaid (MaineCare) non-emergency transportation through a model which has proven to be both cost effective and consumer-responsive. Regional Providers currently contract for wheelchair vans (where available), taxis, bus passes and tickets, air transportation, as well as directly providing van and bus service.

We agree with the vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and stated on page 48605, August 24, 2007 *Federal Register* that, "***the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.***"

Provisions of the proposed regulation would have the opposite impact in the State of Maine:

If the current model for providing non-emergency medical transportation (NEMT) in Maine is defined as a brokerage system, all of the current Regional Providers would have to cease providing the current van and bus trips that represent some of the most cost-effective service in this rural state.

The prohibition on broker self-referrals has taken the issues of fraud and abuse, and kickbacks exhibited by physicians and applied it erroneously to what current practice is in Maine. The designated Regional Transportation Providers are each non-profit organizations. As such, there are no "owners", and "employees" do not derive any financial benefit from the direct provision of low cost transportation. (Section 1877) Unless the Secretary created an exception, stating that the Maine model did not pose a risk of program or patient abuse, a statewide system in place for 28 years would have to be torn down. It is highly probable that adding an independent brokerage to a system that is already well coordinated and cost efficient would have the unintended consequence of raising costs as another layer of administration and infrastructure would be created.

It is unclear what is defined as "rural" in the proposed rule, in that "any area that is outside an urban area" begs the question of what definition of "urban area" you use. In a state with a statewide population of 1.4 million, Maine's four "urban" areas are each under 200,000 population, with the smallest being around 25,000 (contiguous to the Portsmouth/Dover, N.H. urban area).

The proposed guideline that "the Medicaid program was paying no more than the rate charged to the general public" also begs the question of who is defined as "general public" in a rural state where the majority of transportation available is demand-response, not fixed-route public transportation, and where a majority of rural persons transported are low-income, persons with disabilities, and elderly. In Maine, Regional Transportation Providers contract with various state agencies with a variety of targeted consumers, as well as receiving other county and local funds for specific trip purposes. Who is the "general public" in this current model, where fares and donations received from persons whose trips are not eligible through any state or federal contracts, including Medicaid, have to be kept artificially low in order to make typical long-distance rural trips affordable.

General public transportation funding (FTA Section 5311) represents a small percentage of the total funding available to the coordinated Regional Transportation systems in Maine. In many areas, it is provided as a result of existing alternatively funded services (including Community Services Block Grant, Child Welfare, Developmental Disability, and other human service funding, including Medicaid). General public service fares were never intended to represent the cost of providing that service, but are deeply subsidized by the FTA operating funds. If Medicaid does not want to pay in excess of what the "general public" pays, there would need to be additional funds beyond the "general public fare" to cover the operating costs that FTA recognizes.

The proposed rule does not make allowance for currently existing models for the provision of NEMT that meet the financial, oversight and contractual guidelines proposed.

We would request that further time be allowed for the solicitation of comments, including from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

James C. Wood, Transportation Director
KVCAP
97 Water St.
Waterville, ME 04901-6339
jimw@kvcap.org

Submitter : Ms. Betty Bradshaw
Organization : Area Agency on Aging of Southeast Arkansas, Inc.
Category : Individual

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Ms. Betty Bradshaw
Organization : Area Agency On Aging of Southeast Arkansas, Inc.
Category : Individual

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2234-P-17-Attach-1.DOC

**AREA AGENCY ON AGING OF SOUTHEAST ARKANSAS, INC.
dba Southeast Arkansas Transportation (SEAT)
File Code CMS-2234-P**

Provisions of the Proposed Regulations

We strongly support the proposed regulations to give states the option to “establish a non-emergency medical transportation program 1902(a)(70)” without having to request a waiver in regard to statewide operation, freedom of choice of providers, and comparability of services for groups.

The regulations as written stymie and impede the states in optimizing medical transportation services for Medicaid beneficiaries who need access to medical care, but have no other means of transportation. Requiring the states to establish a transportation “brokerage” rather than a transportation program is counterproductive, costly, cumbersome, unnecessary, and conflicts with the appropriate federal and state roles inherent in this Medicaid federal-state partnership.

The federal role should be to require states to design and develop transportation services with checks and balances to prevent fraud and abuse rather than to mandate a specific method (brokerage) to control fraud and abuse. States need the latitude to design and develop transportation programs where the broker system is one choice rather than a basic mandate for all states. In the approval process, the federal partner appropriately assures that the state’s transportation program has controls to prevent fraud and abuse. In the event there are fraudulent or abusive unanticipated outcomes when the transportation plan is implemented, the states may address these issues through evaluation and refinement until all issues related to fraud and abuse are resolved.

“Broker” implies “agent” to arrange for needed transportation services. Arranging transportation with providers by these rules requires a separate entity to actually transport Medicaid beneficiaries. In our experience, serving as broker in a ticket to ride program proved to be inefficient and ineffective resulting in poor quality of services with little control over problem resolution. Working through a third party made it extremely difficult to correct rider concerns and corrections occurred much too slowly.

The regulatory focus must be on providing quality, cost effective transportation services with adequate safeguards including those related to safety, risk management, competence and qualification, compliance, as well as conflicts of interest and fraudulent and abusive practices rather than on just preventing fraud and abuse as the proposed regs seem to emphasize.

Coordination is essential to the provision of cost effective, efficient transportation services. SEAT operates a seamless public transit and Medicaid non-emergency transportation system that expands our ability to meet the spiraling demand for services from a transportation disadvantaged population primarily in the economically depressed Mississippi River Delta. By “seamless,” we simply mean that public transit and Medicaid eligible passengers receive the same timely, courteous, reliable, and safe transportation and are not readily identifiable by payment source. Further, depending on the trip purpose, a passenger may ride under the public transit or Medicaid transportation programs. By combining these two funding sources at the point of delivery, we are able to provide more and better service and achieve economy of scale. Rural public transit and medical non-emergency transportation operating in tandem are a perfect example of coordination.

Finally, we are concerned about the issue of Medicaid's payment for services not exceeding what the public pays. While the concept is sound, the potential for misapplication of this requirement is rather extensive. Clarification is needed to assure that Medicaid pays its fair share of the costs of operating transportation services.

The Federal Transit Administration (FTA) funded transit services require that the public pay nominal fares for rides. The fares are set contributions and do not cover the full costs of services. The fares offset a small percentage of the costs. FTA transit services are subsidized. The fares are paid by the public but do not represent full costs and should not be used as a measure to set Medicaid's payment.. Rather, Medicaid's cost sharing should be set by the standard of full costs of services provided on behalf of the state Medicaid Program as Medicaid beneficiaries may not be charged fares when riding under Medicaid transportation. (Bus passes and tickets are a separate consideration for more ambulatory and independent passengers.)

To best understand these comments, it is important to know that SEAT is a coordinated rural transportation system providing both public transit and Medicaid non-emergency transportation. SEAT has served as transportation "broker" and "provider" for Medicaid in this area of the state since the inception of Arkansas' transportation waiver program in 1998. SEAT is a demand-response system with full ADA compliance, portal to portal service, a rather large customer call center, and about 100 vehicles and trained professional drivers in service daily. Last year, SEAT provided 338,000 one way trips and drove over 3 million miles. It is to be noted that self referrals and steering are a non-issue as a result of the state's choices in designing Arkansas' Medicaid transportation program.

These perplexing, vague proposed regulations have the potential to destroy highly successful transportation services if implemented as written. We implore CMS to rewrite these rules giving the states the maximum flexibility to craft optimal transportation programs.

Respectfully submitted,

Betty M. Bradshaw

President/Chief Executive Officer

Area Agency on Aging of Southeast Arkansas, Inc.

Submitter : Mr. Eugene Skibitsky
Organization : Western Maine Transportation Services, Inc.
Category : Other Health Care Provider

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

General

General

Please see attachment

CMS-2234-P-18-Attach-1.DOC

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

**Re: Medicaid Program: State Option to Establish
Non-Emergency Medical Transportation Program**

Re: CMS-2234-P

By electronic submittal: www.cms.hhs.gov/eRulemaking

Western Maine Transportation Services, Inc., the designated Regional Transportation Corporation for Androscoggin, Oxford and Franklin Counties in western Maine, is a private non-profit organization incorporated in the State of Maine whose service includes the provision of non-emergency medical transportation to persons residing in our service area.

“State legislation enacted and made effective on June 21, 1979 provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. The approval of each plan by the Department of Transportation with the consent of the Department of Health and Human Services is required by law.

In December of 2004, by Executive Order of the Governor, an Interagency Coordinating Committee was established in response to the Olmstead Decision and a Presidential Executive order requiring demonstrated transportation coordination efforts. MDOT was designated the lead agency for this committee which includes representatives from the policy level of DHHS (including MaineCare and Elder Services) and the Department of Labor. In addition to developing a five year strategic plan, the Committee will review and approve regional plans.” *Maine DOT, Guide to Transportation Management*

As such, since 1979 the State of Maine has been providing Medicaid (MaineCare) non-emergency transportation through a model which has proven to be both cost effective and consumer-responsive. Regional Providers currently contract for wheelchair vans (where available), taxis, bus passes and tickets, air transportation, as well as directly providing van and bus service.

We agree with the vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and stated on page 48605, August 24, 2007 *Federal Register* that, “***the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.***”

Provisions of the proposed regulation would have the opposite impact in the State of Maine:

If the current model for providing non-emergency medical transportation (NEMT) in Maine is defined as a brokerage system, all of the current Regional Providers would have to cease providing the current van and bus trips that represent some of the most cost-effective service in this rural state.

The prohibition on broker self-referrals has taken the issues of fraud and abuse, and kickbacks exhibited by physicians and applied it erroneously to what current practice is in Maine. The designated Regional Transportation Providers are each non-profit organizations. As such, there are no "owners", and "employees" do not derive any financial benefit from the direct provision of low cost transportation. (Section 1877) Unless the Secretary created an exception, stating that the Maine model did not pose a risk of program or patient abuse, a statewide system in place for 28 years would have to be torn down. It is highly probable that adding an independent brokerage to a system that is already well coordinated and cost efficient would have the unintended consequence of raising costs as another layer of administration and infrastructure would be created.

It is unclear what is defined as "rural" in the proposed rule, in that "any area that is outside an urban area" begs the question of what definition of "urban area" you use. In a state with a statewide population of 1.4 million, Maine's four "urban" areas are each under 200,000 population, with the smallest being around 25,000 (contiguous to the Portsmouth/Dover, N.H. urban area).

The proposed guideline that "the Medicaid program was paying no more than the rate charged to the general public" also begs the question of who is defined as "general public" in a rural state where the majority of transportation available is demand-response, not fixed-route public transportation, and where a majority of rural persons transported are low-income, persons with disabilities, and elderly. In Maine, Regional Transportation Providers contract with various state agencies with a variety of targeted consumers, as well as receiving other county and local funds for specific trip purposes. Who is the "general public" in this current model, where fares and donations received from persons whose trips are not eligible through any state or federal contracts, including Medicaid, have to be kept artificially low in order to make typical long-distance rural trips affordable.

General public transportation funding (FTA Section 5311) represents a small percentage of the total funding available to the coordinated Regional Transportation systems in Maine. In many areas, it is provided as a result of existing alternatively funded services (including Community Services Block Grant, Child Welfare, Developmental Disability, and other human service funding, including Medicaid). General public service fares were never intended to represent the cost of providing that service, but are deeply subsidized by the FTA operating funds. If Medicaid does not want to pay in excess of what the "general public" pays, there would need to be additional funds beyond the "general public fare" to cover the operating costs that FTA recognizes.

The proposed rule does not make allowance for currently existing models for the provision of NEMT that meet the financial, oversight and contractual guidelines proposed.

We would request that further time be allowed for the solicitation of comments, including from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

Eugene R Skibitsky, General Manager
Western Maine Transportation Services, Inc.
76 Merrow Road
Auburn, Maine 04210

Submitter : Mr. Edward Griffin
Organization : MV Transportation
Category : Private Industry

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

Docket: CMS-2234-P - State Option to Establish Non-Emergency Medical Transportation Program

MV Transportation is the largest provider of paratransit services in the nation, currently operating in 27 states and the District of Columbia. MV got its start in the Medicaid and human service transportation business and has been providing non-emergency transportation services throughout our entire 31 year history. We have always served, and continue to serve today, human service agencies in both small and large communities providing passengers with critical transportation service to agency programs, dialysis treatments, congregate meals, senior activities, shopping, medical appointments and other life-sustaining needs.

We have a strong presence in the State of Florida, operating in seven (7) counties under the nationally recognized coordinated transportation model. In that capacity we operate in many different delivery models and capacities: as contracted direct service provider for Community Transportation Coordinators (CTCs) and Transit Authorities; complete turnkey operations as a CTC; complete turnkey operations under the guidance and control of a governmental CTC, Broker of Medicaid services; and finally, Broker and Provider of Medicaid services. As a private company, we can provide the exact adaptation necessary for each local decision-making body to create a public/private partnership that is in the best interest of that community and those taxing authorities funding the service.

With the success experienced in Florida and elsewhere by allowing State and Local governments flexibility in designing coordinated transportation delivery models, we believe that the Section 1877 conflict of interest language is being applied in a way that is not in the best interest of the overall management of the program and also has an unintended consequence of creating an anti-business climate by restricting a company from both managing and providing the services. In essence, it appears to be a defacto sole source regulation. By advocating and creating an exclusive brokerage approach, this language could limit the number of potential businesses and organizations that would compete to provide these services. While we recognize that the Deficit Reduction Act contains restrictions concerning referrals and conflicts of interest, the proposed rule does not create an environment that allows states to embrace these requirements in a way that also allows a free market approach. In many cases, it may be in the best interest of all stakeholders to allow a turnkey approach to demand management and service provision.

Most states, and certainly Florida, have a vast experience in non-emergency medical transportation. We have seen firsthand from our experience in Florida and elsewhere that states are capable of designing systems that can manage perceived conflicts of interests that might arise when a broker is involved in the direct delivery of service. We think that the states should develop procedures that control a broker/ provider during operations rather outright excluding them from the process.

Submitter : Ms. Helen Davis
Organization : Texas Medical Association
Category : Health Care Professional or Association

Date: 09/21/2007

Issue Areas/Comments

General

General

The proposed regulations do not seem to allow Medicaid programs to reimburse families for mileage when using their own vehicle to travel to medical appointments. Texas currently reimburses families for mileage. Many families own or have access to vehicles, but cannot afford the costs of fuel to travel to their appointments. In a state as large as Texas, retaining a mileage reimbursement option is an important aspect of a viable non-emergency medical transportation system. Excluding mileage reimbursement, and thus forcing patients to rely on vans, taxis or public transportation, is likely to increase the number of patients who fail to show-up for appointments. High 'no show' rates contribute to physicians' dissatisfaction with Medicaid and thus their reluctance to participate.

Furthermore, if families are forced to use vans or taxis instead of their own vehicle, they will be forced to spend more time in the office both before and after visits because of the inherent challenges of coordinating taxi or van pick up times.

We respectfully ask that the regulations be amended to expressly allow states to reimburse patients for mileage relating to medical appointments.

Thank you for your consideration.

Submitter : Mr. William Steele
Organization : Pinellas Suncoast Transit Authority
Category : Local Government

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2234-P-21-Attach-1.PDF



September 21, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2244-P
Post Office Box 8017
Baltimore, MD 21244-8017

RE: Comments to Docket Number CMS-2234-P

Dear Administrator McClellan:

On behalf of the Pinellas Suncoast Transit Authority (PSTA), I write to provide comment on the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking (NPRM) concerning Non-Emergency Medical Transportation, published August 24, 2007 at 72 FR 48604.

PSTA serves the residents and visitors in Pinellas County within the larger Tampa Bay area. The Authority operates over 40 bus routes with an annual ridership over 11 million. As well, PSTA operates paratransit service with a daily ridership over 800 and annual ridership over 250,000. This year our Americans With Disabilities Act (ADA) demand response expenses have increased by over \$300,000 and we expect the trend to continue. Because of these rising expenses, I submit the following comments on the proposed rulemaking:

Section 440.170(a)(4)(ii)(B)(4)(iii)

The proposed rule improperly endorses transferring the costs of transporting patients on local public transportation agencies. While we appreciate CMS' efforts to provide maximum flexibility to state and local governments, one aspect of the proposed rule could be potentially detrimental to PSTA. Specifically, proposed Section 440.170(a)(4)(ii)(B)(4)(iii) addresses requirements applicable when a state or local government creates a transportation brokerage to provide non-emergency medical transportation. That subsection would require the government brokerage to document that the "Medicaid program is paying no more than the rate charged to the general public." It is this requirement that could potentially transfer the vast majority of these transportation costs from the federally supported Medicaid program to local PSTA taxpayers.

To further burden state and local governments that fund the operation of public transportation with additional paratransit trips without reimbursement for the fully allocated costs of providing that transportation would unfairly shift that burden from the Medicaid program to PSTA and abdicates the CMS role of providing non-emergency transportation services to Medicaid recipients.

This result is not mandated by the *Deficit Reduction Act of 2005* and, in fact, conflicts with other federal initiatives, specifically, the United We Ride Program, as described in Executive Order 13330 (EO 13330), *Human Services Transportation Coordination*, issued February 24, 2004. That Executive Order tasks the Secretary of Health and Human Services, among others, with promoting interagency cooperation in the provision of transportation services. In contrast, the result of this proposed rule is the abandonment of such cooperation.

The proposed rule should be withdrawn and the matter submitted to the Interagency Transportation Coordinating Council, created by EO 13330, to ensure any future CMS rulemaking remains consistent with the United We Ride Program and the Executive Order.

Section 440.170

As recognized in the NPRM, Section 202 of the *Unfunded Mandates Reform Act* requires CMS to assess the costs associated with any proposed rule that mandates spending in excess of \$120,000,000. Given the burden associated with paratransit trips, we believe CMS should perform and make publicly available a detailed study of the number of trips likely to be shifted to local responsibility and the financial impact of those trips. In addition to the burdensome operating costs discussed above, any significant increase in the paratransit load borne by public transportation agencies would also occasion substantial capital costs to fund additional vehicles and maintenance facilities. Taken together, the operating and capital burden on state and local governments could easily surpass \$120,000,000. A perfunctory statement in the NPRM that the proposed rule "would have no consequential effect" on the regulated state, local, and tribal governments is insufficient to meet CMS' obligation under the Act.

We greatly appreciate the opportunity to comment on this rulemaking. Feel free to contact us with any questions.

Sincerely,

PINELLAS SUNCOAST TRANSIT AUTHORITY



William P. Steele
Interim Executive Director

WPS:mn

Submitter : Mr. Bob Krause
Organization : Office of Public Transit, Iowa DOT
Category : State Government

Date: 09/21/2007

Issue Areas/Comments

General

General

Iowa is a "Coordination State" and created the nations first law for the coordination of human services transportation. The spirit of that law is now embodied in the Federal Interagency Coordinating Council on Access and Mobility, of which HHS is a member.

Coordination works to create new service by spreading the costs over several services through service contracts with individual agencies.

An example of cost savings comes from the Head Start arena. A few years ago federal regulations were passed that had the practical impact of breaking a coordinated service agreement by which an Iowa rural regional transit agency gave Head Start service while at the same time providing elderly and disabled service in a small town in Northwest Iowa. In the coordinated agreement, Head Start children were transported to the Head Start center in the morning and picked up and dropped off in the afternoon at their homes. The utilization of the vehicle was for 1/2 hour in the morning and 1/2 hour. The TOTAL ANNUAL COST (operations plus capital) to the Head Start program for transportation was \$2,000. This was because the vehicle was used for elderly and disabled taxi service in that small town during the remainder of the day.

After Head Start transportation regulations came into effect, the transit agency was offered a FREE specialized bus by the local Head Start Agency. However, the annual operations contract went to \$10,000 annually. This was because the vehicle had to carry the total cost of the relatively few Head Start rides, and could not be used for any other purpose. If the annualized capital cost of the free bus is \$10,000, and add to that the annual operations cost, you can see that the new TOTAL ANNUAL COST of Head Start Transportation in this small town went from \$2,000 to 20,000. That is a 10 fold increase in costs that has been caused by failure to coordinate with a multi-contract coordinated transit agency.

This same cascading cost impact will occur with Medicaid if brokerages are not allowed to provide long term coordination contracts with transit agencies as part of their service mix. The economic structure of rural transit agencies, especially, relies on contracts. A ride-based brokerage system which may work well in a competition rich area will actually have the opposite effect in a competition poor area and will lead to stove-piped high cost single service operations. Not only will this be to the detriment of the taxpayer, but it will hurt other HSS constituencies such as Head Start and persons with disabilities.

IN order to encourage coordinated transportation within the brokerage system, the language will have to be changed.

Specifically, there needs to be a special section in the rule that deals with coordinated transit service states that have rural regional transit agencies. The extensive discussions of individual trips in the rule indicates that the authors are unfamiliar with coordinated transportation services driven by coordination contracts between transit agencies and human service providers. The new section needs to conceptualize an efficient mechanism to bring Medicaid into this coordinated service. Brokerages for coordinated rural regional systems should be allowed to reside with the rural regional transit agency, provided the regional transit agency can make a showing that total cost to Medicaid is significantly reduced by parallel coordinated service contracts with other human services agencies, and that all human service transportation would be reduced if Medicaid is broken out of the coordination mix.

As a final note, the phrase "The contract with the broker provides for payment that does not exceed actual costs calculated as a distinct unit, excluding personnel or other costs shared with or allocated from parent or related entities" is ambiguous, and can be read two ways -- either to include or exclude these costs in the final analysis.

Submitter : Ms. Connie Garber
Organization : York County Community Action Corp.
Category : Other Health Care Provider
Issue Areas/Comments

Date: 09/21/2007

GENERAL

GENERAL

It is unclear what is defined as rural in the proposed rule, in that any area that is outside an urban area begs the question of what definition of urban area you use. In a state with a statewide population of 1.4 million, Maine's four urban areas are each under 200,000 population, with the smallest being around 25,000 (contiguous to the Portsmouth/Dover, N.H. urban area).

The proposed guideline that the Medicaid program was paying no more than the rate charged to the general public also begs the question of who is defined as general public in a rural state where the majority of transportation available is demand-response, not fixed-route public transportation, and where a majority of rural persons transported are low-income, persons with disabilities, and elderly. In Maine, Regional Transportation Providers contract with various state agencies with a variety of targeted consumers, as well as receiving other county and local funds for specific trip purposes. Who is the general public in this current model, where fares and donations received from persons whose trips are not eligible through any state or federal contracts, including Medicaid, have to be kept artificially low in order to make typical long-distance rural trips affordable.

General public transportation funding (FTA Section 5311) represents a small percentage of the total funding available to the coordinated Regional Transportation systems in Maine. In many areas, it is provided as a result of existing alternatively funded services (including Community Services Block Grant, Child Welfare, Developmental Disability, and other human service funding, including Medicaid). General public service fares were never intended to represent the cost of providing that service, but are deeply subsidized by the FTA operating funds. If Medicaid does not want to pay in excess of what the general public pays, there would need to be additional funds beyond the general public fare to cover the operating costs that FTA recognizes.

The proposed rule does not make allowance for currently existing models for the provision of NEMT that meet the financial, oversight and contractual guidelines proposed. Although perhaps not intended, the proposed rule penalizes the State of Maine: We implemented a statewide strategy decades ago that has maximized access to healthcare for Medicaid consumers, and now the state would be forced to dismantle it or add an additional layer of administration, all at higher cost.

Finally, we would request that further time be allowed for the solicitation of comments, including from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

Connie Garber, Transportation Director
 York County Community Action Corporation
 6 Spruce Street P.O. Box 72 Sanford, Maine 04073
 207 324-5762 x2930 cgarber@yccac.org

General

General

Department of Health and Human Services
 Centers for Medicare and Medicaid
 7500 Security Blvd.
 Baltimore, Maryland 21244-1850

Re: Medicaid Program: State Option to Establish
 Non-Emergency Medical Transportation Program
 CMS-2234-P

By electronic submittal: www.cms.hhs.gov/eRulemaking

York County Community Action Corporation, the designated Regional Transportation Provider for York County, is a private non-profit organization incorporated in the State of Maine whose service includes the provision of non-emergency medical transportation to persons residing in our service area. YCCAC has provided transportation to the 1,000 square mile area since 1970. In the last year, over 272,000 rides were provided, connecting people to needed destinations.

State legislation enacted and made effective on June 21, 1979 provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. The approval of each plan by the Department of Transportation with the consent of the Department of Health and Human Services is required by law.

In December of 2004, by Executive Order of the Governor, an Interagency Coordinating Committee was established in response to the Olmstead Decision and a Presidential Executive order requiring demonstrated transportation coordination efforts. MDOT was designated the lead agency for this committee which includes representatives from the policy level of DHHS (including MaineCare and Elder Services) and the Department of Labor. In addition to developing a five year strategic plan, the Committee will review and approve regional plans. Maine DOT, Guide to Transportation Management

As such, since 1979 the State of Maine has been providing Medicaid (MaineCare) non-emergency transportation through a model which has proven to be both cost effective and consumer-responsive. Regional Providers currently contract for wheelchair vans (where available), taxis, bus passes and tickets, air transportation, as well as directly providing van and bus service.

We agree with the vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and stated on page 48605, August 24, 2007 Federal Register that, the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.

Provisions of the proposed regulation would have the opposite impact in the State of Maine:

If the current model for providing non-emergency medical transportation (NEMT) in Maine is defined as a brokerage system, all of the current Regional Providers would have to cease providing the current van and bus trips that represent some of the most cost-effective service in this rural state.

The prohibition on broker self-referrals has taken the issues of fraud and abuse, and kickbacks exhibited by physicians and applied it erroneously to what current practice is in Maine. The designated Regional Transportation Providers are each non-profit organizations. As such, there are no owners, and employees do not derive any financial benefit from the direct provision of low cost transportation. (Section 1877) Unless the Secretary created an exception, stating that the Maine model did not pose a risk of program or patient abuse, a statewide system in place for 28 years would have to be torn down. It is highly probable that adding an independent brokerage to a system that is already well coordinated and cost efficient would have the unintended consequence of raising costs as another layer of administration and infrastructure would be created.

(comments continued below)

Submitter : Ms. Lenna Kottke
Organization : Special Transit
Category : Individual

Date: 09/21/2007

Issue Areas/Comments

General

General

As Executive Director of Special Transit, a private non-profit provider of transportation services for older adults and people with disabilities, I must register objection to proposed section 440.170(a)(4)(ii)(B)(4)(iii) which requires a broker of Non-Emergency Medical Transportation (NEMT) services to document that the Medicaid program is paying no more than the rate charged to the general public.

This provision would be disastrous for private non-profit providers such as Special Transit who provide NEMT services under contract to transportation brokerages. Our actual cost per trip is approximately \$21.50. We ask our riders to pay a fare of \$2.00 for intra-city trips and \$4.00 for regional trips. Our negotiated reimbursement rate from the NEMT program in 2006 averaged \$10.11, with variables including length of trip and whether the passenger was ambulatory or required wheelchair-accessible transportation. The Medicaid reimbursement covers less than half the actual cost of the trip; the rider fare covers another 10%. We utilize grants from local governments, United Way and donations from foundations, corporations and individuals to cover the remainder of the cost.

If the Medicaid reimbursement cannot exceed the rider fare, we will have to stop providing NEMT trips. Our other sources of revenue are not adequate to make up such a steep drop in reimbursement rates. We are the major provider of wheelchair-accessible transportation in a multi-county area of Colorado. If we pull out of the program, there are not enough for-profit providers (who may be able to charge the actual cost of the trip to their affluent riders) to meet the medical transportation needs of Medicaid-eligible, mobility-limited individuals.

Private non-profit transportation providers are a mainstay of NEMT programs. The delicate balance of funding we maintain depends on every stakeholder paying a fair share of the cost of serving low-income individuals with disabilities, advanced frailty and chronic health conditions. If we lose money on every trip, we cannot make it up in volume.

Submitter : Mrs. Lynn Jarman
Organization : Children's Home and Aid
Category : Social Worker

Date: 09/21/2007

Issue Areas/Comments

General

General

As a society we are only as strong as our weakest link. Transportation for poor families to medical visits helps everyone in the community by seeing that children are vaccinated and that families stay together even when one member is ill by receiving the medical care they need in the least restrictive environment to remain in the community. Public health crisis can and will occur if you remove access to doctors, treatment centers, and hospitals. If you force families to choose between food and transportation to non-emergency medical care they will choose food every time and let the check ups or maintenance visits go. Diabetics will go without seeing their physicians, children will miss well child visits, people who are released from hospitals due to emergency situations will have no way to get to follow up care and the costs will sky rocket as medical issues that could have been successfully dealt with in the community now require inpatient care. Sometimes changing one item within a system wreaks havoc within the overall system. This is one of those initiatives.

Submitter : Mr. Craig Zurhorst
Organization : Western Maine Transportation Services
Category : Other Association

Date: 09/21/2007

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment

General

General

The proposed rule does not make allowance for currently existing models for the provision of Non-Emergency Medical Transportation that meet the financial, oversight and contractual guidelines proposed.

We would request that further time be allowed for the solicitation of comments, including input from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

We appreciate your thoughtful consideration of this issue.

Sincerely,

Craig Zurhorst

Community Relations Director
Western Maine Transportation Services, Inc.
76 Merrow Road
Auburn, ME 04210
(207) 212-2096 cell
(207) 333-6972 office
czurhorst@westernmainetrans.org

CMS-2234-P-26-Attach-1.RTF

September 21, 2007

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Re: Medicaid Program: State Option to Establish Non-Emergency Medical Transportation Program

By electronic submittal: www.cms.hhs.gov/eRulemaking

Western Maine Transportation Services, the designated Regional Transportation Provider for Androscoggin, Franklin and Oxford Counties, is a private, non-profit organization, incorporated in the State of Maine whose service includes the provision of Non-Emergency Medical Transportation to persons residing in our service area.

"State legislation enacted, and made effective on June 21, 1979, provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. State law requires the approval of each plan by the Department of Transportation, with the consent of the Department of Health and Human Services.

In December of 2004, by Executive Order of the Governor, an Interagency Coordinating Committee was established in response to the Olmstead Decision and a Presidential Executive order requiring demonstrated transportation coordination efforts. Maine DOT was designated the lead agency for this committee which includes representatives from the policy level of the Department of Health & Human Services (including MaineCare and Elder Services) and the Department of Labor. In addition to developing a five year strategic plan, the Committee will review and approve regional plans." *Maine DOT, Guide to Transportation Management*

As such, since 1979, the State of Maine has been providing Medicaid (MaineCare) non-emergency transportation through a model that has proven to be both cost effective and consumer-responsive. Regional Providers currently contract for wheelchair vans (where available), taxis, bus passes and tickets, air transportation, as well as directly providing van and bus service.

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However, **Provisions of the proposed regulation** would have the opposite impact in the State of Maine:

If the current model for providing Non-Emergency Medical Transportation (NEMT) in Maine is defined as a brokerage system, all of the current Regional Providers would have to cease providing the current van and bus trips that represent some of the most cost-effective service in this rural state.

The prohibition on broker self-referrals erroneously assumes the problems of fraud, abuse and kickbacks experienced with some physicians are also problems experienced with designated transportation providers in Maine.

The designated Regional Transportation Providers are each non-profit organizations. As such, there are no "owners", and "employees" do not derive any financial benefit from the direct provision of low cost transportation. (Section 1877) Unless the Secretary created an exception, stating that the Maine model did not pose a risk of program or patient abuse, a statewide system in place for 28 years would have to be torn down. It is highly probable that adding an independent brokerage to a system that is already well coordinated and cost efficient would have the unintended consequence of raising costs as another layer of administration and infrastructure would be created.

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We appreciate your thoughtful consideration of this issue.

Sincerely,

Craig Zurhorst

Community Relations Director
Western Maine Transportation Services, Inc.
76 Merrow Road
Auburn, ME 04210
(207) 212-2096 cell
(207) 333-6972 office
czurhorst@westernmainetrans.org

cc: The Honorable Susan Collins, The Honorable Olympia Snowe, The Honorable Michael Michaud,
The Honorable Thomas Allen

Submitter : Ms. Sara Trafton
Organization : Coastal Trans, Inc.
Category : Other Health Care Provider

Date: 09/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2234-P-27-Attach-1.DOC

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

**Re: Medicaid Program: State Option to Establish
Non-Emergency Medical Transportation Program**

By electronic submittal: www.cms.hhs.gov/eRulemaking

Coastal Trans, Inc., the designated Regional Transportation Provider for the State of Maine Region 5 counties of Sagadahoc, Lincoln, and Knox and the towns of Brunswick and Harpswell, is a private non-profit organization incorporated in the State of Maine whose service includes the provision of non-emergency medical transportation to persons residing in our service area.

“State legislation enacted and made effective on June 21, 1979 provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. The approval of each plan by the Department of Transportation with the consent of the Department of Health and Human Services is required by law.

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We agree with the vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and stated on page 48605, August 24, 2007 *Federal Register* that, “*the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.*”

Provisions of the proposed regulation would have the opposite impact in the State of Maine:

If the current model for providing non-emergency medical transportation (NEMT) in Maine is defined as a brokerage system, all of the current Regional Providers would have to cease providing the current van and bus trips that represent some of the most cost-effective service in this rural state.

The prohibition on broker self-referrals has taken the issues of fraud and abuse, and kickbacks exhibited by physicians and applied it erroneously to what current practice is in Maine. The designated Regional Transportation Providers are each non-profit organizations. As such, there are no "owners", and "employees" do not derive any financial benefit from the direct provision of low cost transportation. (Section 1877) Unless the Secretary created an exception, stating that the Maine model did not pose a risk of program or patient abuse, a statewide system in place for 28 years would have to be torn down. It is highly probable that adding an independent brokerage to a system that is already well coordinated and cost efficient would have the unintended consequence of raising costs as another layer of administration and infrastructure would be created.

It is unclear what is defined as "rural" in the proposed rule, in that "any area that is outside an urban area" begs the question of what definition of "urban area" you use. In a state with a statewide population of 1.4 million, Maine's four "urban" areas are each under 200,000 population, with the smallest being around 25,000 (contiguous to the Portsmouth/Dover, N.H. urban area).

The proposed guideline that "the Medicaid program was paying no more than the rate charged to the general public" also begs the question of who is defined as "general public" in a rural state where the majority of transportation available is demand-response, not fixed-route public transportation, and where a majority of rural persons transported are low-income, persons with disabilities, and elderly. In Maine, Regional Transportation Providers contract with various state agencies with a variety of targeted consumers, as well as receiving other county and local funds for specific trip purposes. Who is the "general public" in this current model, where fares and donations received from persons whose trips are not eligible through any state or federal contracts, including Medicaid, have to be kept artificially low in order to make typical long-distance rural trips affordable.

General public transportation funding (FTA Section 5311) represents a small percentage of the total funding available to the coordinated Regional Transportation systems in Maine. In many areas, it is provided as a result of existing alternatively funded services (including Community Services Block Grant, Child Welfare, Developmental Disability, and other human service funding, including Medicaid). General public service fares were never intended to represent the cost of providing that service, but are deeply subsidized by the FTA operating funds. If Medicaid does not want to pay in excess of what the "general public" pays, there would need to be additional funds beyond the "general public fare" to cover the operating costs that FTA recognizes.

The proposed rule does not make allowance for currently existing models for the provision of NEMT that meet the financial, oversight and contractual guidelines proposed.

We would request that further time be allowed for the solicitation of comments, including from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

Sara Trafton, Transportation Director
Coastal Trans, Inc.
43 Bath Rd.
Brunswick, ME. 04011
207-443-6207 trafton@mchinc.org

Submitter : Mr. Tom Mauser
Organization : Colorado Department of Transportation
Category : State Government

Date: 09/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Mr. Jon McNulty
Organization : Regional Transportation Program, Inc.
Category : Other Health Care Provider

Date: 09/22/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2234-P-29-Attach-1.RTF

CMS-2234-P-29-Attach-2.RTF

September 22, 2007

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

**Re: Medicaid Program: State Option to Establish
Non-Emergency Medical Transportation Program**

By electronic submittal: www.cms.hhs.gov/eRulemaking

Regional Transportation Program, Inc. (RTP) is the designated Regional Transportation Provider for Cumberland County, Maine. RTP is a private non-profit organization incorporated in the State of Maine whose service includes the provision of non-emergency medical transportation to persons residing in our service area.

“State legislation enacted and made effective on June 21, 1979 provided that the State be divided into geographic regions with a Biennial Operations Plan required to coordinate, plan and describe the provision of public transportation in Maine. The Regional Providers, within funding limits, are charged with providing access to transportation across their entire region. The approval of each plan by the Department of Transportation with the consent of the Department of Health and Human Services is required by law.

In December of 2004, by Executive Order of the Governor, an Interagency Coordinating Committee was established in response to the Olmstead Decision and a Presidential Executive order requiring demonstrated transportation coordination efforts. MDOT was designated the lead agency for this committee which includes representatives from the policy level of DHHS (including MaineCare and Elder Services) and the Department of Labor. In addition to developing a five year strategic plan, the Committee will review and approve regional plans.” *Maine DOT, Guide to Transportation Management*

As such, since 1979 the State of Maine has been providing Medicaid (MaineCare) non-emergency transportation through a model which has proven to be both cost effective and consumer-responsive. Regional Providers currently contract for wheelchair vans (where available), taxis, bus passes and tickets, air transportation, as well as directly providing van and bus service.

We agree with the vision for transportation developed by the Center for Medicare and Medicaid Services (CMS) and stated on page 48605, August 24, 2007 *Federal Register* that, “*the flexibility to provide cost effective transportation programs provide opportunities to modernize Medicaid, makes the cost of the program and health care more affordable, and expands coverage for the uninsured.*”

Provisions of the proposed regulation would have the opposite impact in the State of Maine:

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The proposed rule does not make allowance for currently existing models for the provision of NEMT that meet the financial, oversight and contractual guidelines proposed.

We would request that further time be allowed for the solicitation of comments, including from consumers, along with additional research and discussion, particularly including the federal interagency Coordinating Council on Access and Mobility (CCAM), mandated by Presidential Executive Order 13330.

Jon B. McNulty, Executive Director
Regional Transportation Program, Inc.
127 St. John Street
Portland, Maine 04102-3072
Email: jmcnulty@rtprides.org

Submitter : Mrs. Lisa Bacots

Date: 09/23/2007

Organization : FL Commission for the Transportation Disadvantaged

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

General

General

See attachment.

CMS-2234-P-30-Attach-1.DOC

September 23, 2007

Department of Health and Human Services
Centers for Medicare and Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Re: Medicaid Program: State Option to Establish Non-Emergency Medical
Transportation Program

By electronic submittal: www.cms.hhs.gov/eRulemaking

Provisions of the Proposed Regulations

The Florida Commission for the Transportation Disadvantaged (Commission) is a legislatively created state agency charged with ensuring quality and efficient transportation services are provided to persons who are elderly, disabled, low income and children-at-risk in the State of Florida. Currently, the Commission is on contract with the Florida Medicaid Program to administer and manage the Non-Emergency Transportation Program under a brokerage relationship.

We appreciate the opportunity to comment on the proposed rule relating to the Medicaid Program and the State Option to Establish a Non-Emergency Medicaid Transportation Program. We support the letter submitted by Mr. Dale Marsico, Executive Director of the Community Transportation Association of America.

Our comments are summarized below:

- On page 48605, s. 440.170(a)(4): The discussion related to the competitive bidding process states that State and local bodies that wish to serve as brokers should compete on the same terms as non-governmental entities. The current State of Florida laws regarding competitive procurement allow a state entity to forgo the competitive bidding process if the agency can prove they can provide the service at the same quality, level, and price as a private company. We would be concerned that the intent of the competitive bidding process language as discussed in this proposed rule may conflict with current state laws that allow government entities the first right of refusal in providing services.
- On page 48606, section 1877 of the Act: The language relating to the proposal that a broker be an independent entity may be too restrictive. States should be allowed to determine who is the best broker for their

transportation program. This language could potentially limit the number of entities that would be eligible to bid on these services.

- On page 48606, Governmental Brokerages: In the second paragraph of this section, the language appears to prohibit the payment of services that are normally shared with or paid by other governmental units. The State of Florida recently enacted a rate methodology process, which is intended to pool together different funding agencies human service transportation dollars to ensure the coordination of these transportation services and in return a more cost effective rate is created. The rates paid to providers are inclusive of numerous different state and federal agencies in order to better utilize economies of scale and ensure the most cost effective transportation is being provided. We believe this is in the spirit of the United We Ride initiative.
- On page 48606, Governmental Brokerages: In the second paragraph of this section, the proposed rule also discusses that Medicaid pays no more than the rate charged to the general public. The State of Florida encourages a negotiation process between the Medicaid provider and the transit entity so a fair rate is paid for services, if the Medicaid provider is utilizing the ADA service a transit entity is required to provide. The Medicaid agency is a funder of transportation services and should be expected to pay the fully allocated costs of the actual transportation services being provided.

The Commission appreciates the opportunity to comment on this proposed rule. If more information is needed on the items above, please feel free to contact me at (850) 410-5711.

Thank you.

Lisa M. Bacot
Executive Director
Florida Commission for the Transportation Disadvantaged
605 Suwannee Street, MS 49
Tallahassee, FL 32399-0450
Phone: 850-410-5711
Fax: 850-410-5752
Email: lisa.bacot@dot.state.fl.us
Web: www.dot.state.fl.us/ctd

Submitter : Peter Crowell

Date: 09/23/2007

Organization : Montrose County SeniorCitizens Transportation, Inc

Category : Other Association

Issue Areas/Comments

General

General

Montrose County Senior Citizens Transportation, Inc. is a Colorado non-profit corporation providing transportation to seniors, disabled and low-income job seekers in Montrose, Colorado. Other than a small taxi company, we are the only transportation organization in the county. We currently provide more than 3,500 trips per month to our clients.

1. The comment period allowed, 30 days, is not adequate to allow affected agencies in rural areas such as ours, to learn of the proposed rulemaking and to respond effectively. We respectfully request that the comment period be extended to 120 days.

2. The proposed Conflict of Interest regulation as applied to transportation would contravene provisions of the United We Ride Program, as described in Executive Order 13330 (EO 13330), Human Services Transportation Coordination, issued February 24, 2004. That Executive Order tasks the Secretary of Health and Human Services, among others, with promoting interagency cooperation in the provision of transportation services. In particular, the conflict of interest provision would defeat our agency's efforts to work with other transportation providers, such as the taxi company, to provide service to a variety of senior and disabled citizens who depend on our agency for transportation to and from medical appointments.

3. The proposed regulations provide that our agency may no longer charge Medicaid for the fully allocated cost of paratransit transportation and must charge no more than the maximum fare or fee charged to the general public. In a community such as ours, where there is no other transportation for disabled Medicare clients, this requirement cannot apply. But the issue remains: how can a transportation agency operate when it is not allowed to charge the cost of its services to the entity mandating the service? An agency such as ours could not maintain Medicare service without these funds.

We respectfully request that CMS reconsider the implementation of these regulations until more study has been undertaken regarding the impact of the proposed regulations on small, rural transportation agencies.

Peter Crowell, Board President

Submitter : Mr. Dale Madison

Date: 09/23/2007

Organization : Mr. Dale Madison

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2234-P-32-Attach-1.PDF

#32

Dale Madison
6576 Edward Street
Mentor, Ohio 44060
W: 440.368.5656 • C: 440.251.2609
<dmadison@ncweb.com>

23 September 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2244-P
Post Office Box 8017
Baltimore, Maryland 21244-8017

RE: Comments to Docket Number CMS-2234-P

Administrator McClellan:

The writer is now retired after 30+ years in the transit industry, and feels compelled to make the comments below.

Once again, the federal government has proposed a rule that will be seriously detrimental to the health of America's transit agencies. The proposed rule is fatally flawed, and should be withdrawn.

Since passage of the *Americans with Disability Act*, transit agencies have become the "dumping ground" for any number of social service agencies who no longer want to be responsible for transporting their clients. ADA service operated by transit agencies continues to experience growth, some of it double-digit. Transit agencies have had to cut regular line service to provide the locally-funded budget resources necessary to operate more ADA service.

Specifically, proposed section 440.170(a)(4)(ii)(B)(4)(iii) will require the government brokerage to document that the "Medicaid program is paying no more than the rate charged to the general public." The cost of an average paratransit trip in 2005 (the latest year for which statistics are currently available) was over \$22.62. *Public Transportation Fact Book*, May 2007. ADA and 49 CFR 37 restrict public transportation agencies from charging more than "twice the fare that would be charged to an individual paying full fare (i.e., without regard to discounts) for a trip of similar length, at a similar time of day, on the entity's fixed route system." Transit agencies therefore get, perhaps, \$5 for a trip that costs \$23.

The vast majority of these transportation costs from the federally supported Medicaid program will be unfairly transferred to locally funded public transit agencies. The proposal abdicates the CMS role of providing non-emergency transportation services to Medicaid recipients. The proposal prohibits public transit agencies from achieving a level playing field with for-profit private operators.

Already in Ohio we have examples of a private operator in Dayton being selected to transport persons from Delaware County to Columbus. The local transit agency in Delaware County is precluded from participating in any part of that transport. Not only is that transit agency closer, they are also cheaper.

The proposal flies in the face of such other federal initiatives as the United We Ride Program (EO 13330). That Executive Order tasks the Secretary of Health and Human Services, among others, with promoting interagency cooperation in the provision of transportation services. In contrast, the result of this proposed rule is the abandonment of such cooperation. The proposed rule should be withdrawn and the matter submitted to the Interagency Transportation Coordinating Council, created by EO 13330, to ensure any future CMS rulemaking remains consistent with the United We Ride Program and the Executive Order.

Inherently anti-public transit, the proposal is fatally flawed. It must be withdrawn and re-written to address the issues raised here to ensure transit agencies have a level playing field and are properly reimbursed for their efforts.

Sincerely,

Dale Madison