



**AMERICAN MEDICAL RESPONSE**

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September 24, 2007

Herb B. Kuhn, Acting Deputy Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, Southwest  
Washington, DC 20021

SEP 24 2 11 PM '07  
DHS

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

Dear Mr. Kuhn:

American Medical Response ("AMR") appreciates the opportunity to comment on the above-referenced CMS proposed rule (the "Proposed Rule"). AMR is the largest ambulance supplier in the country, providing emergency and non-emergency medical transportation to four million patients annually in 36 states. As the 911 provider in hundreds of communities throughout the United States, we are a vital part of the nation's health care delivery system. Additionally, AMR is a manager of transportation for many large health plans and hospitals, including the the country's largest health maintenance organization. Our transportation more than 6 million lives nationally. AMR also provides non-ambulance non-emergency medical transportation ("NEMT") brokerage services in the State of Texas in several of the state's largest population centers which encompass over 900,000 Medicaid beneficiaries and results in AMR managing approximately 3000 trips per day.

AMR commends CMS for establishing a process, consistent with the requirements set forth in Section 6038 of the Deficit Reduction Act of 2005 (the "DRA"), that will facilitate the establishment of NEMT brokerage arrangements for state Medicaid beneficiaries on a cost-effective basis, while assuring quality.

AMR is concerned, however, that proposed section 440.170(a)(4)(ii) is overly broad and would impede the ability of brokers to provide timely and appropriate access to NEMT for beneficiaries. As drafted, this section would prohibit the broker and certain related parties from providing NEMT, or from making a referral or subcontracting to another transportation service provider, if the broker has a "financial relationship" with the transportation provider, as defined in 42 CFR § 411.354(a), with "transportation broker" substituted for "physician" and "non-emergency transportation" substituted for a "DHS". This provision

addresses the Congressional mandate in the DRA to include conflict of interest provisions similar to those found in the physician "Stark Law" in NEMT brokerage contracts. Our specific concerns about this provision are as follows:

**1. An NEMT Services Contract Would Constitute a Prohibited Financial Relationship.**

Although we know this was not intended, literal application of proposed section 440.170(a)(4)(ii) will preclude the broker from making a referral to any NEMT provider with which the broker has a NEMT services contract, since that contract would constitute a "financial relationship" as defined in Stark regulation Section 411.354(a), as referenced in proposed section 440.170(a)(4)(ii)(A)(1). This anomaly does not occur with respect to the application of the Stark Law to physician services, since Stark has exceptions that exempt this situation (e.g., the Stark exception for personal services and management contracts). In the context of the Proposed Rule, perhaps the most efficient and clearest way to address this issue is to add a provision stating as follows:

"A subcontract between the broker and a transportation service provider for the provision of transportation services to the broker pursuant to a brokerage contract referenced in paragraph (a)(4)(i)(D) shall not constitute a financial relationship for purposes of this section."

Alternatively, this issue could be addressed through the addition of the Stark Law exceptions discussed in Part 3 of this letter below.

**2. Exceptions Should Be Added To Provide the Broker With Discretion to Use Its Own Resources as Needed to Assure Adequate Service.**

We also believe that the exceptions currently found in proposed paragraph (a)(4)(ii)(B) are too narrow. As drafted, a broker would be entitled to refer to itself, or to another company with which it has a financial relationship, only:

- In a rural area, as defined, when there is no other provider *determined by the state* to be qualified, except the broker;
- If the needed transportation is so specialized that there is no other provider *determined by the state* to be qualified, except the broker;
- When the availability of other providers *determined by the state* to be qualified is insufficient to meet the need for transportation.

These exceptions suggest that the state will either make determinations as to the sufficiency of other qualified providers or will establish standards for doing so. However, it is unclear how or when the state would establish these standards or make the required determinations, or how it would monitor compliance by the broker. It is unclear, for example, whether the state will make determinations relative to the availability of other qualified providers standards at the inception of the contract, or whether the state would simply audit or

evaluate the broker's determinations on this issue during the pendency of the contract. In either case, the Proposed Rule is impractical. The availability of other qualified providers, or the sufficiency of the service available from other providers, will sometimes vary from day to day, and in some instances from hour to hour. If the state attempts to make determinations as to the availability of other providers at the inception of the brokerage agreement, the broker may find itself unable to meet the demand for services when the availability of other transportation resources decreases. If the state attempts to make such determinations on an ongoing basis during the pendency of the contract, or to monitor the broker's determinations, it will require the state to engage in a level of supervision over the performance of the contract that will not be feasible. Further, the decision as to whether the availability of other providers is sufficient is not always clear cut. The following provides an example:

*A dialysis patient has completed his dialysis treatment and, in a weakened state, is in need of NEMT back to the patient's home or long-term care facility. Due to unusually high demand, no other NEMT providers are available to transport the patient until 2 hours later. The only way the broker is able to arrange for timely NEMT at the appropriate level of care is to refer the call to its own resource.*

To address this problem, we recommend that an additional exception be added that would permit the provider to make referrals to its own NEMT resources, or to another entity with which it has a financial relationship, based on its own determination that the use of such resources are necessary to provide timely, cost-effective services at the appropriate level of care under the circumstances that may exist at any given time or when otherwise determined to protect the health and welfare of the Medicaid beneficiary. We propose limiting the use of this exception by the broker to a maximum of 10% of all NEMT arranged for by the broker during any month of the contract. This would provide the broker with sufficient flexibility to ensure timely and adequate services at any given time.

We believe that an additional exception is required to address the circumstances that frequently arise when a state implements a new NEMT brokerage program or extends an existing program to a new area. Frequently, it is difficult for the broker to secure contracts with providers in some communities, since those providers are sometimes resentful of (or resistant to) the transition from an "open" Medicaid program to a broker program. Often, it takes as long as 90 days before the broker can secure the necessary contracts required to efficiently and effectively provide timely services to the Medicaid population. Another example is associated with the fact that at times states are uncertain of the actual quantity of trips that may occur in certain jurisdictions, resulting in demand initially exceeding available resources upon contract implementation. To address these phenomena, we recommend that an exception be made that would permit the broker to use its own resources, as necessary to provide timely, cost-effective services at the appropriate level of care during this 90-day transition period. This exception would not be subject to the 10% limitation suggested above for the post-90 day period.

In order to implement both of these exceptions with a single provision, we suggest adding the following additional language to paragraph (a)(4)(ii)(B):

“The broker determines, based on the circumstances at the time transportation is ordered, that the delivery of transportation by the broker or a transportation provider referred to in paragraph (a)(4)(ii)(A) of this section is necessary to provide timely, cost-effective and quality transportation, or is otherwise in the best interest of a beneficiary. This exception shall not be utilized for more than 10% of the total non-emergency medical transportation trips ordered by the broker during any calendar month, except during the first ninety days following the effective date of the brokerage contract.”

**3. Additional Exceptions Found in the Stark Law Should be Added to Address Innocent and Appropriate Financial Relationships Between Brokers and Providers.**

We also note that although proposed section 440.170(a)(4)(ii)(A)(1) incorporates the broad prohibitions of the Stark Law, it includes only a narrow set of exceptions. However, circumstances may exist where a broker has a financial relationship with another NEMT provider in the same community which is totally unrelated to the brokerage contract. For example, the broker may operate an emergency medical services (“EMS”) business in the community which has an overflow contract with another provider of both EMS and NEMT. Another example would be where the broker leases garage space or crew quarters from a NEMT provider in the community, perhaps for posting the broker’s crews or ambulances used in its EMS business. Yet a third example would be a situation in which the broker has a contract to purchase fuel from a NEMT provider in the community, or visa versa. Under each of these scenarios, regardless of whether the financial relationship between the parties reflects appropriate fair market value, the broker will be precluded from making a referral to, or subcontracting with, the other provider. While the Stark Law includes exceptions that would address each and every one of these scenarios (as well as others), the Proposed Rule does not.

To address these situations, we recommend that certain of the Stark Law exceptions be incorporated into the proposed rule. Exceptions that should be added include, but are not necessarily limited to, the Stark exceptions for rental of space and equipment; personal services arrangements; payments for bonafide services; fair market value compensation; risk sharing arrangements; compliance training; indirect compensation arrangements; community wide health information systems; charitable donations; and isolated transactions. See 42 C.F.R. § 411.357(a), (b), (d), (f), (i), (j), (l), (n), (o), (p) and (u). In addition, exceptions should be added for ownership and publically traded securities and mutual funds. (See 42 C.F.R. § 411.356 (a) and (b)). In the absence of these exceptions, innocent and appropriate financial relationships between a broker and an unrelated NEMT provider would preclude that provider from participating in the network assembled by the broker.

**4. The Proposed Rule Should Clarify that Referrals to the EMS System are Excepted.**

Finally, we recommend that the Proposed Rule more clearly address the scenario in which the broker also provides EMS in the same community in which it acts as an NEMT broker. As drafted, the Proposed Rule would prohibit the broker “from providing non-

emergency medical transportation services or making a referral” to another transportation service provider if a financial relationship exists between the parties. We do not believe this provision is intended to preclude a broker from making a referral to a commonly owned EMS provider, or an EMS provider with which it has a financial relationship, in those circumstances in which the broker receives a request which is more appropriately referred to the 911 system. We recommend that this be clarified.

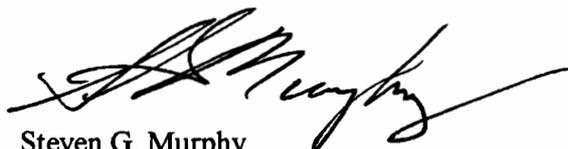
### CONCLUSION

In closing, we believe that, in general, the Proposed Rule will provide sound ground rules for state Medicaid NEMT broker programs. However, the conflict of interest provisions are overly broad and should be modified in the following respects:

- To clarify that a contract between the broker and NEMT provider for the delivery of NEMT in order to perform the state brokerage contract does not constitute a prohibited financial relationship;
- To provide the broker with discretion to use its own resources, or refer to another provider with which it has a financial relationship, when deemed necessary by the broker to provide timely, cost-effective and quality transportation, or to otherwise protect the health and welfare of the beneficiary, subject to a 10% limit in a calendar month, except during the first 90 days of the brokerage contract;
- To include other exceptions found in the Stark Law so that innocent and appropriate financial relationships between a broker and a NEMT provider do not preclude the provider from participating in the network; and
- To clarify that a broker may refer to an EMS system in which the broker may provide EMS services.

Thank you for considering our views. If you have any questions or would like to discuss our comments, please do not hesitate to contact the undersigned.

Very truly yours,



Steven G. Murphy  
Executive Vice President  
Government and National Services



Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2234-P  
Mail Stop C4-26-05  
7500 Security Blvd.  
Baltimore, MD 2144-1850

September 24, 2007

To whom it concerns:

On behalf of the over 70 transit providers who are members of the Colorado Association of Transit Agencies (CASTA), we wish to provide comment on the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking (NPRM) concerning Non-Emergency Medical Transportation.

CASTA is a non-profit trade association of more than 120 public and private organizations, including transit systems, governmental entities, planning organizations and vendors. Our comments are regarding two sections of the proposed rules.

First, while our state Medicaid representatives assure us that the proposed rules were designed to provide maximum flexibility for state and local governments, we find that an aspect of the proposed rule ultimately ends up harming the very same state and local governments that fund transit. Specifically, the proposed section 4403170 (a) (ii) (B) (4) (iii) requires a government brokerage document that the "Medicaid program is paying no more than the rate charged to the general public." The average cost of a paratransit trip in 2005 (the latest year for which statistics are currently available) was over \$22.00. This requirement effectively transfers the cost of the majority of the transportation costs from the federally supported Medicaid program to locally funded transit agencies.

Many of the Colorado providers have determined that if the Medicaid reimbursement cannot exceed the rider fare, they will cease to provide non-emergency Medicaid transportation (NEMT) trips. In effect, CMS will be abdicating their role of providing non-emergency transportation services to Medicaid recipients. This result is obviously counter to other federal initiatives. CASTA is also involved in both the Colorado Coordinating Council and the Denver Regional Mobility Access Council. Both organizations evolved from the United We Ride program, as described in the Executive Order titled Human Services Transportation Coordination, which promotes interagency

cooperation in the provision of transportation services. This is in sharp contrast with the results of the proposed rule.

Second, the proposed rule under “Requirements of the Provisions for State Plans,” prohibits a brokerage to also furnish transportation services. A broker providing transportation is NOT analogous to a physician making referrals for certain designated health services. The organizational setup and accountability is vastly different in the transportation field than it is in the medical field.

In many parts of Colorado it is difficult to find organizations willing and able to broker transit trips in small communities or regions. Such service, with its low and sporadic flow of referrals and high overhead, is a waste of limited Medicaid dollars. Existing community transportation systems play the role as broker and as one of the providers. Unlike a physician’s concern with a bottom line, these providers are non-profit organizations, interested in providing the most rides possible, not with lining their own pockets. Their work can be monitored and held accountable, just as they are now by local and Federal funding sources.

CMS benefits by taking advantage of existing administrative structures and phone banks already established and paid for by other sources. The proposed rule would force these efficient and effective agencies into choosing between a broker and provider role, potentially leaving one role unfilled, and the clients in that region under- or unserved.

Colorado enjoys a myriad of useful community transportation systems that have been established over the years by strong partnerships between federal, state and local governments, and we cannot help but feel dismay at proposed rules that seek to undermine the effectiveness and efficiency of existing NEMT services. Please withdraw this proposed rule and submit the matter to the appropriate body, namely the Interagency Transportation Coordinating Council.

Sincerely,

A handwritten signature in black ink that reads "Elena Wilken". The signature is fluid and cursive, with the first name being more prominent.

Elena Wilken  
Executive Director  
Colorado Association of Transit Agencies

September 24, 2007

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-2234-P  
Post Office Box 8017  
Baltimore, Maryland 21244-8017

**RE: Comments to Docket Number CMS-2234-P**

Administrator McClellan:

On behalf of Access Services, 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.

Our comments address two sections of the NPRM, definitions, and address the impact on Access Services, a California public benefit corporation (local governmental agency) that provides ADA paratransit in Los Angeles County, on behalf of 44 Municipal Transit Operators and Transportation Authorities:

- I. Provisions of the Proposed Regulations,
- II. Collection of Information Requirements,
- III. Definition of Secured Service
- IV. Impact on Access Services and California State Coordinating Entities

**I. Provisions of the Proposed Regulations**

***The Proposed Rule Improperly Endorses Transferring the Costs of Transporting Recipients onto Local Public Transportation Agencies***

While we appreciate CMS' efforts to provide maximum flexibility to state and local governments, one aspect of the proposed rule would be devastating to the public transportation agencies funded by those same state and local governments. 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 would effectively transfer the vast majority of these transportation costs from the federally supported Medicaid program to locally funded public transit agencies.

Mandated by the *Americans with Disabilities Act* and 49 CFR Part 37, public transportation agencies operating 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.” 49 CFR 37.131(c). The average national cost of providing an ADA paratransit trip in 2005 (the latest year for which statistics are currently available) was over \$22.62. *Public Transportation Fact Book*, 58<sup>th</sup> Edition, May 2007, Tables 6 and 48. Clearly, even twice the fare of a typical bus trip cannot defray more than a small fraction of that actual cost. In some systems, paratransit means cutting other services depended on by the general public.

The DOT regulations, however, allow for a higher fare or fee to be charged for “agency trips” or what is often described as “premium service.” 49 CFR 37.131(c)(4). This provision recognizes the reality that sponsoring agencies often desire or require a different or higher level of service(s) for some individuals than what is provided under the non-discrimination provisions of the ADA. The proposed CMS requirement that “the Medicaid program is paying no more than the rate charged to the general public” unrealistically and over-simplistically assumes that the Medicaid service is the same as the service provided to the general public, when it may well not be. Any final CMS regulations need to distinguish different types and levels of services provided to meet recipients’ needs, and to pay accordingly.

To further burden the 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 effectively and unfairly shifts that burden from the Medicaid program to those state and local governments and abdicates the CMS role of providing non-emergency transportation services to Medicaid recipients and the obligation that State plans “ensure necessary transportation for recipients to and from providers.”

This result is not mandated by the *Deficit Reduction Act of 2005* and, in fact, flies in the face of 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 on Access and Mobility (CCAM), created by EO 13330

and of which HHS is a significant member, to ensure that any future CMS rulemaking remains consistent with the United We Ride Program and the Executive Order.

## II. Collection of Information Requirements

### *The Proposed Rule's Impacts on State and Local Governments should be Reevaluated*

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 under the proposed rule and the financial impact of those trips. We note that, 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.

Moreover, stressing state and local governments with the additional burden of under-funded non-emergency medical transportation requirements threatens the ability to provide paratransit services to the ever-growing population of seniors and persons with disabilities. In attempting to provide flexibility, the proposed rule would instead damage the availability of transportation services to the seniors and persons with disabilities most reliant on those services.

Further, the proposed requirement that the broker/provider could only be reimbursed “for costs that are unique to the distinct brokerage function” and that costs “shared with or paid by other governmental units” could not be accounted for would almost necessarily guarantee higher actual costs for the brokerage function. Such a result is certainly not what should be intended in the interest of CMS’ public stewardship.

We also believe that public transportation agencies can provide stability, flexibility, and professionalism of service that may be difficult for small private or non-profit entities to maintain. The recent month-long budget delay in California was replete with extensive media coverage about how Medicaid transportation service to individuals (among other human service programs) was “threatened” by the state’s non-payment of reimbursements. Public transportation agencies – often directly because of their multiple funding sources – can more dependably maintain service levels during such local fiscal emergencies.

This insufficiently-explored impact on state and local governments is an additional reason this proposed rule should be withdrawn in favor of additional study and coordination.

With regard to the minimal estimate of a total of \$560 nationally in increased direct costs to States to complete the proposed templates of State Plan amendments, we believe that the

actual burden to the affected public and public agencies is seriously understated. The level of documentation proposed to be required of potential and actual public agency brokers is extensive, and the likelihood of having to submit additional documentations to justify costs that are already regularly monitored annually by the Department of Transportation through the National Transit Database and through other statutory Triennial Reviews is probably unnecessary. We would be pleased to provide more detailed information about these existing requirements at your convenience. In addition, the CCAM has been working to identify more uniform and common provisions for various federal agency reporting requirements to minimize duplication.

Finally, and in summary, while the Federal Register Notice states (page 48605) that “We are proposing that State and local bodies that wish to serve as brokers compete on the same terms as non-governmental entities,” the proposed provisions appear to force a precisely opposite result. If anything, the additional burdensome requirements to avoid a perception by CMS that there is some inherent conflict of interest for governmental transportation providers is unfounded. CMS’ desire to “assure an arms-length transaction” is in no way more endangered by inter-governmental relationships than by contractual dependence on private and non-profit providers.

### **III. Definition of Secured Service**

#### **The Proposed Definition of “Secured Transportation” Must be Clarified**

The proposed language in 42 CFR 440.170(a)(4) about “secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals” is unclear and must be clarified. As written, it appears that standard airbags in a sedan would qualify. If this language is intended to address vehicle standards including wheelchair securement and/or occupant restraints such as contained in 49 CFR 38.23(d), it should so specify. We do not understand what kind of “safety needs” might be envisioned by CMS, for example, for recipients with cognitive or mental disabilities in contrast to equipment specifically intended for wheelchair users.

### **IV. Impact on Access Services and California State Coordinating Entities**

#### **Access Services Concerns about the Proposed Rules:**

##### Access Services Organization

Access Services is a state mandated local governmental agency created in 1992, by 44 of Los Angeles County's public transit agencies to:

- administer and manage the **delivery of regional Americans with Disabilities Act paratransit service (ACCESS PARATRANSIT)**, and
- coordinate human service agency transportation as the **Consolidated Transportation Services Agency (CTSA)**. California State Law requires the

designation of an agency as CTSA in each region, to ensure a clearinghouse for transportation coordination resources and opportunities.

In 1994 Access Services was organized as a California public benefit (private nonprofit) corporation and designated as the LA County CTSA to ensure continued implementation of the coordinated ADA paratransit plan and coordination of social service agency transportation in the County. Access Services is a "governmental" agency within the meanings of the California Fair Political Practices Act and the California Open Meetings and Records Act (Brown Act).

#### Potential Impact on Access Services and CTSA's across California

Access Services would potentially qualify as a Governmental Brokerage, although it is not performing that function at this time. The increased desire to coordinate human services and public transportation services, as evidenced by United We Ride, and the more recent SAFETEA-LU transportation reauthorization legislation, to provide services in a more cost effective and efficient manner, has led to discussions amongst California stakeholders on viable implementation options, which include equitable cost sharing for transportation provided by Public Transit to Medicaid eligible individuals.

We strongly feel that a majority of MediCaid NEMT trips can be served effectively by public transportation (including bus, rail and specialized services like dial-a-rides, taxi-vouchers and paratransit), with equitable cost reimbursements, as evidenced in Utah and nearly 25 other states (Medicaid Non Emergency Transportation: National Survey 2002-2003, published by the National Consortium on the Coordination of Human Services Transportation). *However, the proposal to reimburse Governmental Brokerages and providers the fare, and not the cost of transportation would result in reduced interest in serving those clients, unless they qualify for the public services.*

Access Services could provide high quality service to NEMT clients who need curb-to-curb or wheelchair accessible van service, but if they are not eligible for ADA paratransit service, which is a more stringent assessment, they would not be considered for the services, since Access Services cannot bear the cost of the additional trips.

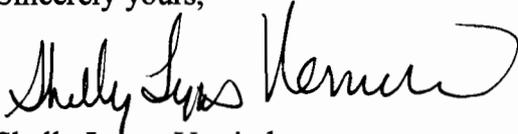
If however, as a "Governmental Broker", ASI were to provide NEMT trips by accessible minivans (for those clients determined to be eligible for that mode), it would cost approximately \$30-40 per trip, compared a much higher per trip cost by private entities (anecdotally \$80 appears to be the statewide average cost of an NEMT trip). Such an arrangement on a nationwide scale could save Medicaid services more than the \$120 million threshold required for a financial impact assessment; the proposed regulations would prevent that from occurring.

Similarly, if a Medicaid NEMT trip was directed by a broker to a Transit Bus, that transit provider could be reimbursed by Medicaid \$30 (national average cost of a bus pass) bus pass, which would be higher than the fare for one bus trip but could be used indefinitely

for a month, but still cost significantly less than the cost of a single one-way Medicaid NEMT trip given the cost structure in place in CA.

We greatly appreciate the opportunity to assist CMS in implementing the *Deficit Reduction Act of 2005* and stand ready to provide information, research, or other assistance necessary in fully exploring the consequences of implementation strategies. For additional information, please contact Arun Prem of my staff at (213) 270-6082 or [prem@asila.org](mailto:prem@asila.org).

Sincerely yours,



Shelly Lyons Verrinder  
Executive Director  
Access Services

cc: Centers for Medicare & Medicaid Services, Office of Strategic Operations & Regulatory Affairs  
Office of Information & Regulatory Affairs, Office of Management & Budget



THE PRINCE GEORGE'S COUNTY GOVERNMENT



Jack B. Johnson  
County Executive

Department of Public Works and Transportation  
Office of Transportation

September 25, 2007



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

RE: Docket Number CMS-2234-P  
CR: PARA-TRANSIT - Americans with Disabilities Act (ADA)

Dear Sir or Madam:

The Prince George's County Department of Public Works and Transportation (DPW&T) 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 and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) on August 24, 2007 (at 72 FR 48604).

DPW&T appreciates the efforts of Congress (in 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. However, we believe that one provision will actually be more burdensome to DPW&T, as well as to other state and local governments that fund transportation services for Medicaid recipients.

**Provision of the Proposed Regulations**

The *Americans with Disabilities Act* and 49 CFR Part 37 require that 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 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." (Per 49 CFR 37.131 (c).)

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

Centers for Medicare & Medicaid Services  
September 25, 2007  
Page Two

the general public." We agree with the American Public Transportation Association (APTA) and others that this provision would further burden the state and local governments that fund public transportation 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.

We also concur with the recommendation of APTA that CMS withdraw the proposed rule and submit the matter to the Interagency Transportation Coordinating Council.

**Regulatory Impact Statement**

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 and others note, 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."

We, therefore, concur 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.

Thank you for the opportunity to provide comments on this proposed rule, which would affect our agency and our taxpayers.

Sincerely,



J. Rick Gordon  
Associate Director, Office of  
Transportation

JRG/lac

cc: Haitham A. Hijazi, Director  
James E. Raszewski, Chief, Division of Transit  
Franklin A. Bell, Chief, Transit Planning Section  
Kevin Thornton, Transit Planning Section