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November 19, 2009

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2232-P2
Post Office Box 8010
Baltimore, Maryland 21244-8010

RE: Centers for Medicare and Medicaid Services Docket Number CMS-2232-P2

Dear Acting Administrator Frizzera:

On behalf of the more than 1,500 member organizations of the American Public Transportation Association (APTA), I write to provide comment on the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking (NPRM) entitled "Medicaid Program; State Flexibility for Medicaid Benefit Packages," published October 30, 2009, at 74 FR 56151.

About APTA

APTA is a non-profit international trade association of more than 1,500 public and private member organizations, including transit systems; high speed rail agencies; planning, design, construction and finance firms; product and service providers; academic institutions; and state associations and departments of transportation. More than ninety percent of Americans who use public transportation are served by APTA member transit systems.

APTA Fully Supports the CMS Proposal to Delay Implementation of and Make Substantial Revisions to the Final Rule

As explained in our March 24, 2008 comments, we believe the then proposed and now final rule is seriously flawed both as a matter of legislative interpretation and practical governance. In addition to changes required by the intervening events identified in the NPRM, the rule should be revised to clearly state that the assurance of medically necessary transportation for Medicaid recipients remains a vital aspect of the program.

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The Final Rule Is Inconsistent with the Underlying Legislation

While Section 6044 of the *Deficit Reduction Act of 2005* (the Act) allows states to amend their Medicaid benefit packages to "benchmark equivalent packages" that provide health care benefits akin to those available in the private sector, the final rule goes far beyond the Congressional intent by relieving state agencies of their responsibility to provide transportation to and from care providers. Nowhere does the Act authorize states to amend their plans "without regard to the assurance of transportation to medically necessary services requirement." That phrase is found only in Section 440.390 of the final rule and is without a statutory basis.

In addition to allowing benchmark plans, the Act specifically addresses the responsibility to assure non-emergency medical transportation to Medicaid recipients in Section 6083(a)(3) which provides specifically for public brokerage of non-emergency medical transportation (NEMT). It is disingenuous to read the "notwithstanding any other provision of this title" language of Section 6044 and interpret it as to allow CMS to ignore another provision in the very same Act. Clearly, that language was intended only to resolve conflicts with the broader provisions of Title 42, U.S. Code, not the *Deficit Reduction Act* itself.

In revising the final rule, we urge CMS to remove Section 440.390.

The Proposed Rule Would Effectively Shift the Financial Burden of Non-Emergency Medical Transportation to Local 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 with disabilities. Under the final rule, the financial burden of transporting Medicaid recipients already likely to have limited access to private transportation and already likely to require these more expensive paratransit services is, through application of Part 37, effectively transferred to public transit agencies at staggering costs. The cost to a transit agency of an average paratransit trip in 2005 (the latest year for which statistics are currently available) was over $22.62 (*Public Transportation Fact Book*, 58th Edition, May 2007, Tables 6 and 48). The fares paid by paratransit riders, limited to 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)) offsets only a small fraction of those costs, at best.

This transfer of financial burden, without provision of funding to offset the costs to local transit agencies, would amount to an unfunded mandate. The practical result of the rule would deal a devastating blow to local transit agencies. Faced with these new costs, transit agencies would be faced with a Hobson's choice – raising fares, raising the burden on local taxpayers to offset the costs, or cutting service to all riders. Any savings experienced by the federal Medicaid program will be more than matched by the burden shifted to local taxpayers and the riding public. This amounts to an abdication of CMS' role of providing non-emergency transportation services to Medicaid recipients and a direct imposition of costs on transit agencies.

In reviewing the then proposed rule, officials of the Federal Transit Administration noted it would negatively impact the many Medicaid beneficiaries who rely on bus passes now provided through the program for NEMT services. Even if the exemption from mandatory enrollment for those who are "blind or disabled" in Section 440.315 was broadly construed, many Medicaid beneficiaries would never obtain vital medical services simply because they could not get to treatment facilities. Whether the impact is in paratransit programs, bus pass programs, or – as is most likely – both, it is the local transit agencies that will bear the financial burden of CMS' 'savings' of federal funds.

The Final Rule is Inconsistent with Overarching Federal Policy

The final rule flies in the face of other federal initiatives, specifically, the United We Ride Program, as established pursuant to Executive Order 13330 (EO 13330), *Human Services Transportation Coordination*, issued by the President on 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.

As this rule is revised, CMS should consult with the Interagency Transportation Coordinating Council on Access and Mobility (CCAM), created by EO 13330, to ensure consistency with the United We Ride Program and the Executive Order. APTA further requests that any further proposals that affect the NEMT program should be brought to CCAM for discussion about their coordination impacts before such proposals are submitted to OMB for review or released to the public for comment.

We 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 James LaRusch of my staff at (202) 496-4808 or jlarusch@apta.com.

Sincerely yours,

William Millar
President

WWM/jpl