



March 24, 2008

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2232-P
Post Office Box 8017
Baltimore, Maryland 21244-8017

RE: Comments to Docket Number CMS-2232-P
“Medicaid Program: State Flexibility for Medicaid Benefit Packages”

Dear Administrator McClellan:

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 February 22, 2008, at 73 FR 9714.

About APTA

APTA is a non-profit international trade association of more than 1,500 public and private member organizations, including transit systems; 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.

The Proposed Rule Violates the Clear Intent of the *Deficit Reduction Act of 2005* (Provisions of the Proposed Rule)

The proposed rule is seriously flawed both as a matter of legislative interpretation and practical governance. It should be withdrawn and replaced with clear direction that the assurance of medically necessary transportation for Medicaid recipients remains a vital aspect of the program.

CMS predicates this rulemaking on section 6044 of the *Deficit Reduction Act of 2005* (the Act). That provision 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. CMS goes far beyond the Congressional intent of allowing benchmark plans by proposing to relieve state agencies of their responsibility to provide transportation to and from care providers.

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William W. Millar

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, US Code, not the *Deficit Reduction Act*.

We note that while CMS dutifully cites the Act’s authority for benchmark plans, it also appends statements to that recitation that appear nowhere in the legislation. Specifically, the assertion that a “State has the option to amend its State plan to provide benchmark or benchmark-equivalent coverage *without regard to comparability, statewideness, freedom of choice, the assurance of transportation to medically necessary services and other requirements*” (73 Fed.Reg. 9714, 9715, emphasis added) appears nowhere in the legislation and implies far more than Congress ever expressed or can reasonably be said to have intended.

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. With this proposal, 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. While CMS hides behind a technical reading to find no violation of the Unfunded Mandates Act, the practical result of this proposed 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.

The proposed rule purports to exempt individuals who are “blind or disabled” from being required to enroll in a benchmarked program. If this is true, how will such determinations be made, and what protections for continuing non-emergency medical transportation through the Medicaid program will remain in effect? At a recent forum, Federal Transit Administration staff indicated their belief that even if this exemption is broadly construed, implementation of the benchmarking proposal may have a negative impact on the ability to continue utilization of bus passes for NEMT services, an allowable use for which we have previously commended CMS in its interpretations. 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.

This proposal 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. 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, to ensure any future CMS rulemaking remains consistent with the United We Ride Program and the Executive Order. APTA further requests that any further proposals that affect the Non-Emergency Medical Transportation program should be brought to the Interagency 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 jlarsch@apta.com.

Sincerely yours,



William W. Millar
President