



NATIONAL ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS
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March 20, 2008

Kerry N. Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1541-P
Box 8012
Baltimore, Maryland 21244-8012

Dear Administrator Weems:

The National Association of Emergency Medical Technicians (NAEMT) would like to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule entitled “Medicaid Program; State Flexibility for Medicaid Benefit Packages” (the “Proposed Rule”), 73 Fed. Reg. 9714 (February 22, 2008).

Founded in 1975, NAEMT is a professional association representing EMTs and paramedics, and advocating for EMS practitioners and quality patient care is one of its primary missions. As the largest, national EMS association, we are often asked to speak on behalf of EMS-related issues such as this one.

Section 6044 of the Deficit Reduction Act of 2005 (Pub. L. 109-171) amended the Social Security Act (the “Act”) by adding a new Section 1937, which allowed states to amend their Medicaid State Plans to provide alternative benefit packages to certain Medicaid populations. The Proposed Rule would incorporate this statutory framework into the Medicaid regulations. NAEMT is concerned by the CMS proposal to exempt the benchmark and benchmark-equivalent packages from the assurance of transportation requirement set forth in 42 C.F.R. §431.53. Our comments are limited to the exemption from the assurance of transportation requirement and to certain other issues pertaining to the provision of medically necessary ambulance services to Medicaid recipients.

Exemption from the Assurance of Transportation Requirement

NAEMT is concerned that the CMS proposal to exempt benchmark and benchmark-equivalent packages from the assurance of transportation requirement may have the unintended consequence of reducing recipients’ access to essential medical services, thereby undermining the goal of the Medicaid program.

The federal assurance of transportation requirement is set forth at 42 C.F.R. §431.53, which requires each state to assure that Medicaid recipients have transportation to and from medically necessary services. HCFA, the predecessor to CMS, has previously recognized that the goals of the Medicaid program would be undermined if needy individuals were unable to get to and from healthcare providers (see Section 6-20-20 of

the old Medicaid Assistance Manual). Thus, the assurance of transportation requirement is a vital component of the Medicaid program. Within this federal mandate, states have broad flexibility to provide necessary transportation in the most cost-efficient manner.

In the Proposed Rule (at page 9715), CMS notes that private health insurance plans generally do not offer non-emergency medical transportation as a benefit to enrollees, and that it would be a strong disincentive for states to be required to supplement a benchmark package with additional transportation benefits. While it is true that many private health insurance plans do not cover wheelchair vans and other forms of non-emergency transportation, large numbers of private health insurance plans do cover non-emergency ambulance transports.

CMS needs to consider the fact that private insurance enrollees differ from Medicaid enrollees, in that Medicaid enrollees will frequently have additional needs and/or limitations not present with private insurance enrollees. Enrollees in private insurance plans will typically have a choice of insurance plans, thereby allowing them to select the insurance plan that best meets their needs. Enrollees in private insurance plans will also generally have greater financial resources to pay for any non-covered services under those insurance plans. By contrast, the Proposed Rule would permit states to force certain recipients to enroll in a specific benchmark or benchmark-equivalent package, without regard to whether this package is appropriate given their individual circumstances.

When medically necessary ambulance transportation is excluded from the benchmark coverage, it could impose a significant financial hardship on the recipient, as he or she may be required to pay out-of-pocket for any non-covered services. Consider a patient who is confined to his or her bed, and, therefore, can only be moved by ambulance. If that recipient were forced to enroll in one of these benchmark packages that did not cover non-emergency ambulance transportation, the recipient may choose to forego necessary medical care, rather than incur the serious financial hardship associated with paying for a private ambulance service to and from their doctor. CMS should not be forcing individuals to choose between their health and financial ruin.

Benchmark-Equivalent Health Benefits Coverage

Under Section 1937 of the Act, a benchmark-equivalent package must offer a specific range of services set forth in proposed Section 440.335(b)(1) – (5). In addition, the plan must have an aggregate actuarial value at least equal to the value of the benchmark packages. NAEMT believes that the majority—if not all—qualifying benchmark plans cover emergency ambulance services. In large part, this is because these plans recognize emergency ambulance transportation as a key component of an efficient healthcare system.

To ensure that enrollees in benchmark-equivalent plans receive coverage that is qualitatively equivalent to these benchmark plans, NAEMT urges CMS to require benchmark-equivalent plans to also cover emergency ambulance transportation. This

could be accomplished by further clarifying that the reference to “emergency services” in proposed Section 440.335 includes emergency ambulance services.

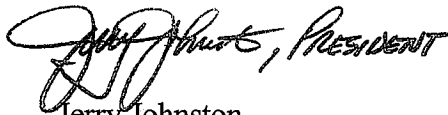
Definition of “Medically Frail”

In proposed Section 440.315, CMS defines classes of individuals who would be exempt from mandatory enrollment in state benchmark or benchmark-equivalent coverage. One category of excluded individuals is recipients who are “medically frail” or who otherwise have “special medical needs”. In the Proposed Rule, CMS offered a definition of “special medical needs.” NAEMT urges CMS to include in any definition of “medically frail” a recipient who “does or would be likely to require medically necessary ambulance transportation, because their physical or mental condition is such that transportation by any means other than by ambulance would be likely to jeopardize the patient’s health or safety.”

Consider again the recipient who is confined to his or her bed, and, therefore, can only be moved by ambulance. This recipient has special medical needs that can only be provided by an ambulance service, i.e., this recipient can not rely upon family members or public transportation for transport to his or her healthcare providers. Forcing this recipient to enroll in a benchmark plan that does not cover non-emergency ambulance transportation would constitute a grave financial hardship.

Thank you for your consideration of these comments. If you or your staff should have any questions regarding our comments, please contact me or Pam Cohen, Executive Director of NAEMT.

Sincerely,


Jerry Johnston
President