

second paragraph of the column, the language "Responsiveness Test: Charitable Trusts. Before enactment of the PPA," is corrected to read "*Responsiveness Test: Charitable Trusts*. Before enactment of the PPA,".

2. On page 42336, column 2, in the preamble, under the paragraph heading "*Qualification Requirements for Type III Supporting Organizations Prior to Enactment of the Pension Protection Act*", seventh line of the second paragraph of the column, the language "trust under state law, (2) each publicly" is corrected to read "trust under State law, (2) each publicly".

3. On page 42336, column 3, in the preamble, under the paragraph heading "*PPA Amendments to Qualification Requirements for Type III Supporting Organizations*", second line of the second paragraph, the language "enacted Code sections 509(d) and" is corrected to read "enacted Code sections 509(f) and".

4. On page 42336, column 3, in the preamble, under the paragraph heading "*PPA Amendments to Qualification Requirements for Type III Supporting Organizations*", third line from the bottom of the column, the language "Protection of 2006," as Passed by the" is corrected to read "Protection Act of 2006," as Passed by the".

LaNita Van Dyke,

Chief, Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel (Procedure and Administration).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 440

[CMS-2234-P]

RIN 0938-A045

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement section 6083 of the Deficit Reduction Act of 2005 which provides States with additional State plan flexibility to establish a non-emergency, medical transportation brokerage program, and to receive the Federal medical assistance percentage rate. This

authority supplements the current authority that States have to provide non-emergency medical transportation to Medicaid beneficiaries who need access to medical care, but have no other means of transportation.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 24, 2007.

ADDRESSES: In commenting, please refer to file code CMS-2234-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to <http://www.cms.hhs.gov/eRulemaking>. Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2244-P, P.O. Box 8017, Baltimore, MD 21244-8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2234-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main

lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donna Schmidt, (410) 786-5532.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-2234-P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.cms.hhs.gov/eRulemaking>. Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

A. General

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of section 6083 of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, on February 8, 2006, States

now have new options to create programs that are more aligned with today's Medicaid populations and the health care environment. Cost sharing, benefit flexibility through benchmark plans, the health opportunity accounts (HOA), and the flexibility to design cost-effective transportation programs provide opportunities to modernize Medicaid, make the cost of the program and health care more affordable, and expand coverage for the uninsured.

B. Statutory Authority

Section 6083 of the DRA amended section 1902(a) of the Social Security Act (the Act) by adding a new section 1902(a)(70), which allows States to amend their Medicaid State plans to establish a non-emergency medical transportation brokerage program without regard to statutory requirements for comparability, state-wideness, and freedom of choice. This proposed regulation would provide States with the flexibility granted by the statute.

II. Provisions of the Proposed Regulations

[If you choose to comment on issues in this section, please include the caption "Provisions of the Proposed Regulations" at the beginning of your comments.]

A. Overview

The Department of Health and Human Services (DHHS) began issuing guidance about the new flexibilities available to States within months of the enactment of the DRA. On March 31, 2006, DHHS issued a State Medicaid Director letter providing guidance on the implementation of section 6083 of the DRA. The proposed regulation would formalize the guidance issued on non-emergency medical transportation programs. The proposed regulation would add a new paragraph (4) to 42 CFR 440.170(a).

B. Requirements of the Provision for State Plans

Under § 431.53, States are required in their Title XIX State plans to ensure necessary transportation of Medicaid beneficiaries to and from providers. Expenditures for transportation may be claimed as administrative costs, or a State may elect to include transportation as medical assistance under its State Medicaid plan.

Before enactment of the DRA, if a State wanted to provide transportation as medical assistance under the State plan, it could not restrict beneficiary choice by selectively contracting with a broker, nor could it provide services differently in different areas of the State

without receiving, under section 1915(b) of the Act, a waiver of freedom of choice, comparability, and state-wideness otherwise required at section 1902(a) of the Act. These waivers allowed States to selectively contract with brokers and to operate their programs differently in different areas of the State.

The DRA gives the States greater flexibility in providing non-emergency medical transportation. States are no longer required to obtain a section 1915(b) waiver in order to provide non-emergency transportation as an optional medical service through a competitively contracted broker. A State plan amendment for such a brokerage program eliminates the administrative burden of the 1915(b) biannual waiver renewal. Under new section 1902(a)(70) of the Act, a State may now use a non-emergency medical transportation brokerage program when providing transportation as medical assistance under the State plan, notwithstanding the provisions of sections 1902(a)(1), 1902(a)(10)(B), and 1902(a)(23) of the Act, concerning state-wideness, comparability, and freedom of choice, respectively.

Current regulations provide that when a State includes transportation in its State plan as medical assistance, it is required to use a direct vendor payment system that is consistent with applicable regulations at § 440.170(a), and it must also comply with all other requirements related to medical services, including freedom of choice, comparability, and state-wideness. To implement the provisions of section 1902(a)(70) of the Act, we propose revising § 440.170(a) to add a new paragraph (4), Non-emergency medical transportation brokerage program, to reflect the increased flexibility allowed by the DRA.

We propose allowing, at the option of the State, the establishment of a non-emergency medical transportation brokerage program. We believe that this may prove to be a more cost-effective way of providing transportation for individuals eligible for medical assistance under the State plan, who need access to medical care or services and have no other means of transportation.

As provided by the statute, we propose specifying in § 440.170(a)(4) that the broker could provide for transport services that include wheelchair vans, taxis, stretcher cars, bus passes and tickets, secured transportation. We are interpreting "secured transportation" in this context to mean a form of transportation containing an occupant protection

system that addresses the safety needs of disabled or special needs individuals.

The Deficit Reduction Act also provides that other forms of transportation may be included as determined by the Secretary to be appropriate. At this time, we are not proposing to determine any additional transportation services to be generally appropriate. We are proposing, however, to allow States to identify additional transportation alternatives that are otherwise covered under the State plan (and not specific to services available through transportation brokers). CMS will review these alternatives in the State plan amendment approval process for transportation services generally. In that process, we will consider individual circumstances in the State and applicable utilization controls. For example, air transportation may be appropriate in States with significant rural populations and low population density, but not in other States. Even in those States, air transportation may only be appropriate with appropriate utilization controls. Thus, we are proposing to make this determination in the context of our review of State plan amendments based on the information furnished by the State.

At § 440.170(a)(4), we propose that the competitive bidding process be consistent with applicable Department regulations at 45 CFR 92.36, based on the State's evaluation of the broker's experience, performance, references, resources, qualifications and cost, and that the contract with the broker include oversight procedures to monitor beneficiary access and complaints, and ensure that transport personnel are licensed, qualified, competent, and courteous. We are proposing that State and local bodies that wish to serve as brokers compete on the same terms as non-governmental entities.

We propose in paragraph (a)(4)(iv) to include prohibitions on broker self-referrals and conflict of interest, based on the prohibitions on physician referrals under section 1877 of the Act (42 U.S.C. 1395nn). Section 1877 of the Act generally prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity, with which he or she (or an immediate family member) has a financial relationship (ownership or compensation) unless an exception applies. In addition, to prevent other types of fraud and abuse, the anti-kickback provisions in section 1128B(b) of the Act (42 U.S.C. 1320a-7b(b)) and the provisions in the civil False Claims Act (31 U.S.C. 3729) also apply to this transportation program as

they apply to the Medicaid program generally.

We believe that the Congress intended that section 1877 of the Act and the applicable regulations be used as a model for establishing broker prohibitions on referrals, conflicts of interest, and impermissible kickbacks, in order to prevent fraud and abuse.

A financial relationship, as defined in our regulations implementing section 1877 of the Act at § 411.354(a), includes any direct or indirect ownership or investment interest in the entity that furnishes designated health services and any compensation arrangement between such an entity and the physician or an immediate family member of the physician.

Section 1877 of the Act includes certain ownership and investment exceptions, compensation exceptions, and some exceptions that apply to ownership, investment, and compensation relationships. In addition, section 1877(b)(4) of the Act allows the Secretary to create an exception in the case of any other financial relationship that does not pose a risk of program or patient abuse.

For purposes of new § 440.170(a), we propose that the term "transportation broker" include contractors, owners, investors, Boards of Directors, corporate officers, and employees.

We propose to use the definition of "financial relationship" as set forth in regulations at § 411.354(a) by means of cross-reference, with the term "transportation broker" substituted for "physician" and "non-emergency transportation" substituted for "DHS." We propose to use the definition of "immediate family member" or member of a "physician's immediate family" as set forth in the physician self-referral provisions in § 411.351, with the term "transportation broker" substituted for "physician."

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 and that the broker may not 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.

Similar to some of the ownership exceptions in section 1877 of the Act, we propose including exceptions for a non-governmental broker that provides transportation in a rural area when there is no other qualified provider available; when the necessary transportation provided by the non-governmental

broker is so specialized that no other qualified provider is available; or when the availability of qualified providers other than the non-governmental broker is insufficient to meet the existing need.

For purposes of this regulation we propose that a qualified provider would be any Medicaid participating provider or other provider determined by the State to be qualified. A "rural area," as defined in § 412.62(f)(iii), is any area that is outside an urban area. These exceptions address specific circumstances in which there is a lack of transportation resources and there is documentation to support these exceptions.

Governmental Brokerages

We did not wish to prevent a government entity that is awarded a brokerage contract through the competitive bidding process from referring an individual in need of transportation service to a government transportation provider that is generally available in the community. Therefore, we have included an exception to allow such a governmental broker to provide an individual transportation service or to arrange for the individual transportation service by referring to or subcontracting with another government-owned or -controlled transportation provider, when certain conditions have been met that will assure an arms-length transaction.

The broker would first be required to be a distinct governmental unit, and the contract could not include payment of costs other than those unique to the distinct brokerage function. This means the contract could not provide for payment of costs normally shared with or paid by other governmental units (such as a regional transportation authority). This requirement would ensure that the distinct broker unit did not have direct financial conflicts of interest resulting from commingling funding with State or local general revenue funds. Second, the broker would have to document, after considering the specific transportation needs of the individual, that the government provider was the most appropriate, effective, and lowest cost alternative for each individual transportation service. And third, the broker would have to document that for each individual transportation service, the Medicaid program was paying no more than the rate charged to the general public. Because there could still be conflicts of interest resulting from management oversight from a parent or related governmental unit, we considered proposing to limit the exception to circumstances where the

distinct unit governmental broker was independent of external review and oversight by the parent entity. However, we currently believe that the proposed conditions would be sufficient to protect against inappropriate inter-governmental referrals.

We are soliciting comments, suggestions, and examples regarding the following exceptions mentioned above: the service area is rural and there is no other Medicaid participating or qualified provider available except the non-governmental broker; the transportation provided by the non-governmental broker is so specialized that no other qualified provider is available (including comments on how "specialized" should be defined); available qualified providers other than the non-governmental broker are insufficient to meet the need; the broker is a distinct government unit and is paid only for costs that are unique to the distinct brokerage function and the broker documents that services provided by any other governmental entity are the most appropriate, least costly alternative, and the Medicaid program is paying no more than the rate charged to the public.

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. We also propose that in referring or subcontracting with transportation providers, the broker be prohibited from withholding necessary transportation from a recipient or providing transportation that is not the most appropriate and cost-effective means of transportation.

Under section 1905(a)(28) of the Act, the Secretary is given the authority to specify any other medical care which can be covered by the State. We would therefore use authority to make Federal financial participation available at the medical assistance rate for the cost of the brokerage contract, providing that such a contract complied with the requirements set forth in this regulation.

In accordance with Federal requirements in sections 1902(a)(2) and 1903(w) of the Act and applicable Federal regulations described at § 433.50 through § 433.74, under the brokerage contract with the State Medicaid agency, the non-Federal share of the Medicaid payments made for operating a transportation brokerage program could only be derived from permissible sources and must comply with the applicable statute and regulations cited above. Also, the return of any Medicaid payments (directly or

indirectly) to a State or local government entity under the non-emergency transportation brokerage program is prohibited.

We propose that the State, in contracting with the broker, would be required to specify that violation of these provisions would be deemed to be a breach of contract and that the State could move to terminate the contract with the broker.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 6083 of the DRA (Non-emergency Medical Transportation Brokerage Program) provides States with the option to submit a State Plan amendment (SPA) to establish a non-emergency medical transportation brokerage program. To effectuate this option, States must submit an amendment to their existing State Plan. CMS has provided States with a letter providing guidance on this provision and the implementation of the DRA, and an associated SPA template for use by States to modify their Medicaid State plan if they choose to implement this option.

The template is a total of five pages and we estimate that it will take no more than 12 minutes for a State to actually complete and submit the template to CMS. The potential number of respondents is 56 (50 States, DC, and five territories); however, we do not expect the territories and/or all 50 states to respond. We estimate that only five States will submit annually. Once approved, the State will not need to

resubmit unless it is materially changing the brokerage program.

At this rate, it will cost no more than \$50 (or $\$50 \times \frac{1}{5} \text{ hrs} \times 5 \text{ states}$); the national total for the first year could be potentially \$560 ($56 \times \10).

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn: Melissa Musotto, [CMS-2234-P], Room C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Katherine Astrich, CMS Desk Officer, CMS-2244-P, katherine_astrich@omb.eop.gov. Fax (202) 395-6974.

IV. Regulatory Impact Statement

[If you choose to comment on issues in this section, please include the caption "Regulatory Impact Statement" at the beginning of your comments.]

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We estimate that this regulation will have estimated budget savings of \$60 million between FY 2006 and FY 2010 due to the implementation of section 6083 of the Deficit Reduction Act of 2005. This rule would not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA,

small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6.5 million to \$30.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this rule would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$120 million. This rule would have no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule and subsequent final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation would not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 440

Grant programs—health, Medicaid.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), as amended.

2. A new authority citation is added in numerical order to § 440.1 to read as follows:

§ 440.1 Basis and purpose.

* * * * *

1902(a)(70), State option to establish a non-emergency medical transportation program.

* * * * *

3. Section 440.170 is amended by revising paragraph (a)(2) and adding new paragraph (a)(4) to read as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) * * *

(2) Except as provided in paragraph (a)(4), transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency.

(3) * * *

(4) *Non-emergency medical transportation brokerage program.* At the option of the State, and notwithstanding § 431.50 (statewide operation) and § 431.51 (freedom of choice of providers) of this chapter and § 440.240 (comparability of services for groups), a State plan may provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide non-emergency medical transportation services for individuals eligible for medical assistance under the State plan who need access to medical care or services, and have no other means of transportation. These transportation services include wheelchair vans, taxis, stretcher cars, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation otherwise covered under the state plan.

(i) Non-emergency medical transportation services may be provided under contract with an individual or entity that meets the following requirements:

(A) Is selected through a competitive bidding process that is consistent with 45 CFR part 92.36 and is based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs.

(B) Has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous.

(C) Is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services.

(D) Is subject to a written contract that imposes the requirements related to prohibitions on referrals and conflicts of interest described at § 440.170(a)(4)(ii), and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or subcontract.

(ii) Federal financial participation is available at the medical assistance rate for the cost of a written brokerage contract that:

(A) Except as provided in paragraph (a)(4)(ii)(B) of this section, prohibits the broker (including contractors, owners, investors, Boards of Directors, corporate officers, and employees) from providing non-emergency medical transportation services or making a referral or subcontracting to a transportation service provider if:

(1) The broker has a financial relationship with the transportation provider as defined at § 411.354(a) of this chapter with "transportation broker" substituted for "physician" and "non-emergency transportation" substituted for "DHS"; or

(2) The broker has an immediate family member, as defined at § 411.351 of this chapter, that has a direct or indirect financial relationship with the transportation provider, with the term "transportation broker" substituted for "physician."

(B) Exceptions: The prohibitions described at clause (A) of this paragraph do not apply if there is documentation to support the following:

(1) Transportation is provided in a rural area, as defined at § 412.62(f), and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(2) Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(3) Except for the non-governmental broker, the availability of other Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

(4) The broker is a distinct government entity and the individual

service is provided by the broker, or is referred to or subcontracted with another government-owned or operated transportation provider generally available in the community, if the following conditions are met:

(i) 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;

(ii) The broker documents that, with respect to the individual's specific transportation needs, the government provider is the most appropriate and lowest cost alternative; and

(iii) The broker documents that the Medicaid program is paying no more than the rate charged to the general public.

(C) Transportation providers may not offer or make any payment or other form of remuneration, including any kickback, rebate, cash, gifts, or service in kind to the broker in order to influence referrals or subcontracting for non-emergency medical transportation provided to a Medicaid recipient.

(D) In referring or subcontracting for non-emergency medical transportation with transportation providers, a broker may not withhold necessary non-emergency medical transportation from a Medicaid recipient or provide non-emergency medical transportation that is not the most appropriate and a cost-effective means of transportation for that recipient for the purpose of financial gain, or for any other purpose.

(E) The non-Federal share of all Medicaid payments under the transportation brokerage program must be in compliance with applicable Federal requirements in sections 1902(a)(2) and 1903(w) of the Act, and applicable Federal regulations set forth at § 433.50 through § 433.74 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: August 30, 2006.

Mark B. McClellan,
Administrator, Centers for Medicare & Medicaid Services.

Approved: May 10, 2007.

Michael O. Leavitt,
Secretary.

Editorial Note: This document was received at the Office of the Federal Register on August 13, 2007.

[FR Doc. E7-16172 Filed 8-23-07; 8:45 am]

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