

HEALTH WEALTH CAREER

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP) LEGISLATIVE ANALYSIS

DECEMBER 27, 2019



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EXECUTIVE SUMMARY

The Act of June 22, 2018 (P.L. 258, No. 40) (Act 40 of 2018) amended the Human Services Code and required the Department of Human Services (DHS) to issue a request for applications (RFA) to competitively procure a statewide broker or regional brokers to administer the Commonwealth of Pennsylvania's (Commonwealth) Medicaid non-emergency medical transportation (NEMT) program or Medical Assistance Transportation Program (MATP) under a capitated full risk arrangement.¹ DHS issued RFA 28-18 on December 21, 2018. Subsequently, the Human Services Code was again amended by the Act of June 28, 2019 (P.L. 168, No 19) (Act 19 of 2019), which required an analysis of the impact of a full-risk broker model, as designed by RFA 28-18, on MATP before DHS could enter into agreements with brokers; therefore, DHS put the procurement on hold. DHS was to collaborate with the Pennsylvania Departments of Transportation (PennDOT) and Aging (PDA) in completing the analysis. In response to Act 19 of 2019, DHS also established an MATP Analysis Workgroup (Workgroup).

The Workgroup was comprised of representatives from: DHS, including the Offices of Medical Assistance Programs, Long Term Living and Mental Health and Substance Abuse Services, PennDOT, PDA, County Commissioners Association of Pennsylvania, and the Pennsylvania Association of County Human Services Administrators. Mercer was selected as the entity to complete the required legislative analysis. While Mercer was responsible for completing the required analysis, the Workgroup met weekly over several months to oversee the methodology used in completing the analysis, provide relevant information such as source data, impact statements from stakeholders as required by legislation, other information as requested by Mercer, and review and provide feedback on the analysis prior to finalization.

¹ In Pennsylvania, the Medicaid Program is known as the Medical Assistance (MA) Program.

The Commonwealth has a complex Human Service Transportation (HST) system with the goal of providing affordable, accessible, individualized transportation for people with limited mobility options. The major components of the HST system include:

- MATP — provides necessary NEMT to Medicaid-eligible consumers to and from MA enrolled providers for the purposes of receiving treatment, medical evaluation or purchasing prescription drugs, or medical equipment at no cost. Rides can be provided through fixed-route public transportation, demand response paratransit, volunteers (rare and excluded from this analysis) or mileage reimbursement if the consumer has access to a private vehicle but lacks the funds for fuel, parking, or tolls.
- Senior Shared-Ride Program (SSRP) — allows individuals age 65 years and older to use public paratransit Shared-Ride services at a reduced rate. Riders pay 15% of the fare as a copay, and state lottery funds are used to pay the remaining 85% of the fee. PennDOT administers the program, but the local transportation providers have a high degree of flexibility in setting the parameters of their operations.
- Area Agencies on Aging (AAA) — offer alternative transportation programs for seniors. Each AAA has autonomy in determining how it can best serve the seniors of its community.
- Americans with Disabilities Act (ADA) Complementary Paratransit — is federally required of fixed-route public transportation providers. The program is administered by the fixed-route provider and provides rides for people living within three-fourths of a mile from a fixed-route, but who cannot access the fixed-route option because of their disabilities.
- Persons with Disabilities Program (PwD) — provides rides beyond those required by ADA Complementary Paratransit. Individuals between the age of 18 years and 64 years receive reduced rates on reservation shared-ride services. Like the SSRP, the PwD is a PennDOT administered program.
- Non-*medical* transportation (different from non-*emergency* as in NEMT) — is for MA consumers, when such transportation is authorized through individual service plans developed under existing Medicaid home- and community-based waivers. Non-medical transportation includes transportation to community activities, grocery shopping, religious services, employment, volunteer services, and other activities as specified in the individual service plan. Most of these consumers receive or will receive their non-medical transportation through the Community HealthChoices managed care organizations (MCOs). In addition, individuals with Intellectual and Developmental Disabilities (IDD) may receive non-medical transportation benefits through their Medicaid home- and community-based waiver programs.

DHS oversees the entire MATP, and the Commonwealth offers and provides funding for MATP in all 67 counties. MATP operates differently across the Commonwealth:

- Fifty-four counties operate MATP at least partially through an in-house or county model; however, differences in how the counties operate their programs exist. The three models of operation are as follows:
 - Seven counties operate the program as a sole service provider. In this model, the county is the MATP provider or provides some MATP transportation services but has full responsibility for monitoring the administration of the program, subject to DHS oversight.
 - Thirty-eight counties operate a vendor model. In the vendor model, all the program components for MATP, both transportation and administration are handled by a vendor, usually a transit agency. Subject to DHS oversight, the county is responsible for monitoring and oversight of the program.
 - Nine counties operate a hybrid model, which means that the county may share responsibility with a vendor for providing NEMT services or some components of MATP. Typically, some of the program components are administered by a subcontracted transit provider in coordination with the county.
- A broker model was introduced in Philadelphia County in 2005 and remains the MATP delivery model there today.
- Twelve counties have elected to allow DHS to manage NEMT services. DHS has direct agreements with transit agencies to provide NEMT.

The Commonwealth has flexibility in how the NEMT program is structured. Other possible NEMT configurations exist, some of which do not use brokers at all and others using brokers differently than the statewide via three regions configuration outlined in RFA 28-18. It is important to note that the focus of this analysis and the observations noted are only for the proposed MATP design, as written in RFA 28-18. Furthermore, in the context of Pennsylvania, all references to proposed statewide or regional brokers in this analysis are understood to be consistent with the design of RFA 28-18 and do not address other possible configurations.

Since the issuance of RFA 28-18, some stakeholders have expressed concerns with changing to a statewide full-risk, capitated broker model for MATP without further analysis. Specifically, stakeholders are concerned about the loss of benefits to consumers and transportation providers when rides from all HST programs, including MATP, are not coordinated, as well as any unintended consequences to the rest of the HST system.

As it relates to federal and state law, regulations, and policies, the Commonwealth has flexibility in how the MATP is operated. The regional broker model would utilize 1902(a)(70) (42 U.S.C. § 1396a(a)(70)) State Plan Amendment (SPA) authority, which has been used for the Philadelphia County broker that was implemented in 2005 and continues today. The 1902(a)(70) SPA authority for a broker has different regulations than those applicable to the current county

models, and allows for higher federal medical assistance percentage (FMAP) reimbursement of MATP expenses. Since Medicaid is a jointly funded program between states and the federal government, the federal government reimburses Medicaid expenses at the rate of each state's FMAP, which is 50% for administrative expenses and 50% or higher for medical expenditures. The Center for Medicare & Medicaid Services (CMS), is the entity responsible for federal oversight of Medicaid programs. Currently, outside of Philadelphia County (a broker model), the Commonwealth receives the 50% administrative FMAP for MATP. Switching to a regional broker model allows DHS to claim the higher medical expenditure match rate across all 67 counties.

Counties currently coordinate both MATP and HST rides. Each county has flexibility in how it administers these programs, and this autonomy has its advantages for consumers and providers. Leveraging of resources across programs helps to lower trip costs. Additionally, when the MATP and HST coordinator are the same, it is a one-stop-shop for consumers, which can streamline the consumer experience. For example, a consumer could call the same coordinator to schedule a medical trip with MATP and then add to it a non-NEMT trip with another HST program, like SSRP or ADA Complementary Paratransit, as part of the total round trip. The coordination of fleet resources also helps maintain lower public fares and expand operations because some fixed costs are spread over more consumers. The coordination of programs also provides opportunities for consumers to address other social determinants of health.

While county autonomy in administration has advantages, this arrangement also creates challenges in state oversight, accounting, and procurement as requirements for HST programs and MATP differ. These differences can lead to complexity in meeting the requirements of different sets of regulations. Additionally, if an MATP coordinator is using administrative resources such as staff, call centers, or office space for more than MATP work, those administrative expenses need to be allocated to their respective programs. CMS requires a generally accepted and consistent allocation process to prevent cross-subsidization of federally funded programs. CMS disallowances of federal financial participation for MATP have resulted in the need for MATP coordinators to be knowledgeable and compliant with MATP funding requirements to ensure the approval of federal funds. Some counties, no longer able or willing to be an MATP coordinator due to the administrative complexity of federal funding requirements, have opted out of the program. When a county opts out of MATP, DHS is responsible for finding a provider to continue the federally required NEMT. As a temporary solution, DHS has used non-solicitation awards (sometimes referred to as "sole-source agreements"); that is, DHS awards the MATP work to a qualified provider without using a competitive process. Because this is seen as a temporary solution, procurement risks exist if DHS repeatedly uses non-solicitation grant awards.

The review of the administration of NEMT programs by other states revealed that three main NEMT models are used across the nation — (1) in-house management models, (2) managed care models, and a (3) broker model. State Medicaid programs vary in their use of these models, or combinations of models, for NEMT. Eight states solely use an in-house management model where a state government entity coordinates the NEMT program, on a statewide or county level. Ten states solely

use MCOs to administer NEMT benefits, and each MCO operates its NEMT program independently and like a broker. Twenty states solely use an NEMT broker model where the broker is at full or partial-risk. Finally, twelve states and the District of Columbia use a hybrid model, which is a combination of any of the prior models. Pennsylvania uses a hybrid MATP model in that Philadelphia County is operated under a broker model, and the other counties are administered as in-house or county models.

Other states have switched to NEMT brokers, and their experiences are diverse. Some states reported better cost control, improved quality and safety, and maintained access for consumers. Some states, however, have reported increases in consumer complaints and wait times, a decline in trip coordination with other HST, decreased participation in rural areas, and increased costs. Rural areas seem to feel an amplified impact because they serve smaller populations across large geographic areas. Since each state has flexibility in how they run both their Medicaid and NEMT programs, it is difficult to extrapolate a state's experience, good or bad, onto Pennsylvania.

While it may not be appropriate to apply experiences from other states to Pennsylvania, a careful review of the advantages and disadvantages of maintaining the in-house county models versus implementing the proposed broker model in Pennsylvania needs to be considered before a change. Currently, in the Commonwealth, some counties have joined together as municipal authorities, or multicounty groups, which balances county independence while sharing resources and synchronizing policies and processes leading to better efficiency. Many feel the current system works well and should not be changed. However, it should be recognized that since DHS performs semi-annual compliance monitoring, converting to a broker system and the corresponding decrease in the number of entities would allow DHS to conduct more in-depth reviews.

Funding for the in-house MATP comes from DHS allocations, and each counties' final allocation always matches their final expenditures. This arrangement has little utilization management or accountability of providers, which could lead to potential overutilization, whether intentional or fraudulent. Funding for a broker is a capitation rate paid per member per month, which means the broker is paid a set amount every month based on the number of covered members, regardless of the number of trips provided. This arrangement provides an incentive for brokers to provide NEMT services in a cost-effective manner using the most appropriate mode of transportation for a particular consumer. For oversight to counter any inappropriate reduction in services to consumers, quality measures are essential to any full-risk arrangement to ensure consumers continue to receive needed services.

A switch to a statewide or regional broker will have impacts on county staffing, but the final impacts are difficult to determine. Counties currently may have overlapping MATP and HST staff and resources so that these counties may need to maintain similar levels of staffing even absent their MATP work. If brokers remove revenue from public transportation programs, the fares of other HST consumers will likely have to rise to cover the lost funding, or access will be reduced proportionally to compensate for lost revenue. While it may be easy to focus on a single fiscal impact, such as

increased FMAP from transitioning to a broker model (estimated at \$13.6 million), the potential total costs and savings to the Commonwealth cannot fully be quantified. There are too many tangential impacts and downstream effects (e.g., the unknown impact for the employment-related losses and unknown impact for increases in second-order medical costs for consumers if their medical conditions worsen) that would not be fully understood until potentially years after implementation.

The impact of a change on consumers should be a focus of decision-makers when evaluating a switch to a broker model. Survey and consumer complaint results from various periods and sources indicate generally high satisfaction levels with the current MATP. Consumer complaints indicate most issues are with the drivers and trips themselves (e.g., a late arrival) and less with the administrative MATP coordinator. This distinction is an important point as there will always be complaints with any service, but on average, consumers seem satisfied with the administration of the program and how it operates today.

It's unclear why, but the overall utilization of the MATP has decreased over time. As MA enrollment has increased in recent years, the number of MATP trips taken has remained flat over that period of expansion. If populations are unaware of the program, members may be missing cost-saving medical visits.

The switch to a broker model may potentially lead to raised public fares, reduced hours, or smaller service areas. The MATP consumer will be insensitive to these changes because Medicaid will pay them. If that same consumer uses other HST services for non-MATP trips, they would be affected by the higher fares. Higher fares can change consumers' behaviors, leading to additional impacts on HST as a whole. Additionally, a transition from the current model to a broker model could confuse consumers (different phone numbers, vehicles, and drivers). Frustrated MATP consumers may forgo rides, or substitute them with costly ambulance trips. The use of a readiness reviews and requiring brokers to have a detailed implementation work plans, as required in RFA 28-18, could help mitigate these risks.

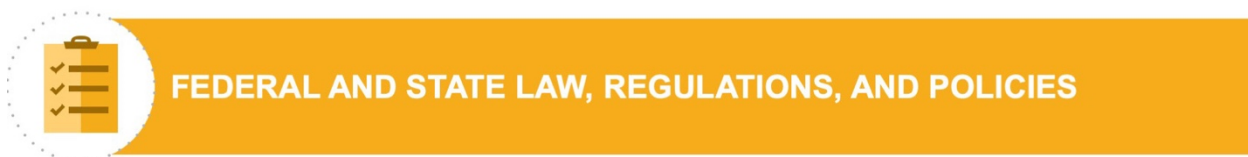
In conclusion, the Commonwealth has a respectable MATP NEMT program. DHS, however, has concerns over the long-term viability of the way the program is currently structured and operated, and the broker model within the scope of RFA 28-18 is potentially one solution. Other states' broker experiences have been mixed. The current in-house county models have their advantages and disadvantages, and brokers bring unique advantages and disadvantages as well. From a fiscal perspective, DHS could save money with a broker, but county transit budgets could suffer proportionally to how much brokers disengage with other public transportation programs. Lastly, MATP and HST consumers are a mix of low-income, medically needy, and aged populations. These consumers will probably react poorly to a model change if it is unsuccessfully transitioned from the in-house model. MATP is multi-faceted and requires careful consideration of interconnected regulations, programs, and consumers.



INTRODUCTION

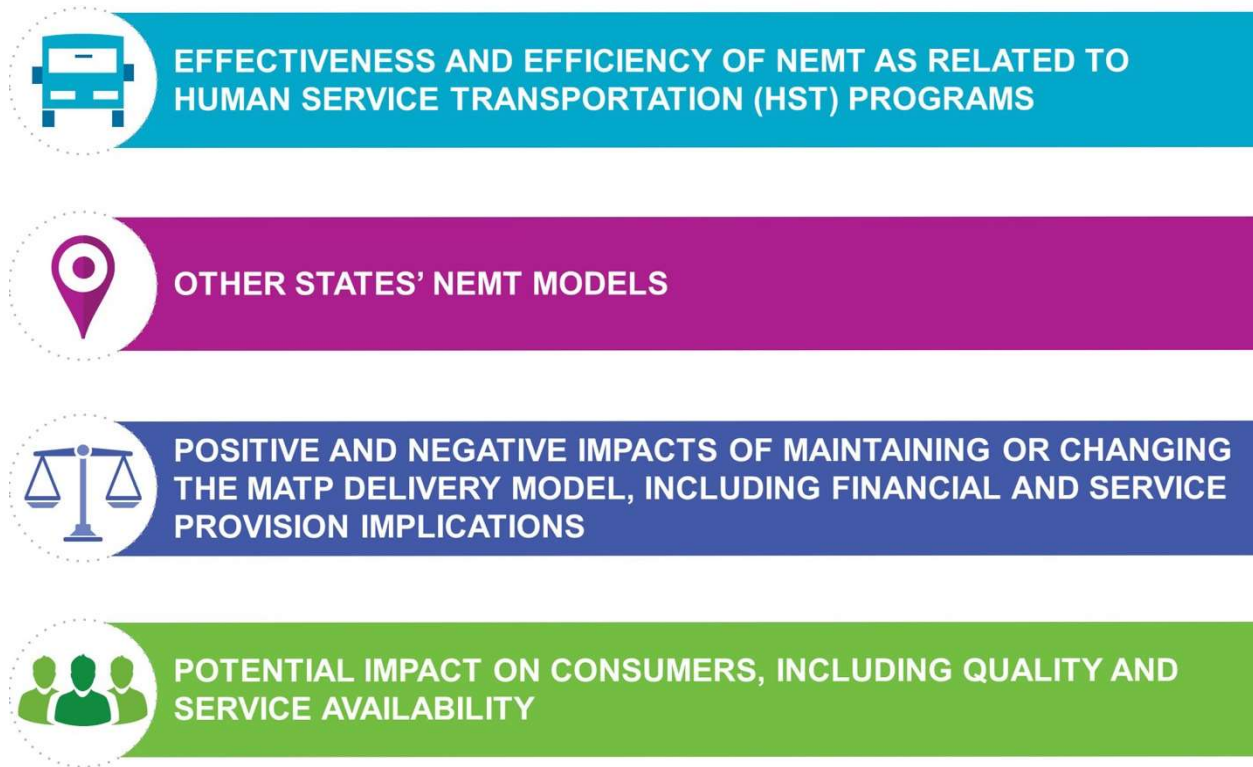
The Act of June 22, 2018 (P.L. 258, No. 40) (Act 40 of 2018) amended the Human Services Code and required the Department of Human Services (DHS) to issue a request for applications (RFA) to competitively procure a statewide broker or regional brokers to administer the Commonwealth of Pennsylvania's (Commonwealth) Medicaid non-emergency medical transportation (NEMT) program or Medical Assistance Transportation Program (MATP) under a capitated full risk arrangement.² DHS issued RFA 28-18 on December 21, 2018 (can be viewed on PA eMarketplace).³ Subsequently, the Human Services Code was again amended by the Act of June 28, 2019 (P.L. 168, No 19) (Act 19 of 2019), which required an analysis of the impact of a full risk broker model on MATP before DHS could enter into agreements with brokers; therefore, DHS put the procurement on hold. DHS was to collaborate with the Pennsylvania Departments of Transportation (PennDOT) and Aging (PDA) in completing the analysis.

This analysis encompasses the current MATP model and the potential impacts of changing to a full-risk, capitated broker model as defined in RFA 28-18. The five major topics to be covered in this analysis are:



² In Pennsylvania, the Medicaid Program is known as the Medical Assistance (MA) Program.

³ PA eMarketplace, "RFA 28-18," available at <http://www.emarketplace.state.pa.us/Solicitations.aspx?SID=RFA%2028-18>, accessed 26 July 2019.



In response to Act 19 of 2019, DHS established an MATP Analysis Workgroup (Workgroup). The Workgroup was comprised of representatives from:

- DHS, including the Offices of Medical Assistance Programs, Long Term Living and Mental Health and Substance Abuse Services.
- Pennsylvania Department of Transportation (PennDOT).
- Pennsylvania Department of Aging (PDA).
- County Commissioners Association of Pennsylvania (CCAP).
- Pennsylvania Association of County Human Services Administrators.

During the Workgroup's first meeting on July 23, 2019, Mercer was selected as the entity to complete the required legislative analysis. While Mercer was responsible for completing the required analysis, the Workgroup met weekly over the next several months to oversee the methodology used in completing the analysis, provide relevant information such as source data, impact statements from stakeholders as required by legislation, other information as requested by Mercer, and review and provide feedback on the analysis prior to finalization.

CURRENT HUMAN SERVICE TRANSPORTATION BACKGROUND

The Commonwealth's goal as it relates to HST is to provide affordable, accessible, individualized transportation for people with limited mobility options.⁴ To provide additional context and to help frame the issues explored in this analysis, listed below are some of the more substantial funding sources of HST trips. Depending on reporting from the various organizations and which values are compared, it is important to note that both programs can report the same funding and trips (i.e., reported twice, but coordinated to only be paid once).



For example, a senior Shared-Ride trip may be eligible for payment by a combination of lottery funds and by MATP funds, with both programs coordinating the payment and counting the trip depending on their reporting.

MATP, in its current form, provides NEMT to Medicaid-eligible consumers at no cost. Rides can be provided through fixed-route public transportation, demand response paratransit, volunteers (rare, and excluded from this analysis), or mileage reimbursement if the consumer has access to a private vehicle but lacks the funds for fuel, parking, or tolls. For paratransit, requests must be made at least one day in advance and up to 14 days in advance of the scheduled medical appointment (same-day in the case of urgent care). The pick-up window is 15-minutes before and after the scheduled departure time (30 minutes total), and a consumer is not to be dropped off or picked up more than an hour before and after the medical appointment. MATP trips may be coordinated with other HST, as further described below.⁵ For the state fiscal year (SFY) 2019 (i.e., July 1, 2018, to June 30, 2019), statewide MATP transportation only costs, estimated from DHS data, are approximately \$114.1 million for 8.3 million trips (an average of \$13.75 per trip).

Senior Shared-Ride Program (SSRP) allows individuals age 65 years and older to use public paratransit Shared-Ride services at a reduced rate. Riders pay 15% of the fare as a copay, and state lottery funds are used to pay the remaining 85% of the fee.^{6,7} PennDOT administers the program, but the local providers have a high degree of flexibility in setting the parameters of their operations. Typically, requests must be made at least the day before service, fares are based on the distance of the ride, and the pick-up window is 15-minutes before and after the desired departure

⁴ Pennsylvania Department of Transportation, Pennsylvania Department of Public Welfare, Pennsylvania Department of Aging, Pennsylvania Office of the Budget, *Human Service Transportation Coordination Study Summary Report*, available at <https://www.penndot.gov/Doing-Business/Transit/InformationandReports/Documents/HST%20Coordination%20Study%207-16-09.pdf>, accessed 21 October 2019.

⁵ Pennsylvania Department of Human Services, "Medical Assistance Transportation Program Standards & Guidelines," available at <http://matp.pa.gov/PDF/MATPStandardsGuidelines.pdf>, accessed 21 October 2019.

⁶ The copay is effectively capped because most max distance-based fares end around \$50.00 per trip. This max fare is designed so that 85% of it matches the maximum Pennsylvania Lottery reimbursement rate of \$42.50 per ride.

⁷ Dually eligible MATP and SSRP consumers are not charged the 15% copay for MATP eligible trips, because the cost is covered by MATP, which will also cover any MATP consumer costs above the maximum Pennsylvania Lottery reimbursement rate as well as the general public fare for escorts.

time (30 minutes total). In SFY 2019, an estimated \$66.5 million in lottery funds (the 85%) supported 3.3 million trips (an average of \$20.15 lottery funding per trip, not including rider copay).

Area Agencies on Aging (AAA) offer alternative transportation programs for seniors. Each AAA has autonomy in determining how it can best serve the seniors of its community. Many choose to offset all or a portion of the SSRP 15% copay to allow seniors to travel at a lower out-of-pocket cost on shared-ride services. For SFY 2019, approximately \$3.6 million was spent on only copays for 1.5 million trips (an average of \$2.40 per trip towards the SSRP rider copay).

Americans with Disabilities Act (ADA) Complementary Paratransit is federally required of fixed-route public transportation providers. The program provides rides for people living within three-fourths of a mile from the route, but who cannot access the fixed-route option because of their disabilities. The trip can be requested for the same hours and days as the fixed-route service. Trip requests must be accepted as late as the day before service and up to 14 days in advance. The pick-up window can be no more than one hour before and after the desired departure time, and helplines must be available seven days a week during regular business hours. The fare for the trip is limited to twice the fare that would have been paid for a comparable trip on the regular fixed-route service (an exception exists for higher fares permitted if charged to a social service agency).⁸ In SFY 2018, ADA Complementary Paratransit expenses were \$55.3 million for 1.8 million trips (an average of \$30.72 per trip).

Persons with Disabilities Program (PwD) provides rides beyond those required by ADA Complementary Paratransit. Individuals between the age of 18 years and 64 years receive reduced rates on reservation shared-ride services. Like the SSRP, the PwD is a PennDOT administered program and follows similar parameters for consumer options and operations (like the 15% copay). For SFY 2019, an estimated \$7.1 million in funding (the 85%) supported 0.4 million trips (an average of \$17.75 funding per trip, not including rider copay).

Non-medical transportation (different from non-emergency as in NEMT) is for Medicaid consumers when such transportation is authorized through individual service plans developed under Medicaid home-and community-based waivers. Non-medical transportation includes transportation to community activities, grocery shopping, religious services, employment, volunteer services, and other activities as specified in the individual service plan. Most of these waivers have been absorbed by the newly implemented Community HealthChoices (CHC) program. Therefore, consumers in CHC receive their non-medical transportation through their CHC managed care organizations (MCOs). RFA 28-18 provides that brokers will also coordinate non-medical transportation with the CHC-MCOs. Based on calendar year (CY) 2017 (i.e., January 1, 2017, to December 31, 2017) waiver fee-for-service (FFS) data from DHS, these consumers' non-medical

⁸ See 49 CFR § 37.131, available at <https://www.ecfr.gov/cgi-bin/text-idx?SID=68f710e85045b56fc4a26c80af6da8aa&mc=true&node=pt49.1.37&rgn=div5>, accessed 10 October 2019.

transportation costs per person are significantly more than their NEMT counterparts' medical transportation costs per person, because the former ride more frequently, which may be employment-related rides and accessing long-term services and supports. They are approximately a 0.5% subset of all eligible MATP consumers and are mostly located in the Southeast. For CY 2020, funding is forecasted at approximately \$23.1 million for 0.9 million non-medical trips (an average of \$25.67 per non-medical trip). In addition, individuals with IDD are also MATP eligible and may receive non-medical transportation benefits through their Medicaid home- and community-based waiver programs.

Pennsylvania HST Programs

The following table provides a high-level overview of the previously described transportation programs, the number of trips provided, and the cost of those trips. Note, between programs, there are different types of rides, services, and payment structures. The goal of providing these amounts is to provide scale between programs relative to the others. Directly comparing only average funding per trip may lead to incorrect conclusions about what it costs to run these programs and the services they provide. All trips and rides are defined as one-way for one consumer and not a round trip. (Average funding per trip is based on rounded trip funding and trip counts.)

TRANSPORTATION PROGRAMS AND KEY METRICS

| PROGRAM | RIDE MODE | RIDER COST | TRIP FUNDING | TRIP COUNT | AVERAGE FUNDING PER TRIP |
|---|--------------------------|--------------------------------|--------------|------------|--------------------------|
| MATP (SFY 2019 estimate) | Mixed ⁹ | \$0 (Medicaid) | \$114.1M | 8.3M | \$13.75 |
| SSRP (SFY 2019) | Paratransit | 15% Copay (Public) | \$66.5M | 3.3M | \$20.15 |
| AAA (SFY 2019) | Paratransit (Copay Only) | <15% Copay (Qualified Seniors) | \$3.6M | 1.5M | \$2.40 |
| ADA (SFY 2018) | Paratransit | 2x Max Fare (Public) | \$55.3M | 1.8M | \$30.72 |
| PwD (SFY 2018) | Paratransit | 15% Copay (Public) | \$7.1M | 0.4M | \$17.75 |
| Non-medical transportation (CY 2020 CHC estimate) | Mixed (CHC Only) | \$0 (Medicaid) | \$23.1M | 0.9M | \$25.67 |

CURRENT MATP DESIGN

MATP provides NEMT to medical appointments at no cost for Pennsylvanians enrolled in MA who lack other available transportation. Eligibility for MATP services is determined at the County

⁹ Mixed can include fixed-route, paratransit, and mileage reimbursement.

Assistance Office and verified by the MATP coordinating agency. MATP is part of HST because it increases access to healthcare services for a population that typically lacks transport mobility due to limited income or disabilities.

In addition to reviewing quarterly fiscal reports, DHS performs semi-annual compliance monitoring, using a review instrument based on MATP guidelines, policies, and regulations. All MATP models are subject to review and audits by DHS, Auditor General, federal auditors, and persons authorized by DHS to determine compliance with statutes, regulations, and policies.¹⁰ When applicable, DHS also reviews counties' time studies (county sole source provider and hybrids models are subject to review). These time studies are used to measure what proportion of time county employees are working on MATP versus other programs. The results are critical for claiming federal reimbursement for MATP administrative costs. DHS can use sanctions to enforce these MATP Standards and Guidelines.

The Commonwealth offers and provides funding for MATP in all 67 counties. Fifty-four counties operate MATP at least partially through an in-house or county model; however, differences in how the counties operate their programs exist. Some counties either act as a sole service provider or contract with vendors for a portion of the MATP services.

County Sole Service Provider (7 Counties)

Seven counties operate the program as a sole service provider. This model means the county is the MATP provider or provides some of the MATP transportation services (the county might contract with other vendors to meet ride demand) and has full responsibility for monitoring the administration of the program subject to DHS oversight. County staff must complete an MATP time study, and DHS can claim their MATP administration costs as an MATP expense, which are based on the results of this study. The county staff must be dedicated full-time to working on MATP.

County Vendor Model (38 Counties)

Thirty-eight counties operate a vendor model. In this model, all the program components for MATP, both transportation and administration are handled by a vendor, usually a transit agency. Subject to DHS oversight, the county is still responsible for monitoring and oversight of the program. County staff is not directly involved in the day-to-day administration of MATP, so the county is ineligible to claim administrative costs as an MATP expense.

County Hybrid Model (9 Counties)

Nine counties operate a hybrid model, which means that the county may share responsibility with a vendor for providing NEMT services or some components of MATP. Typically, some of the program components are administered by a subcontracted transit provider in coordination with the county. The county staff in this model, who may be assigned full-time to MATP or may also work on other

¹⁰ Pennsylvania Department of Human Services, "Medical Assistance Transportation Program Standards & Guidelines," available at <http://matp.pa.gov/PDF/MATPStandardsGuidelines.pdf>, accessed 21 October 2019.

programs, participate in the CMS-approved time study, and the county can claim administrative costs as an MATP expense. Since a transit agency performs some of the MATP functions for the counties that use a hybrid model, fewer full-time staff at the county level are devoted to MATP. This split means that the county claims less administrative costs for operating the program.

County Broker Model (1 County)

A broker model was introduced in Philadelphia County in 2005 and remains the MATP delivery model there today.

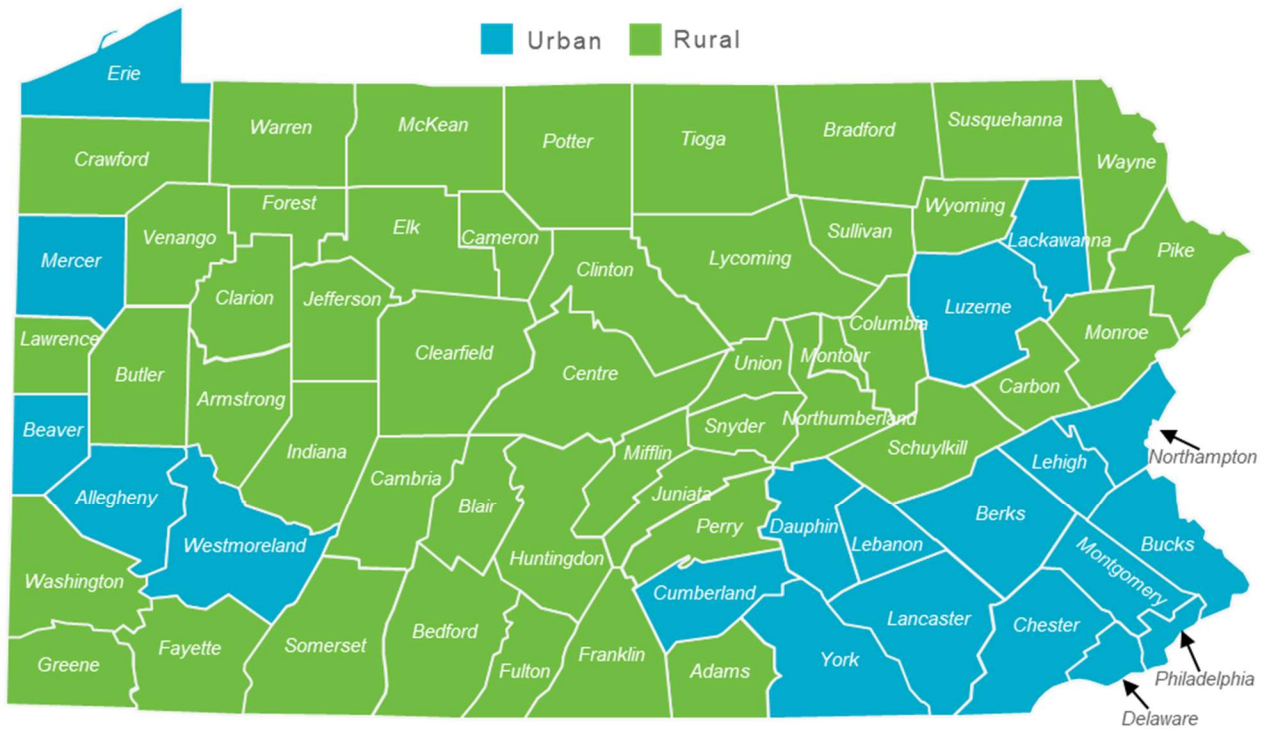
DHS Direct Agreement (12 Counties)

Lastly, twelve counties have elected to allow DHS to manage NEMT services. DHS has direct agreements with transit agencies to provide NEMT. These non-solicitation grant awards are discussed more in Section 2 of this analysis.

Some of the charts in this analysis make a distinction between urban and rural counties. The urban or rural classification is based on the 2010 US Census. Rural versus urban counties are respectively classified by whether they are above or below average population density.

URBAN AND RURAL COUNTIES FOR MATP ANALYSIS

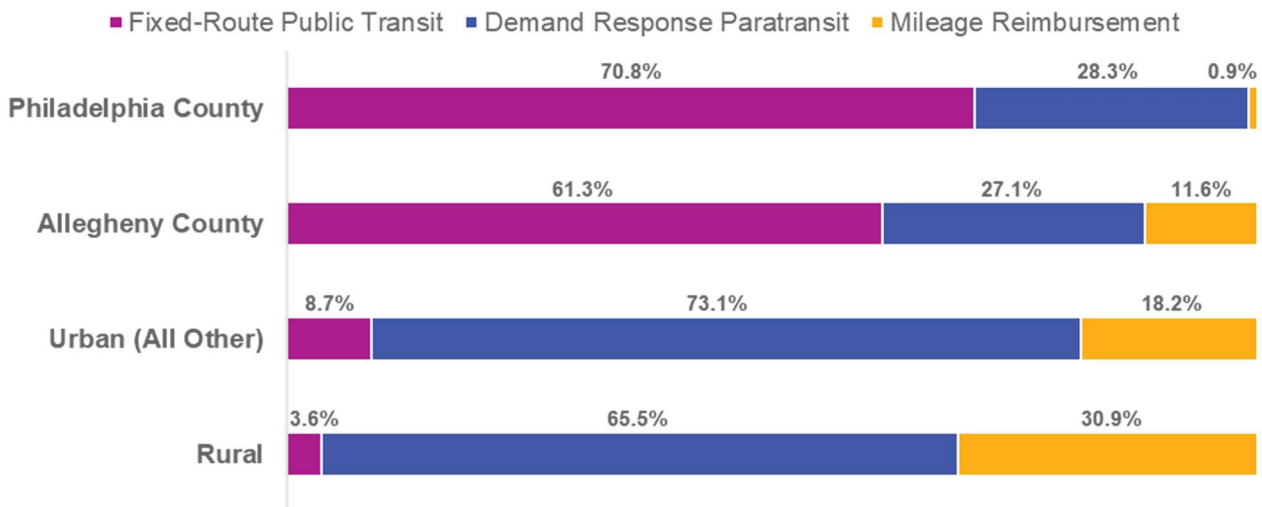
Urban is defined as above average population density.



DHS provided SFY 2019 MATP trips by county and mode of transportation. The following graphic shows the distribution of trip types by geography. Metropolitan areas like the City of Philadelphia (Philadelphia County) and Pittsburgh (Allegheny County) have significantly more fixed-route public transportation options. As displayed, a majority of rides in Philadelphia and Allegheny counties are provided through fixed-route public transit, while the most common modes of transportation for rural and other urban areas are through demand response paratransit.

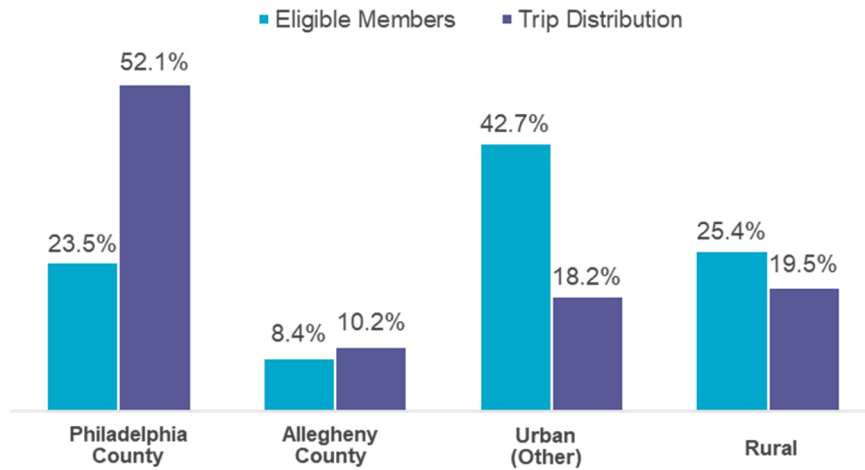
The most common mode of transportation for MATP in rural and urban areas, excluding Philadelphia and Allegheny counties, is demand response paratransit.

DISTRIBUTION OF MATP TRIPS BY LOCATION (SFY 2019)



The next graphic summarizes SFY 2017 data because it was the most recent available year of data with both trips and corresponding MATP eligibility for the same period. The distributions are across locations (colors sum to 100%). Philadelphia County has about a quarter of all eligible consumers; however, the number of trips is due not only to population size but the utilization of the MATP benefit as well. Due to Philadelphia County’s public transportation infrastructure and urban demographics, it is challenging to extrapolate its broker experience, positive or negative, across the Commonwealth.

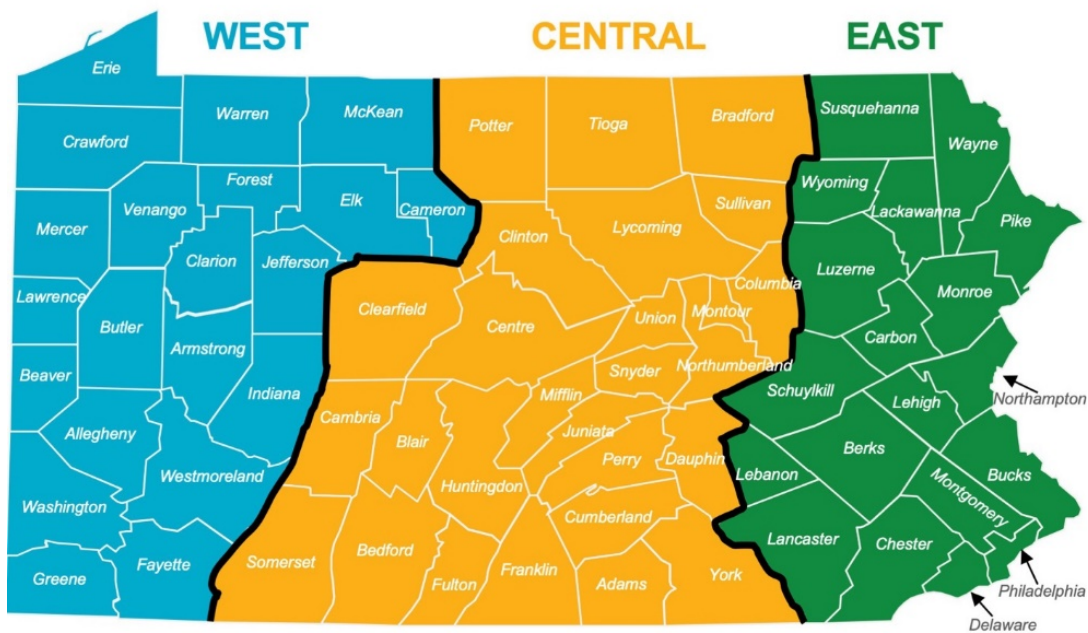
DISTRIBUTION OF MATP-ELIGIBLE MEMBERS AND TRIPS (SFY 2017)



RFA 28-18

DHS issued RFA 28-18 on December 21, 2018, which divided the proposed MATP broker program into three regions: West, Central, and East (see map). RFA 28-18 allows a broker to submit an application for multiple regions; however, DHS will only award two of the three regions to one broker resulting in two or three unique brokers in total. DHS developed the service regions based on service utilization patterns in MATP data.

MATP BROKER REGIONS



After the release of RFA 28-18, DHS held a pre-application conference on January 11, 2019. The conference covered the application forms, scoring, plus timelines. Solicitations were due April 1, 2019. DHS had selected no brokers before the enactment of Act 19 of 2019. At the date of this analysis, the RFA 28-18 is still on hold.

LEGISLATIVE ANALYSIS

The following sections of this document explore the five major requirements of Act 19 of 2019 in further detail. Key observations for consideration are summarized at the end of each section.



1

FEDERAL AND STATE LAW, REGULATIONS AND POLICIES



• "An analysis of current Federal and State law, regulations and policies controlling the nonemergency medical transportation and other human services transportation programs administered in the Commonwealth, including the authorized methods of delivery and limitations or restrictions imposed on the methods of delivery."

—Section 443.12 (E)(1)

This section of the analysis addresses the current Commonwealth and federal laws that apply to MATP and HST generally and those that govern different delivery options for the NEMT benefit. While there is a distinct set of federal regulations that define the Medicaid NEMT benefit, other laws may apply depending on how a state implements the benefit.

While there is a distinct set of federal regulations that define the Medicaid NEMT benefit, a web of other laws may apply depending on how a state implements the benefit.

The analysis of federal laws addresses the applicable requirements for procurement, provider type (e.g., non-governmental and governmental), federal match rate, and duration of the federal authority. The requirements vary based on the delivery model for the NEMT benefit as addressed in more detail below (e.g., administrative service, brokerage model, contracting with MCOs).

PENNSYLVANIA HUMAN SERVICE TRANSPORTATION PROGRAMS — LAWS AND REGULATIONS

MATP

Regulations governing MATP services provided by either direct agreements with DHS or by counties through the Public Assistance Transportation Block Grant are found at 55 Pa. Code Chapter 2070.¹¹ The regulation defines MATP eligibility requirements and the counties (or through direct agreements with MATP providers) are responsible for determining eligibility for services; the scope of NEMT benefits (e.g., payment for escorts for consumers who cannot travel independently); and requirements for notifying applicants or clients of eligibility for MATP benefits. The regulations also describe operational considerations for the MATP program, such as record retention requirements (e.g., client files, trip logs, and records must be retained for four years).

Senior Shared-Ride Program

Section 904 of the Commonwealth's lottery law (P.L. 351, No. 91)(72 P.S. § 3761-904) authorizes PennDOT to use designated lottery funds to subsidize 85% of individual fares under the SSRP program.¹²

Area Agencies on Aging

The Area Agencies on Aging coordinate with PennDOT to link eligible individuals with the SSRP, as authorized under the Commonwealth's lottery law.

ADA Complementary Paratransit

ADA Complementary Paratransit services implemented by states are governed broadly by federal regulation 49 CFR Part 37, Subpart F.¹³ Broadly, these regulations prescribe eligibility standards, types of services, and service criteria, among other program operations required of state paratransit services.

Persons with Disabilities Program

74 Pa.C.S § 1516 directs PennDOT to establish the PwD program.¹⁴ The State law authorizes financial assistance to community transportation systems, which provide PwD services “for up to

¹¹ The Pennsylvania Code, “Chapter 2070. Eligibility for Services Funded Through the Public Assistance Transportation Block Grant,” available at <https://www.pacode.com/secure/data/055/chapter2070/chap2070toc.html>, accessed 1 October 2019.

¹² State Lottery Law (P.L. 351, No. 91), Section 904, available at <https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/1971/0/0091..PDF>, accessed 14 November 2019.

¹³ See 49 CFR. §§ 37.121-37.155, available at <https://www.ecfr.gov/cgi-bin/text-idx?SID=68f710e85045b56fc4a26c80af6da8aa&mc=true&node=pt49.1.37&rgn=div5>, accessed 10 October 2019.

¹⁴ Pennsylvania General Assembly, “Title 74 Chapter 15 Sustainable Mobility Options,” available at https://www.legis.state.pa.us/cfdocs/legis/LI/consCheck.cfm?txtType=HTM&ttl=74&div=0&chpt=15&mobile_choice=suppress, accessed 10 October 2019.

85% of the fare established for the general public for each trip which is outside of fixed-route and paratransit service areas and not eligible for funding from any other program or funding source.”

FEDERAL LAWS

Medicaid is a jointly funded program between states and the federal government. The federal government reimburses Medicaid expenses at the rate of each states’ federal medical assistance percentage (FMAP), which is 50% for administrative expenses and 50% or higher for medical expenditures.¹⁵ These federal funds are approved by the Center for Medicare & Medicaid Services (CMS), the responsible party for federal oversight of Medicaid programs. CMS’s goals are captured in its triple-aim.

CMS “TRIPLE AIM”



IMPROVING
THE PATIENT
EXPERIENCE
OF CARE



IMPROVING THE
HEALTH OF
POPULATIONS



REDUCING THE
PER CAPITA COST
OF HEALTH CARE

Federal regulation at 42 CFR § 431.53 requires the state to ensure and describe how necessary transportation to and from providers will be available for consumers. If the NEMT program is operated as an administrative service and therefore matched at 50%, the state must claim expenditures per an approved Public Assistance Cost Allocation Plan (PACAP). Where the local government agencies administer public assistance programs under a state-supervised system, the state agency’s PACAP must include a cost allocation plan for the local agencies for allowable transportation expenses as approved in the Medicaid State plan. The PACAP is governed by the federal regulations at 45 CFR part 75 and 2 CFR part 200. These PACAP requirements apply to MATP in the sixty-six (66) counties in the Commonwealth in which a broker model is not used. Treating NEMT as an administrative service does not require compliance with the free choice of provider provisions in 42 CFR § 431.51, which means the state could contract with a single provider.

There are four options to claim the higher federal medical match on NEMT services:

- **Direct Vendor Payment Under the State Plan** — MATP services may be claimed as medical services under the State plan and delivered on a FFS basis; however, federal requirements for

¹⁵ Congressional Research Service, “Medicaid’s Federal Medical Assistance Percentage,” available at <https://fas.org/sqp/crs/misc/R43847.pdf>, accessed 30 September 2019.

free choice of provider (42 CFR § 431.51) and statewide availability of the benefit through that delivery system (42 CFR § 431.50) would apply.

- **Section 1915(b) Waiver Authority (Brokerage)** — as described in more detail below, section 1915(b) authority may be used to competitively or selectively contract with brokerages for the delivery of MATP as a medical service.
- **Section 1915(b) Waiver Authority (Managed Care Carve-In)** — if this authority is used to authorize a managed care delivery system, the MATP benefit could be carved into the MCO agreement, and the capitation rates paid to the MCO (which include MATP) are matched at the federal medical match rate.
- **State Plan Brokerage Authority** — as described in more detail below, State plan authority can be used to competitively procure a governmental or non-governmental broker for the delivery of the MATP benefit that would be matched at the federal medical match rate.

Brokerage Option Under the Section 1915(b) Waiver

Historically, the 1915(b) waiver (42 U.S.C. § 1396n(b)) has been available to states to waive Medicaid's requirements for statewide operation, free choice of providers, and comparability of services. In the context of an NEMT broker program, states have most commonly used the 1915(b) waiver authority to waive the "free choice of providers" requirement to contract with NEMT brokers selectively, and the "statewide operation" to create regional differences in program operations. The 1915(b) waiver has been the longstanding option for states to contract with NEMT brokers selectively, but there are considerations for the desirability of this option addressed below.

- **Type of Vendor and Procurement Requirements** — states may selectively procure vendors under section 1915(b) waiver authority. Self-referral by brokers is allowed under this option, unlike section 1902(a)(70) of the Social Security Act, which has limited self-referral options and is described later in this section. The 1915(b) waiver authority also permits competitive procurement. Entities selected are NEMT pre-paid ambulatory plans (PAHPs) subject to the federal managed care regulations specified in 42 CFR § 438.9. NEMT PAHPs are paid through capitated rates or another methodology that differs from State plan rates.
- **Federal Approval Requirements** — states must complete the section 1915(b) waiver template, which requires several assurances and a cost-effectiveness test monitored over the course of the approval period by the CMS Regional Office. Section 1915(b) waivers are generally approved for two years and may be approved for five years if individuals dually eligible for Medicare and Medicaid are covered under the waiver.
- **FMAP Claiming Under a Section 1915(b) Waiver** — states claim NEMT services delivered via a broker model under a section 1915(b) waiver as medical expenditures. Standard FMAP in the Commonwealth for SFY 2020 is 52.25%, with the Affordable Care Act (ACA) Adult Expansion populations at 93.00% and 90.00% FMAP for calendar years 2019 and 2020, respectively.

State Plan Brokerage Authority Through 1902(a)(70) of the Social Security Act

As part of the Deficit Reduction Act of 2005 (P.L. 109-171), Congress amended section 1902 of the Social Security Act to allow states to implement a “Non-Emergency Medical Transportation Brokerage Program” through a SPA. The implementing regulations are found at 42 CFR § 440.170(a)(4). This authority allows states to implement an NEMT broker program notwithstanding the requirements for statewide operation, freedom of choice of providers, and comparability of services that would otherwise apply to services under the State plan. This “1902(a)(70) SPA authority” for the MATP broker program is used in Philadelphia County and is an option for implementing a brokered MATP model statewide.

The implementing regulation at 42 CFR § 440.170(a)(4)(i) provides that states can use the 1902(a)(70) SPA authority if the NEMT broker:

- ✓ Is selected through a competitive bidding process consistent with 45 CFR §§ 75.326 through 75.340 and is based on the state's evaluation of the broker's experience, performance, references, resources, qualifications, and costs.
- ✓ Has oversight procedures to monitor beneficiary access and complaints and ensure transportation is timely, and drivers are licensed, qualified, competent, and courteous.
- ✓ Is subject to regular auditing and oversight by the state to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services.
- ✓ Is subject to a written contract, which imposes the requirements related to prohibitions on referrals and conflicts of interest described at 42 CFR § 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.

Regulations at 42 CFR § 440.170(a)(4)(ii)(A) prohibit the NEMT broker from self-referring if the broker has a financial relationship with the transportation provider or if the broker has an “immediate family member” that has a direct or indirect financial relationship with the transportation providers. Exceptions to these prohibitions exist in certain situations and are described in full at 42 CFR § 440.170(a)(4)(ii)(B). Notably, one of these exceptions on self-referral is for a government entity, so long as certain conditions are met.

A broker model using section 1902(a)(70) SPA authority may be a governmental entity that self-refers (i.e., a public transportation broker that refers members to its public transportation services), if conditions at 42 CFR § 440.170(a)(4)(ii)(B)(4) are met. Specifically, a governmental broker that self-refers must “maintain an accounting system as though it were a distinct unit” (i.e., the contract cannot provide for payment of costs shared by governmental units such as

regional transportation authorities).¹⁶ Payments to the governmental entity are limited to the actual costs calculated as though the broker was a distinct unit, and exclude administrative expenses (i.e., costs of operating a transit authority). The governmental entity must maintain an accounting system with funds allocated and costs charged to the MATP brokerage program completely separate from any other programs as described at 42 CFR § 440.170(a)(4)(ii)(B)(4)(i). This limitation prevents inappropriate or accidental subsidization of non-MA programs with Medicaid funds, which is vital to the federal government because, as noted previously, it pays 50% or more of reported Medicaid expenses. A governmental broker must document that it is the most appropriate and lowest cost alternative for an individual's specific transportation needs, as described at 42 CFR § 440.170(a)(4)(ii)(B)(4)(ii). A governmental broker must also document that it is paying no more for fixed-route public transportation than the cost charged to the general public and no more for paratransit services than the rate charged to other state human service agencies for comparable services as described at 42 CFR § 440.170(a)(4)(ii)(B)(4)(iii). In other words, a government broker that self-refers cannot charge more for NEMT-specific services.



SECTION 1 KEY OBSERVATIONS



- ✓ As it relates to federal and state law, regulations, and policies, the Commonwealth has flexibility in how MATP is operated.
- ✓ The regional broker model would likely utilize the 1902(a)(70) SPA authority, which has already been used for the Philadelphia County broker.
- ✓ The 1902(a)(70) SPA authority for a broker has different regulations than the current county models, but allows for higher FMAP reimbursement on MATP expenses.

¹⁶ Federal Register Preamble, "State Option To Establish Non-Emergency Medical Transportation Program," available at <https://www.govinfo.gov/content/pkg/FR-2008-12-19/pdf/E8-29662.pdf>, accessed 11 December 2019.



2

EFFECTIVENESS AND EFFICIENCY OF NEMT AS RELATED TO HUMAN SERVICE TRANSPORTATION PROGRAMS



- "An analysis of the effectiveness and efficiency of the current nonemergency transportation service delivery as it relates to all human service programs in this Commonwealth."
-
-
-
-

—Section 443.12 (E)(2)

This section addresses how counties currently coordinate both MATP and HST rides. Subject to federal and state requirements, each county has flexibility in how they administer these programs. This autonomy has its advantages for consumers and providers but also creates challenges in state oversight, accounting, and procurement.

Each county has flexibility in how they administer these programs, which can create challenges in state oversight, accounting, and procurement.

COORDINATION ADVANTAGES IN THE CURRENT SYSTEM

Coordination Between MATP and HST

Counties with an in-house model have responsibility for MATP within their area. Most counties use paratransit rides for MATP consumers, except for metro areas dominated by public mass transit, and a few counties with predominantly mileage reimbursement trips. Counties also have other HST rides they coordinate like SSRP, PwD, or ADA Complementary Paratransit. With paratransit being

frequently provided in MATP (because the coordinator determined it to be the most cost-effective option in areas with limited fixed-route options), counties have an opportunity to combine consumers from different programs into the same shared vehicle. This coordination is streamlined if the same entity is scheduling all the MATP and HST consumers.

Consumer Benefits

When counties successfully coordinate MATP, an opportunity to leverage public resources and increase efficiency exists. Consumers can benefit from complementary HST benefits if the transportation programs are in sync. The consumer can make one call to receive benefits from multiple programs.



For example, a consumer could call the same coordinator to schedule a medical trip with MATP and then add to it a non-NEMT trip with another HST program, like SSRP or ADA Complementary Paratransit, as part of the total round trip.

Per stakeholder discussions, interactions with county coordinators can also extend beyond transportation needs. If the in-house staff taking the call are knowledgeable of other government and local resources, they may be able to assist a rider in accessing other human services for better social, mental, and health outcomes, for example, coordinating a shared ride for picking up groceries after a medical appointment provided by MATP. This access aligns with the Commonwealth's goals on better whole-person care outcomes by addressing social determinants of health (SDOH).¹⁷ Similarly, if an MATP rider visits the physical location of the county office, they may be able to access multiple human services at the same time, including the MATP coordinators.

Cost Per Trip

Cost per trip is a standard metric for NEMT efficiency nationally. Different sources, such as the *Transportation Research Board*, and the *2014 National NEMT Survey*, rank the Commonwealth as having one of the lowest cost per NEMT trip. Low costs per trip may be attributable to the Commonwealth's extensive public transit systems in urban areas. Based on the National NEMT Survey, NEMT public transit use and the average cost per trip is modestly correlated (-0.5 *r*-value) for the 24 states, which reported the percentage of NEMT provided via public transit. That is, states with lower NEMT costs per trip on average have more fixed-route public transportation use. Based on data from DHS for SFY 2019, 71% of all MATP trips in Philadelphia County and 61% of MATP trips in Allegheny County are on fixed-route public transportation.

¹⁷ Pennsylvania Pressroom, "Human Services Secretary Participates in Panel on Social Determinants of Health, Highlights Efforts to Increase Whole-Person Care Around Pennsylvania," available at https://www.media.pa.gov/Pages/DHS_details.aspx?newsid=427, accessed 3 October 2019.

Removing those two counties, and recalculating the MATP unit cost, only moves the Commonwealth from a low-cost ranking of third in the nation down to a still favorable ranking of seventh. This result suggests that counties without extensive mass-transit infrastructure are still managing to keep costs down. If the trip has to be made for one consumer, a net marginal benefit may result from adding more consumers until vehicle capacity is reached. This way, the provider will collect more fares per hour and complete more trips at less cost.

COORDINATION CHALLENGES IN THE CURRENT SYSTEM

Out of County Trips

The MATP Standards and Guidelines (based on federal requirements) are generous regarding where consumers can seek care, including providers out of the county. In recent years, the pattern of large provider and hospital systems acquiring and moving smaller medical practices into centralized campuses has emerged. This geographic consolidation is influencing where MATP consumers want and need to go for medical services. Some rural counties lack specialty physicians and service capabilities, and as a result, the only medical options for consumers are out of the county. Some public transit providers may offer out of county trips to the general public if local demand for such trips exists, which would result in the public fare being the maximum rate that could be charged to MATP. Depending on the distance and location, the transportation provider and MATP coordinator might need to negotiate a premium trip rate for an out of county trip, which is unavailable to the public. The time to travel farther distances may create early or late hours for pick-up and drop-off, which are more challenging to align with other consumers requesting rides. Additionally, other HST consumers may not need to go as far.



For example, shared-ride trips tend to be on the shorter side with 78% 10 miles or less, and a little over half the trips at five miles or less based on PennDOT’s SFY 2019 data from their statewide shared-ride scheduling software.

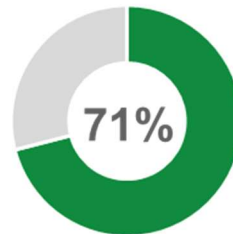
Varying Standards

One of the challenges of coordination between MATP and other HST is protecting the integrity of Medicaid requirements while coordinating programs. The requirements for drivers, fleets, and

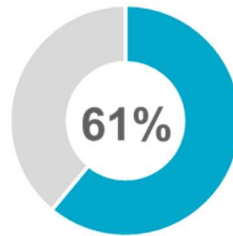
MATP TRIPS ON FIXED-ROUTE PUBLIC TRANSPORTATION

Based on data from DHS for SFY 2019

Philadelphia County



Allegheny County



program compliance differ between public transportation and MATP. The MATP Standards and Guidelines focus on compliance for terms including performance standards, consumer eligibility, and financial reporting, including time studies. MATP coordinators can add additional contract requirements to their transportation providers. In contrast, public transportation has different standards for its drivers, fleet, and access requirements, including detailed compliance tied to accessing federal funds. Federal funds from grant programs like 5307 (Urbanized Area Formula Grants), 5310 (Formula Grants for the Enhanced Mobility of Seniors and Individuals with Disabilities), and 5311 (Formula Grants for Rural Areas).¹⁸ PennDOT shared with the Workgroup some of their tools for ensuring federal compliance for capital, financial management, procurement, maintenance, ADA, and Title VI (nondiscrimination). PennDOT also has performance targets and a comprehensive review of counties' shared-rides. In some cases, MATP may use the local transportation authority to provide rides. In that case, the transportation authority would be required to meet any additional MATP standards and guidelines along with any state and federal requirements for being a public transportation provider.

Differences in public transportation and transportation program requirements can lead to an increase in cost where there is cross-over from one program to serve another. To do this cross-over, the program crossing over must meet the requirements of the other program to provide services to the other population.



For example, public transit agencies may have to incur additional expenses to meet the access and performance standards of MATP as they move to higher levels of compliance. Additionally, Medicaid funding has particularly detailed consumer verification and accounting requirements.

Disallowance and Procurement Risk

If an MATP coordinator is using administrative resources such as staff, call centers, or office space for more than MATP, those administrative expenses must be allocated to their respective programs. It is crucial to have a generally accepted and consistent CMS-approved allocation process, like the PACAP mentioned in Section 1 of this report, to prevent cross-subsidization of federally funded programs.

At the end of 2015, CMS disallowed \$14.5 million in federal financial participation for MATP because CMS found inadequately documented allocation of MATP costs following an approved PACAP, a decision that was upheld by the Departmental Appeals Board and the United States

Currently, 12 counties have exercised their right to refuse the MATP grant, with one more talking to DHS about its intent to terminate at the end of 2019.

¹⁸ Federal Transit Administration, "Grant Programs," available at <https://www.transit.dot.gov/grants>, accessed 12 December 2019.

District Court.¹⁹ This action led to new MATP guidelines requiring more detailed reporting on the allocation of MATP costs, or the development of blended service provider rates, for counties that chose directly to administer their MATP. Per the MATP Standards and Guidelines, counties have the right of first refusal to coordinate MATP. With the changes following the disallowance, some counties are no longer able, or willing, to be the MATP coordinator due to the added administrative requirements. Additionally, some counties have found it more beneficial to forgo independently administering MATP and instead to pool their resources. Currently, 12 counties over time have declined to administer MATP, with one more talking to DHS about its intent to terminate at the end of 2019 because of a lack of staff and the possibility of a broker replacing its program.

When a county declines its opportunity to administer MATP, sometimes with short notice, DHS is responsible for finding a provider to continue the federally required NEMT. As a temporary solution, DHS has used non-solicitation awards (sometimes referred to as “sole-source agreements”); that is, DHS awards the MATP work to a qualified provider without using a competitive process.

Under Commonwealth laws, the Office of the Budget oversees the grant process, including the awarding of grants (which includes MATP because it implements program service delivery) and treats them similarly to contract procurements done under the Commonwealth Procurement Code. For both contract procurements and grant solicitations, the process defaults to competitive procurements first.²⁰ Management Directive 305.20

establishes policy, responsibilities, and procedures for grants and requires Office of Comptroller Operations approval of a non-solicitation grant award through the agency’s submission of a “Request for Approval to Use the Non-Solicitation Award Process for Grant Funds” form, which justifies the use of a non-solicitation grant award. All grant awards, including non-solicitation awards have a maximum agreement period of five years. Once expired, DHS restarts the process with that grant, and if it is through a subsequent non-solicited award, a new justification will be required.

DHS carries the regulatory risk of the comptroller potentially rejecting these justifications at the next non-solicitation request for these same grants because RFA 28-18 soliciting a broker model was released.

Currently, there are two non-solicited grants awarded for MATP, and each covers multiple counties.^{21,22} Both grants were justified and re-justified as non-solicitation grants. DHS had justified

¹⁹ United States District Court, M.D. Pennsylvania, “DEPT. OF HUMAN SERV’S v. U.S. DEPT. OF HEALTH,” available at <https://www.leagle.com/decision/infdco20181002c90>, accessed 27 September 2019.

²⁰ For MATP grants to counties, DHS is permitted to grant funds to the county without the need to do a competitive solicitation. This ability is different from non-solicitation grant awards to non-county entities.

²¹ DHS, “Between the Department of Human Services and South Central Transit Authority,” available at http://contracts.patresury.gov/Admin/Upload/495853_410081368%20RNEW%205-13-19.pdf, accessed 1 October 2019.

²² DHS, “Between the Department of Human Services and Central Pennsylvania Transportation Authority DBA rabbitransit DBA York Co Trans Aut,” available at http://contracts.patresury.gov/Admin/Upload/495852_4100081366%20RNEW%205-13-19.pdf, accessed 1 October 2019.

both awards based on the grantees' provision of transportation services for the counties, the lack of other qualified MATP service providers, and little prospect of cost savings if they pursue a procurement process. Based on supporting grant documents, both awards have a one-year term with the option to extend for an additional year (one grant is already using that additional year).

DHS risks the Office of Comptroller Operations' potential rejection of the non-solicitation grant awards for the next non-solicitation request for these same grants. RFA 28-18 soliciting a broker model was released and included these same counties within its scope. While procurement rules prevent DHS from discussing how many entities have bid on RFA 28-18, it is likely some NEMT brokers could also be qualified MATP coordinators for the counties under current non-solicitation award grants. The move to a broker through a competitive procurement would increase FMAP on MATP expenditures and create savings for DHS. Additionally, the use of a non-competitive process does not allow for an evaluation of different approaches to meeting requirements set forth in a competitive procurement. Without the change to a broker, DHS's ability to secure approval to continue of repeated non-solicitation grant awards presents a significant issue to MATP.



SECTION 2 KEY OBSERVATIONS

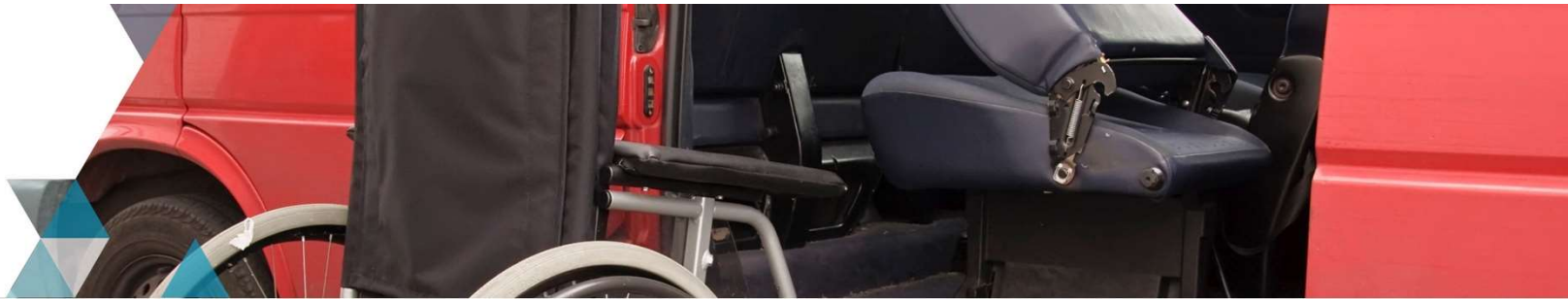


Coordination between the MATP and other HST programs has its benefits:

- ✓ Some costs can be spread across multiple programs.
- ✓ When the MATP and HST coordinator are the same, it is a one-stop-shop for consumers allowing them to access MATP and non-MATP services with the same call.
- ✓ Opportunities for consumers to address other SDOH by combining trips.

Various requirements between public transportation and MATP differ, which creates its own set of unique challenges:

- ✓ Complexity in meeting different sets of regulations.
- ✓ Disallowances from CMS led to increased requirements on MATP coordinators.
- ✓ Procurement risk if DHS repeatedly uses non-solicitation grant awards.



3

OTHER STATES' NEMT MODELS



: "A review of other states' models of delivering nonemergency
 : medical and other human services transportation, including the
 : number of other states that utilize a full-risk brokerage model and
 : the effect a brokerage model has had on public transit in those
 : states."

—Section 443.12 (E)(3)

This section describes the three main NEMT models used across the nation and some of the advantages and disadvantages of each approach. The impact on public transportation is often directly related to coordination efforts amongst the programs. Lastly, a summary is included of other states that switched to a NEMT broker and their experiences.

NEMT DELIVERY MODELS

There are three models state Medicaid programs generally use to deliver NEMT, as shown in the next graphic.

NEMT MODELS USED BY STATE MEDICAID PROGRAMS



IN-HOUSE MANAGEMENT

Where a Medicaid program operates its NEMT program statewide or at the county level.



MANAGED CARE

Where a state includes NEMT services in its contracts with MCOs.



BROKER

Where the program is operated by a separate entity regionally or statewide on a full-risk¹ or a shared-risk² basis.

¹ Full-risk: the broker is at financial risk for performing all requirements in the contract with capitated payments.

² Shared-risk: the broker does not assume all financial risk.

While a majority of state Medicaid programs use only one of these models, several states operate hybrid models (e.g., in-house management and a regional broker). Managed care plans may also subcontract with an NEMT broker to provide contracted NEMT benefits. The Commonwealth operates a hybrid model, with in-house management at the county level and a full-risk capitated broker operating in Philadelphia County. The following information summarizes NEMT models used by other state Medicaid programs as of 2018, as reported by the Transportation Research Board, "Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination."

In-House Management (State or County)

Eight states (Alabama, Maryland, Minnesota, North Carolina, North Dakota, Ohio, South Dakota, and Wyoming) solely use an in-house model. Because the “in-house management” model is generally operated at the county level, this model allows for significant localization and customization of the NEMT delivery.

In an in-house management model, a state government entity, typically Medicaid, coordinates the NEMT program. The entity will be responsible for having systems for taking requests, maintaining a transportation network, verifying consumer information, scheduling rides, and submitting financial reports to state and federal oversight offices. The benefits of the model are described in Section 2 of this report and include customization of their programs and integration with other HST at a personal and local level.

Managed Care

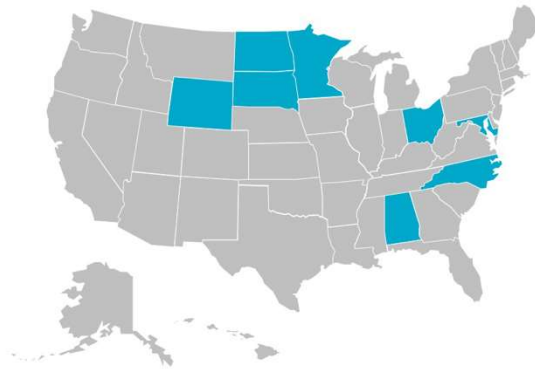
Ten states (Arizona, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, New Mexico, Oregon, and Tennessee) solely use MCOs to administer NEMT benefits. As noted, some managed care entities subcontract with an NEMT broker.

Under a managed care model, an MCO is responsible for managing NEMT services similar to medical benefits. Each MCO operates its own NEMT program, either negotiating a network of NEMT providers or contracting with an NEMT broker to provide NEMT services. Non-public transport routes, times, and services offered to Medicaid patients may be different between MCOs. Most MCOs do not maintain a fleet of vehicles but use vendors — some MCOs include public transportation vendors, to provide rides.

MCOs may have incentives to encourage greater use of the lowest-cost and most appropriate mode of transit because of their capitated payment arrangement with states; therefore, a potential benefit of this model includes lower transportation costs within NEMT programs. A managed care model

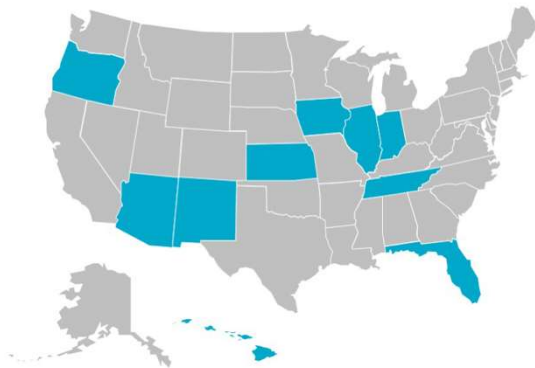
EIGHT STATES THAT SOLELY USE AN IN-HOUSE MODEL

The Commonwealth operates a hybrid model, so it is excluded here.



TEN STATES THAT SOLELY USE MCOs TO ADMINISTER NEMT BENEFITS

The state MCO programs that delegate to an NEMT broker are not distinguished here.



may also have lower fixed administrative costs because it is more centralized than several in-house county coordinators. Additionally, MCOs have access to patients’ medical data and care teams. As part of the ongoing focus of SDOH, the MCO may consider the broader scope of transportation needs for better health outcomes of consumers, which may produce savings independent of other efficiencies gained through this model.

Note, the Commonwealth’s MCOs cover non-emergency medically-necessary *ambulance* transportation because MATP does not cover this service. For other types of trips not covered by MATP, most MCOs have policies of providing NEMT if it is demonstrated to fill a gap in the member’s care.



For example, getting to a food bank or transporting an adult member to a medical appointment and allowing them to bring their children.²³

Broker (Statewide or Regional)

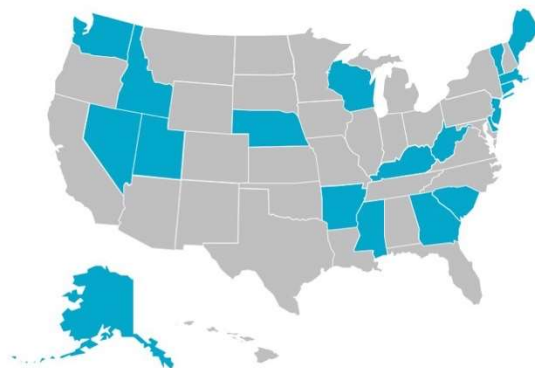
Twenty states (Alaska, Arkansas, Connecticut, Delaware, Georgia, Idaho, Kentucky, Maine, Massachusetts, Mississippi, Nebraska, Nevada, New Jersey, Rhode Island, South Carolina, Utah, Vermont, Washington, West Virginia, and Wisconsin) solely use an NEMT broker model.

The broker is usually a specialized vendor contracted by the state Medicaid agency to coordinate NEMT benefits. The capitated payment arrangement and the more centralized structure make the broker model similar to a managed care model in terms of advantages and disadvantages. Typically, one or two brokers will cover the entire state or a group of counties, depending on whether the broker is statewide or regional.

Different from in-house models, brokers typically operate under a full-risk or shared-risk contract. It is difficult to ascertain the number of states which have a full-risk NEMT contract based on the review of publicly available information. A state may operate a regional

TWENTY STATES THAT SOLELY USE AN NEMT BROKER MODEL

The Commonwealth operates a hybrid MATP model, so it is excluded here.



The benefits of the broker include streamlined contracting and oversight of vendors, as well as a full-risk or shared-risk financial contract.

²³ In MATP, there are cases where a parent can bring a child, but not because it is their child, but because their child is acting as an escort as defined in the MATP Standards and Guidelines.

broker differently around the state, with a full-risk contract in one region and a shared-risk in another.

States that use 1902(a)(70) SPA authority to operate an NEMT brokerage are required to procure it using a competitive bidding process described at 45 CFR §§ 75.326 through 75.340. The 1915(b)(4) waiver authority provides greater flexibility to states in procuring an NEMT broker. States that use 1915(b) waiver authority to operate an NEMT brokerage may, but are not required to follow a competitive bidding process to procure the NEMT broker. The competitive process allows for an agency to set forth technical requirements that must be met, and to evaluate responses to those technical requirements, to determine the approach that best meets its needs as well as price competition. This competition may lower costs but introduces a risk of a broker underbidding, leading to solvency problems once the contract has commenced.

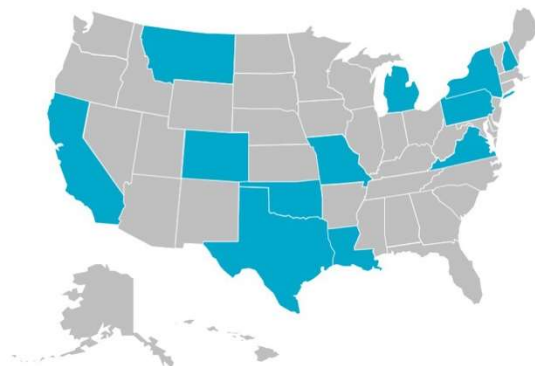
Similar to MCOs, for-profit brokers may have an incentive to seek lowest-cost transportation options as a means for cost savings. A state can guard against inappropriate cost controls through its contracts with brokers. For instance, both the RFA 28-18 and DHS’s agreement for MATP services in Philadelphia County require that the brokers provide the most cost-effective and most appropriate mode of transportation for an individual. As highlighted in the upcoming summaries, some states have experienced similar savings with non-profit entities (like public transit authorities) as the NEMT broker. Brokers that are national entities can leverage their existing assets to administer the program, which may also generate savings. These assets may include consumer apps, fraud, waste and abuse (FWA) processes, or administrative reporting units.

Hybrid

Twelve states (California, Colorado, Louisiana, Michigan, Missouri, Montana, New Hampshire, New York, Oklahoma, Pennsylvania, Texas, and Virginia) plus the District of Columbia use a hybrid of the models described above (in-house management, managed care, and broker). This category includes the Commonwealth, which operates an in-house and broker hybrid model. For other states, the hybrid model may be designed as an in-house NEMT for FFS populations and MCOs for the managed care population. In some states, the FFS population is covered by a broker, while MCOs cover their members under a managed care NEMT model. States, which use the Medicaid managed care model, typically have transitional or other populations that remain in FFS, creating the dichotomy for two different NEMT models within the

TWELVE STATES, PLUS THE DISTRICT OF COLUMBIA, USE A HYBRID OF MODELS

This category includes the Commonwealth, which operates an in-house and broker hybrid model.



same program. Lastly, some states are similar to the Commonwealth, where urban counties use a broker, and the rest of the state has in-house models.

STATE NEMT EXPERIENCES WITH BROKER MODELS

The following summarizes the findings from state case studies, which are included in more detail below. They are from the 2018 publication from the *National Academies Press*, “Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokers on Transportation Coordination,” (NEMT Handbook) and the “State-by-State Profiles for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination,” (State Profiles) unless otherwise noted. Note that the conclusions and findings mentioned within the following state summary sections are based on the literature reviewed and do not reflect the Commonwealth’s opinions or conclusions. Based on the literature, some states have reported better cost control, increased NEMT involvement in urban areas, but decreased participation in rural areas. Some states have reported increases in consumer complaints and wait times and a decline in trip coordination. Rural areas usually felt these effects at an amplified level because they serve smaller populations across large geographic areas.

The federal requirements of NEMT allow states flexibility in how they deliver the service. Similarly, on a larger scale, states have considerable latitude in how they operate and shape their entire Medicaid program. Because of state autonomy and the underlying anatomy of their public transportation systems, it is difficult to transfer and extrapolate the broker experience, positive or negative, of any state onto the Commonwealth. Additionally, it is important to note this analysis did not review other state contract requirements or how states transitioned NEMT services to brokers, other than the observations noted from the literature review.

The NEMT Handbook and State Profiles documents describe state NEMT experiences from changing to an NEMT broker model, including the impact on public transportation in some cases. Below we outline the programs for select states, some of which were selected by stakeholders and the Workgroup. Other states were selected based on the availability of published transition experiences.

Massachusetts

Massachusetts’ NEMT program consists of a regional broker with nine regions, operated under 1115 waiver authority, and leverages its public transportation system by using regional transit authorities as brokers for NEMT. See NEMT Handbook, p. 108 and State Profiles, p. 47. The NEMT Medicaid program is one of six state health and human service agencies, which are part of a coordinated system operated by an HST office. The five remaining agencies include the Department of Developmental Services, Department of Public Health’s Early Intervention Program, the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the

Department of Mental Health.²⁴ Each program retains responsibility for consumer eligibility and allowed trips, plus reimburses the broker for the cost of trips. For administrative expenses, the HST office pays the brokers a flat monthly rate.

The use of public transportation authorities as brokers has resulted in low administrative costs and relatively low costs per trip. Some of those lower costs are because the state held constant for five years (SFY 2009–2014), the pool of administrative money paid to brokers even though the number of rides increased over the same period. HST contracts with six regional public transit authorities to act as brokers, all of which provide transportation services and subcontract with other transportation providers to

The use of regional transit authorities, which serve as NEMT brokers, allows for better coordination of transportation services and has been successful in increasing NEMT trips while controlling costs per passenger trip.

meet the broad array of transportation needs of the Medicaid consumers and other program participants.²⁵ Massachusetts reported consistency in service standards set by the Medicaid agency, which also monitors service quality and all coordinated transportation services. Mobility managers, appointed by the HST office, are in place to promote coordination and allow for the one-stop-shop for NEMT consumers with multiple trip purposes. Because Massachusetts uses regional transit authorities, which serve as brokers for NEMT, they can better coordinate transportation services and have seen success in increasing NEMT trips while controlling costs per passenger trip.

South Carolina

South Carolina's in-house NEMT model transitioned to a full-risk regional NEMT broker model in 2007 and is operated by a national NEMT broker. The NEMT program consists of a regional broker with three regions per 1902(a)(70) SPA authority. See State Profiles, p. 85. When the regional broker was first established, two national NEMT brokers were selected.²⁶ As of 2011, only one NEMT broker is contracted for the three regions. Implementation of the NEMT broker was initially met with controversy, and the state faced challenges, including the loss of potential NEMT bidders.

A review of the South Carolina NEMT Program published in 2009 by the Legislative Audit Council found no evidence indicating whether an in-house or broker model is inherently better for cost and quality. The council found that the broker model provides an incentive to operate efficiently only if the state has an effective procurement and monitoring process in place. The council also found that

²⁴ Mass.gov, "Get A Ride Through the Human Service Transportation Office," available at <https://www.mass.gov/service-details/get-a-ride-through-the-human-service-transportation-office>, accessed 26 September 2019.

²⁵ "Providing Rides Through the HST Brokerage," available at <https://www.mass.gov/service-details/providing-rides-through-the-hst-brokerage>, accessed 26 September 2019.

²⁶ SC DHHS "Transportation Broker Contract Awards," available at <https://www.scdhhs.gov/press-release/transportation-broker-contract-awards>, access 26 September 2019.

expenditures increased at a lower rate than if the in-house model would have continued; however, the efficiency measures that were put in place could have been implemented under the in-house model. The council also recommended a phase-in or pilot period for broker model implementation and a thorough analysis of costs and benefits before deciding on transportation brokers.

A review of consumer complaints and injuries for SFY 2016 and SFY 2017 disclosed that consumer complaints have increased, but injuries have decreased. According to the South Carolina Department of Health and Human Services, the state has required a corrective action plan from the broker in the past due to performance standard issues. The broker reported that complaints in 2017 from Medicaid NEMT consumers amounted to less than 2% of all trips. In 2016, the state attempted to switch brokers upon contract end, but the deal was canceled because the new contract did not meet the proper criteria.²⁷

The state uses one NEMT broker, having had to work through the loss of another.

Washington

Washington State has the oldest regional broker system (started in 1984) and uses six community-based brokers across 13 regions. See State Profiles, p. 99. The state was previously using an in-house local-level model to manage NEMT transportation. The brokers include local planning agencies, councils on aging, and other human services agencies. These brokers contract with several community transportation providers directly. Washington State officials credit the program for controlling transportation costs, improving quality and safety statewide, as well as maintaining access for consumers.

In 2008, the state reported the brokers' local knowledge and experience allowed for value-added solutions in the face of unique local challenges, such as high medical risk and high-cost consumers, and increased utilization of providers. The state has also incorporated performance incentives since 2011, which focus on call center performance and cost-effectiveness. See State Profiles, p. 99.

Arkansas

Arkansas' regional NEMT broker model uses a combination of for-profit national brokers and state-based human services brokers, operated under the 1915(b) waiver authority. Human services brokers include development councils, area agencies on aging, and community action agencies.

²⁷ Tim Smith "Complaints Up, Injuries Down for State's Transportation System for Medicaid Recipients," available at <https://www.greenvilleonline.com/story/news/2017/12/09/complaints-up-injuries-down-states-transportation-system-medicaid-recipients/932219001/>, accessed 26 September 2019.

See State Profiles, p. 11. The state reported its broker model has proven to be cost-effective in 2015.²⁸

In 2019, the state announced it would be terminating its contract with its broker due to the broker not providing the level of service required by the contract, despite opportunities for corrective action.²⁹ Complaints towards the broker included failing to provide rides to consumers causing consumers to miss scheduled medical appointments, failing to submit applications for criminal background checks on drivers, failing to ensure vehicles meet contract-specified requirements, and failing to meet requirements for answering beneficiary calls within required time frames. The state entered into a contract with the second-lowest bidder and is currently addressing the new broker's issues with failing to provide rides to consumers.³⁰

In 2015 the state reported its broker model was cost effective.

In 2019, the state terminated their broker contract and is having issues with their new one.

Texas

Texas' previous in-house management NEMT model was replaced by the regional broker model, where Texas first pilot-tested the program in two areas, then rolled the model out to other regions over time. See NEMT Handbook, p. 153 and State Profiles, p. 91. Texas' current hybrid model includes in-house management in one region and five regional NEMT brokers in the remaining ten regions, operated under 1902(a)(70) SPA and 1915(b) waiver authority. The brokers are four private for-profit agencies and one regional human services agency. The state reported lowered payments for NEMT and reduced FWA due to increased oversight. The heightened and centralized oversight can result in corrective action plans, termination of contracts, and liquidated damage assessments.³⁰

The state reported lower payment for NEMT and reduced FWA due to increased oversight under the broker model.

Survey data has noted increases in consumer complaints after each regional expansion of the broker model.

Within months of awarding broker contracts, the Texas Health and Human Services Commission (HHSC) terminated two poor performing and underqualified brokers due to client safety issues and possible financial fraud. Despite the requirement, HHSC did not seek competitive bids based on pricing and selected brokers with poor performance histories with no justification or documentation

²⁸ The Stephen Group, "The Stephen Group Volume II: Recommendations," available at https://media.arkansasonline.com/news/documents/2015/10/07/TSG_Volume_II_Recommendations.pdf, accessed 1 October 2019.

²⁹ AFMC, "What Providers Should Know About the Non-Emergency Transportation Program," available at <https://afmc.org/health-care-professionals/arkansas-medicaid-providers/net/>, accessed 26 September 2019.

³⁰ Fay Gordon, "Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults," available at <https://www.justiceinaging.org/wp-content/uploads/2016/11/NEMT-Medicaid-Transportation.pdf>, access 26 September 2019.

to support the selections. These procurement and contract management failures, as well as inconsistency in broker selections, contributed to the ultimate termination of these brokers.

After controlling for fuel costs and despite missing broker reported claims, the Legislative Budget Board (LBB) staff reported increased cost per NEMT consumer from 2011 (when the state was using the in-house model) to 2015 (when the state was using the broker model). Cost per beneficiary rose from \$29.11 in 2011 to \$39.38 in 2013 (after one full year of the broker model in Dallas and Houston), and \$59.40 in 2015. In 2016, LBB estimated that the broker model costs \$120.2 million more to operate per year than using the in-house model. Administrative costs represented about \$48.7 million of the \$120.2 million (41%). As a result of moving to the regional broker model, the HHSC decreased full-time equivalent (FTE) positions from around 355 in 2011 to 108 in 2015. This decrease was offset by the non-state staff addition of 580 new administrative positions for the transportation brokers, which is correlated with the administrative cost, which increased from \$22.9 million to \$60.4 million from 2011 to 2016.³¹

Survey data indicates that after each regional expansion of the broker model consumer complaints regarding the quality and reliability of NEMT services increased. The 2011 and 2012 complaint ratio to unique NEMT users was 3.5%, then increased to 9.4% in 2013 upon the completion of the first full year of the broker model in Houston and Dallas. In 2015, with the statewide expansion of the broker model, the complaint ratio increased to 12.9%, while NEMT users decreased from 7.7% in 2009 to 3.8% in 2015. The complaints reported were mostly due to failure to deliver clients to medical appointments and timeliness of service. Some of the decreases in users are attributed to the anti-fraud, compliance, and regulation efforts such as the parental accompaniment rule implemented by the state.³² Even after 2015, when the entire state was under the broker model, an additional decrease of 18.3% in NEMT users occurred.³¹

A survey conducted months into the broker pilot in 2012 looked at NEMT users in both broker and in-house models and reported equal usability and overall satisfaction for both models. Broker user surveys reported more reasonable travel time (noting the urban pilot setting), more likely to miss appointments, and more likely to be dissatisfied with wait times for pick-up. 34% of broker users either reported missing a few or all medical appointments versus 27% among the in-house users. Transportation providers under the broker model reported less satisfaction with the NEMT program than the in-house contracted transportation providers.³¹ The state created a quality performance

The state created a quality performance matrix, which incorporates monetary penalties against brokers when specific performance standards are not met.

³¹ Legislative Budget Board Staff, "Improve The Cost-Effectiveness of Medical Transportation Services for Taxes Medicaid Clients," available at http://www.lbb.state.tx.us/Documents/Publications/Staff_Report/3729_LBB_Staff_Reports.pdf, accessed 4 October 2019.

³² The parental accompaniment rule required children 14 years of age or younger to be accompanied by an adult, and the agency noted decreases in users upon efforts to enforce compliance of this policy.

matrix, which incorporates monetary penalties when specific contract performance standards are not met. They also use this matrix to track and enforce quality in the transportation benefit. Implementing performance standards (including timeliness) for NEMT may increase costs and reduce shared rides. State statute requires the regions to develop coordinated human services-public transportation plans. Most of the regional brokers are not actively involved in developing them, which potentially reduces their effectiveness. There were also reports of decreased NEMT ridership and revenues in rural areas. See NEMT Handbook, p. 153.

New Jersey

New Jersey's in-house county community transportation provider model was replaced by the statewide broker model, operated under a 1902(a)(70) SPA. See NEMT Handbook, p. 116 and State Profiles p. 65. The New Jersey State Medicaid agency reported \$30 million in savings from the switch, and of surveyed consumers, 84% rated their broker interaction positively, 2% neutral, while 14% rated it negatively.³³ The transition was also met with difficulty in that several community and public transportation providers opted out of participation. The main complaints from medical providers are related to the reliability of NEMT, and the state reports there is no longer a one-stop-shop for consumers to contact for multiple trip purposes. As a result of switching to the broker model, there has been a decline in coordinated NEMT trips with other HST services.

The state reports enhanced cost control, reduced fraud risk, and improved access to health services.

Although the statewide broker has been able to provide NEMT services in urban areas, its ability to provide NEMT in rural areas presents a challenge due to a lack of public transportation providers' participation in the program. Due to this deficiency, the broker may not assign trips to rural public transportation providers, which leads to the loss of NEMT

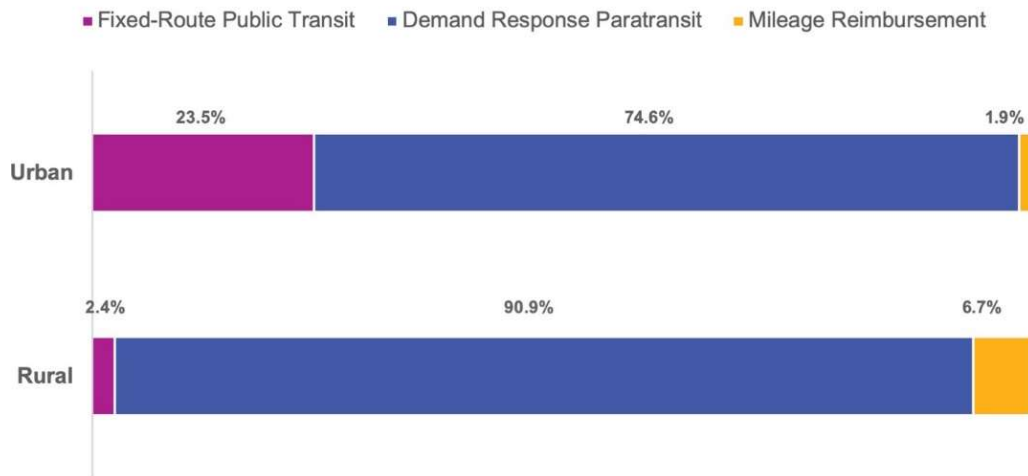
revenue for the providers. Currently, efforts are being made to involve the community and public transportation providers to increase NEMT participation. In 2016, the state agreed to amend its contract with its broker to incorporate elements to enhance performance and improve transportation access for NEMT consumers.³⁴ Performance enhancements included improved complaint collection, electronic tracking of driver location, driver training, customer service training, and shortened wait time standards. Despite challenges, the state reports enhanced cost control, reduced fraud risk, and improved access to health services. The following table shows the distribution of trip types within each geography.³⁵ Note, the use of fixed-route transit in urban areas is significantly less than Pennsylvania's shown in the Introduction Section charts.

³³ TRB, "Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination," available at <http://www.trb.org/Main/Blurbs/177842.aspx>, accessed 26 September 2019.

³⁴ Fay Gordon, "Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults," available at <https://www.justiceinaging.org/wp-content/uploads/2016/11/NEMT-Medicaid-Transportation.pdf>, access 26 September 2019.

³⁵ Island Peer Review Organization, Inc., 2014.

NEW JERSEY TRIP TYPE DISTRIBUTION (2014)



The next table shows the national rank for lowest cost NEMT programs for the states discussed in this section. Unit costs are based on data from the *2014 National NEMT Survey*.

| NEMT BY STATE, AVERAGE TRIP COST RANKING (2014) | | |
|---|-------------------|------|
| STATE | AVERAGE TRIP COST | RANK |
| Pennsylvania | \$12.96 | 3 |
| Massachusetts | \$20.22 | 10 |
| Washington | \$24.89 | 17 |
| Texas | \$28.06 | 20 |
| New Jersey | \$31.11 | 36 |
| Arkansas | \$31.15 | 37 |
| South Carolina | \$33.51 | 38 |



SECTION 3 KEY OBSERVATIONS



State Medicaid programs use various models, or combinations of models, for NEMT service delivery:

- ✓ Eight states solely use an in-house management model where a state government entity coordinates the NEMT program.
- ✓ Ten states solely use MCOs to administer NEMT benefits and each MCO operates its own program, similar to a broker.
- ✓ Twenty states solely use an NEMT broker model where the broker is at full or partial-risk.
- ✓ Twelve states and the District of Columbia use a hybrid model, which is a combination of any of the prior models.

State experiences with NEMT brokers are diverse:

- ✓ Some states reported better cost control, improved quality and safety, maintained access for consumers, and increased NEMT involvement in urban areas when switching to a broker.
- ✓ Some states have reported increases in consumer complaints and wait times, a decline in trip coordination with other HST, decreased participation in rural areas, and increased costs.
- ✓ Rural areas seem to feel an amplified impact because they serve smaller populations across large geographic areas.
- ✓ Each state has flexibility in how they run both their Medicaid and NEMT programs, including differences in contracting methods, contract requirements and implementation strategies. These differences make it difficult to extrapolate a state's experience, good or bad, onto Pennsylvania.



4

POSITIVE AND NEGATIVE IMPACTS OF MAINTAINING OR CHANGING THE MATP DELIVERY MODEL, INCLUDING FINANCIAL AND SERVICE PROVISION IMPLICATIONS



: "An analysis of the positive and negative impact of maintaining
 : the current transportation delivery model versus implementing a
 : full-risk brokerage model as it relates to the State and local
 : government entities, including financial impact."
 :

—Section 443.12 (E)(4)

This section provides an analysis of maintaining the in-house county models versus implementing the proposed broker model. The fiscal impact analyses estimate the potential impacts on different programs as a result of the switch.

THE COUNTY MODEL (IN-HOUSE)

Currently, the Commonwealth receives its MATP authority from its State plan, and all counties use an in-house MATP model except for Philadelphia County, which uses a broker. Subject to state oversight, the county has operational responsibility for MATP, including systems, coordination, and reporting, as described in Section 3 of this report.

Counties maintaining MATP can coordinate with other HST rides and increase the efficiency of all interrelated programs by appropriately combining their funding, assets, and efforts, as described in Section 2 of this report.

MATP coordinators have the authority to develop additional standards to those established by DHS and may use county-specific processes when administering the MATP benefit. This flexibility enables unique but inconsistent county models. Some counties, however, have joined together to balance county independence while sharing responsibilities and synchronizing policies and procedures. These groups foster cost-savings for the counties by leveraging pooled resources and consolidating potentially redundant MATP positions, systems, or processes. These initiatives include:

- Central Pennsylvania Transit Authority (CPTA), a municipal authority (ten counties in south-central Pennsylvania) doing business as rabbittransit.
- South Central Transit Authority, Berks and Lancaster County.
- Area Transportation Authority of North Central Pennsylvania, specific to MATP county profiles: Cameron, Elk, and McKean County.
- BeST Transit servicing Bradford, Sullivan, and Tioga counties.
- Call-A-Ride Service, with Juniata and Mifflin counties.
- STEP with Clinton and Lycoming counties.
- LANta/Carbon County Community Transportation with Lehigh, and Northampton counties.
- TREHAB with Susquehanna and Wyoming counties.

Outside of the multicounty initiatives, the remaining counties have separate programs that lead to each one replicating the work, positions, and eligibility verification required by MATP in each county. In some counties, the MATP and HST coordinating staff and departments are the same. Within the work of administering the program, each county group must also understand and implement the Standards and Guidelines around the program.

Converting to a broker system would decrease DHS's oversight monitoring load from 57 county programs to overseeing two or three brokers in more detail.

For in-house counties, DHS performs semi-annual compliance monitoring, using a review instrument based on MATP guidelines, policies, and regulations. This oversight also includes reviewing time studies for applicable counties. The volume and differing operating models among the various entities to review has made oversight more complex.

Converting to a broker system would decrease DHS's oversight monitoring load from 57 county programs (some MATP grants combine county reporting) to overseeing two or three brokers. Consistent processes within a broker, even though it may cover several counties and require more depth, should make oversight easier through uniformity and fewer points of contact.

Judicious oversight is critical to preventing the kinds of FWA seen in other states.³⁶ Echoing these concerns, the Government Accountability Office in 2016 reported, “According to CMS officials, state Medicaid officials reported that Medicaid claim reviews revealed that NEMT providers overbilled and documented trips poorly and that overpayments tended to occur more frequently in states that delegate NEMT responsibility to counties where officials may not be familiar with documentation requirements.”

The Commonwealth has already experienced a disallowance of federal funding by CMS over NEMT cost allocations, as described in Section 2 of this report. As reported by DHS, since implementing a new cost allocation methodology approved by CMS, and in use by the counties, DHS oversight in recent years has found few financial or compliance issues with MATP.

Funding for the in-house MATP comes from the DHS budget and allocations. Across all counties, the total amount of MATP funding is capped (the last time the cap was reached was in SFY 2012). Counties submit budgets to DHS, which uses them to forecast allocations delivered through public assistance block grants to the county. Throughout the year, DHS reviews quarterly cost reports and adjusts those allocations. If a county has an MATP funding deficit or surplus, then the county submits a revised budget to DHS for review. If DHS approves the revision, then they adjust the county’s allocation for any differences. That means each counties’ final allocation always matches their final expenditures.

Each counties’ final allocation always matches their final expenditures. When funding follows expenditures exactly, it resembles a FFS environment.

When funding follows expenditures exactly, it resembles a FFS environment. Traditionally, states paid Medicaid’s medical providers directly through FFS. If the provider can generate profit under FFS rates, then this arrangement has little utilization management or accountability of providers, leading to potential overutilization, whether mostly unintentional or in a few cases, fraudulent.³⁷ Through the mid-1980s and 1990s, Medicaid FFS programs experienced rapid cost growth and moved away from FFS to a managed care environment where MCOs are paid under capitation

³⁶ CMS, “Medicaid Non-Emergency Medical Transportation Booklet for Providers,” available at <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf>, accessed 3 October 2019.

³⁷ Society of Actuaries, “Provider Payment Arrangements, Provider Risk, and Their Relationship with the Cost of Health Care,” available at <https://www.soa.org/globalassets/assets/Files/Research/Projects/research-2015-10-provider-payment-report.pdf>, accessed 12 November 2019.

arrangements.^{38,39} Now the majority of states use Medicaid managed care models.⁴⁰ Similar to MCOs, a broker paid capitation would also be encouraged to gain cost efficiencies.

THE REGIONAL BROKER MODEL

A broker is usually a specialized vendor contracted by a state to coordinate the entire NEMT benefit for all the counties in the region, and depending on the federal authority used, awarded through competitive procurement.

DHS outlines the MATP standards for brokers in RFA 28-18. These standards are similar to those applicable to the in-house program. These standards include the window for picking up and dropping off consumers, and the types of rides covered. RFA 28-18 also includes performance measures with associated financial assessments for failure to meet these standards, including trip punctuality, call center performance, and timely payments. While both in-house and broker standards require driver clearances, only the RFA has specific language around vehicle standards and semi-annual inspections. Vehicle inspections and maintenance compliance occur for public vehicles purchased with federal funds regardless of the MATP model.

DHS outlined the MATP standards for brokers in the RFA 28-18. These standards align with the current program, so access and performance standards will be similar between the present and proposed models.

Funding for a broker is a per member per month capitation rate. That means payment is made for all eligible MATP consumers regardless if they use the services or not. This capitation arrangement is a system of averages and is standard for at-risk insurers in Medicaid (in some states, MCOs are the NEMT coordinator), Medicare, and is akin to other insurance markets where a transfer of risk is involved. Similar to Medicaid managed care models, a capitation arrangement is expected to result in lower costs due to the appropriate management of healthcare services by the MCO. Capitation payments are developed for a future period, so the broker will not be paid more for increased trips, only more consumers becoming eligible for MATP. Therefore, the

Similar to Medicaid managed care models, a capitation arrangement is expected to result in lower costs by the appropriate management of health care services.

³⁸ American Academy of Actuaries, "Medicaid Managed Care: Savings, Access and Quality," available at https://www.actuary.org/sites/default/files/files/publications/Pub_Pol_Monograph_Medicaid_Managed_Care_Savings_Access_Quality_960401.pdf accessed 13 November 2019.

³⁹ MACPAC, "Annual Growth in Medicaid Enrollment and Spending," available at <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-9.-Annual-Growth-in-Medicaid-Enrollment-and-Spending-FYs-1977%E2%80%942017.pdf>, accessed 13 November 2019.

⁴⁰ Kaiser Family Foundation, "Medicaid Managed Care Market Tracker," available at <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>, accessed 26 September 2019.

broker incentive is to prevent, or reduce if they exist, unnecessary or overly expensive trips because the capitation payment is static until the rates paid are reevaluated (usually on an annual basis by actuaries).

Brokers will have an incentive to control costs. RFA 28-18 requires brokers to use cost-effective public transportation for their consumers whenever possible, which would continue to contribute that portion of revenue to HST efforts.⁴¹ The broker's continued use of public paratransit is more difficult to gauge and will be influenced by the availability of it. The broker may also leverage their regional MATP membership and Medicaid restrictions and try to negotiate lower than public rates, or unsustainable premium trip rates with the local transit authority, which may lead to leading to the transit authority to refuse all contracts with the broker.

A regional broker can centralize and consolidate its administrative work, generating savings from economies of scale. The net savings could be smaller than expected because some counties have overlapping MATP staff and resources with their HST coordination (counties with time studies), which would persist without their MATP work.

A regional broker would centralize and consolidate administrative work.

Through the broker model, there are some key areas of risk to understand, which are covered here:

Utilization Risk

Commonwealth transfers utilization risk to the broker through the capitation rate. Currently, with the in-house model, the number of trips and the amount reimbursed to the coordinator from DHS are one-to-one. If the provider makes more trips, the county reports more trips and DHS pays for more trips. This structure creates FWA opportunities, as previously mentioned. Using a full-risk broker transfers that risk from DHS to the broker since the broker will not be paid for more trips. The number of trips and the amount of reimbursement from DHS are now independent for the rating period. The FWA potential still exists, but the short-term negative payment effects stop at the broker because the capitation rate is already fixed for the rating period. Any unnecessary trip comes out of the broker's bottom line, which is a strong incentive to prevent them. DHS will continue its oversight of unnecessary trips too. The number of trips that do happen during the rating period will then be used to inform the capitation payment for future rating periods. RFA 28-18 does have risk mitigation for substantial and sustained changes in the volume of rides caused by changes in the program design.

Quality Risk

Related to utilization risk, and due to capitation being a fixed payment, brokers may be tempted to cut corners to save money. Quality measures are essential to any full-risk arrangement to offset this

⁴¹ SFY 2016 MATP data from DHS shows that mass transit was about 11% of MATP trip dollars. In the same data, the average trip cost for mass transit was approximately \$2.60, and \$22.00 for paratransit.

behavior. If the broker covers a multicounty area, aggregate regional statistics may overlook quality subtleties in a specific county or demographic. Carefully monitoring brokers' quality at a granular level helps to ensure that access and consumer satisfaction are maintained throughout the region.



For example, the region's total may show average rider wait times are acceptable, but county subtotals reveal the broker is incompliant in a specific county.

Pricing Risk

Pricing risk comes from the capitation rates being potentially too high or low. Insurance risk comes from the volume and distance of MATP rides being more or less than forecasted. These considerations could lead to the broker making excessive profits or jeopardizing their solvency — and subsequently, the entire MATP. As the program matures, experience data will help reduce pricing risks (this may take two to three years). To protect all parties, the Commonwealth may consider risk mitigation arrangements. These arrangements limit the profits or losses of a broker based on performance metrics, such as the percentage of the capitation the broker spent paying for rides versus other costs, similar to minimum medical loss ratios (MLR) for MCOs. RFA 28-18 does not have an MLR-like arrangement.

Operational Risk

Operational risk includes how smooth the transition is from counties to regional brokers. That consists of the handling of consumers' already scheduled rides and readiness in systems and provider networks. It should be noted, RFA 28-18 requires the education of consumers and readiness reviews of selected brokers to ensure they can meet the requirements. If selected, brokers must follow their implementation work plan that was submitted as part of their application.

Lastly, there is the risk that the broker fails to uphold its agreement. Currently, in-house counties also pose this risk, but it is limited to a single county versus a region. Broker failure may be due to noncompliance with reporting, inability to perform critical functions, or insolvency as a risk-bearing entity. The departure of a broker would be a sudden disruption to many consumers.

FISCAL IMPACT

Several counties and groups like public transportation providers, the Pennsylvania Public Transportation Association (PPTA), and CCAP have opposed RFA 28-18 because it will introduce a

third-party player into the HST coordination efforts.^{42,43,44,45,46,47,48} Their concern is that if brokers remove revenue from public transportation, the fares of other HST consumers have to rise to cover the lost funding, or access will be reduced proportionally to compensate for lost revenue. They also expressed concerns that taxpayers might have to contribute more to replace the decreased funding and that higher fares or reduced access would then further discourage consumers from riding, leading to a negative feedback loop in fare hikes and reduced access. Finally, they were concerned that federal transit funds for the Commonwealth would also decrease because of appropriation formulas correlated with factors such as trip volumes.

Public transportation falls into two general categories: fixed-route public transportation, and demand response paratransit. Fixed-route transit, like buses, trains, and subways, can accommodate additional consumers at minimal marginal cost, making it one of the least expensive ride options available. Brokers will likely increase, or keep steady, the volume of MATP consumers they direct to this option. Fixed-route transit may gain from, or at least be insensitive to, the introduction of a broker.

Paratransit is more dynamic and flexible than fixed-route. These cars, vans, or taxis deliver curb-to-curb service and require coordination to maximize the number of people they can serve with the fewest trips. The tradeoff is that additional riders make coordination more complex than single rides. Also, the length of the ride increases for the first consumer picked up, and the last consumers

⁴² Judith Higgins, “OP-ED: Put Brakes On Public Transit Plan,” available at <https://www.yorkdispatch.com/story/opinion/contributors/2019/07/01/op-ed-put-brakes-dismantling-public-transit-plan/1616571001/>, accessed 27 September 2019.

⁴³ Jeff Eggleston, “Stop The Privatization of MATP in PA,” available at <https://www.change.org/p/tom-wolf-stop-the-privatization-of-medical-assistance-transportation-programs-matp-in-pa>, accessed 27 September 2019.

⁴⁴ Kristina Shalhoup, “Lackawanna County and COLTS Taking A Stand Against Privatizing MATP,” available at <https://www.pahomepage.com/news/lackawanna-county-and-colts-taking-a-stand-against-privatizing-matp/>, accessed 27 September 2019.

⁴⁵ Matthew Rink, “Erie-Area Lawmakers Want Changes to Medical Transportation Program Delayed,” available at <https://www.goerie.com/news/20190130/erie-area-lawmakers-want-changes-to-medical-transportation-program-delayed>, accessed 27 September 2019.

⁴⁶ Sarah Cassi, “Change Is Coming For People Who Need Riders To Medical Appoints, And LANTA Is Worried,” available at <https://www.lehighvalleylive.com/news/2019/02/change-is-coming-for-people-who-need-rides-to-medical-appointments-and-lanta-is-worried.html>, accessed 27 September 2019.

⁴⁷ Richard Farr, “Rabbitransit Fears State Change Will Result In Less Service While Costing The State More,” available at <https://www.ydr.com/story/opinion/2019/04/22/rabbitransit-fears-state-change-mean-less-service-higher-costs/3541521002/>, accessed 27 September 2019.

⁴⁸ PPTA, “Impact of Brokerage of Medical Assistance Transportation Program,” available at http://www.ppta.net/pdf/MATP/MATP_Issue_Presentation_3-11-19.pdf, accessed 27 September 2019.

dropped off depending on the order and clustering of destinations. The primary purchasers of public paratransit services are MATP, SSRP, PwD, and ADA Complementary Paratransit.

Paratransit providers earn funding from many sources, the two largest being MATP, and the SSRP. From SFY 2019 data provided from the statewide shared-ride scheduling software, MATP was approximately 34% of trips and 32% of all fare revenue for the shared-ride public transportation service, representing about \$36.3 million in funding. These figures exclude Allegheny and Philadelphia County because they use different scheduling systems.

The portion of this revenue which remains with public transportation after a broker change would be proportional to how engaged the broker stays in HST coordination.

Of the SFY 2019 estimates (\$114.1 million) quoted in the Introduction Section, it is estimated MATP would fund statewide paratransit roughly \$88.8 million in trip costs (estimating 3.7 million statewide paratransit trips at approximately \$24 per paratransit trip). 65% of these trips valued at approximately \$57.7 million are outside of Philadelphia County (already under a broker model). The portion of this revenue that remains with public transportation after a broker change would be proportional to how engaged the broker stays in HST coordination.

To illustrate this proportionality concept, if brokers hypothetically retain 60% of paratransit rides with public transportation outside of Philadelphia County (what this number would be under RFA 28-18 is unknown), and fixed-route trips remain the same, then approximately \$23.1 million will be removed from county budgets in total.⁴⁹ For some counties, their portion of that loss would strain the solvency of their county transportation program.

Increased Federal Share

The expenses for competitively procured brokers are eligible for more federal financial participation than the current administrative match. Under the in-house model, DHS obtains a 50.0% match on MATP expenses because these costs must be classified as administrative costs. Under a competitively procured broker, the costs can be claimed as medical, which increases the FMAP amount to an average of 63.6% (a blend of both the standard medical and enhanced ACA Adult Expansion medical FMAP). The portion paid by the federal government would grow while the Commonwealth's share shrinks.

⁴⁹ This 60% is the rounded compliment to Texas reporting approximately a 41% reduction in rural transit NEMT ridership and revenue after they implemented a broker, and as reported in the "Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokers on Transportation Coordination B-44." What this number might be for Pennsylvania under RFA 28-18 is unknown.

Mercer has previously measured the fiscal impact of the proposed MATP broker model for DHS. SFY 2016 data included county invoices for MATP and expense reports from the broker in Philadelphia County. This data was converted to per member per month rates and projected to SFY 2021 by forecasting membership, trip costs, and trip utilization.

Non-benefit expenses like administration and the underwriting gain component were included to create regional broker rates to compare to county expenses on the same projected basis. The results were that DHS, on the NEMT portion of RFA 28-18, would have a net savings of approximately \$13.6 million in SFY 2021 driven by enhanced FMAP.

Net savings to DHS of approximately \$13.6 million in SFY 2021 driven by enhanced FMAP.

RFA 28-18 outlines that brokers will also manage the non-medical transportation benefit CHC-MCOs currently cover. These costs will not change the FMAP because they will continue to be claimed as medical expenses. CHC-MCOs' capitation payments already include an underwriting gain component, therefore transferring the responsibility to MATP brokers is expected to create no new costs.

Second-order Medical Effects

Social Work in Public Health published a 2014 article, "Nonemergency Medical Transportation and Health Care Visits Among Chronically Ill Urban and Rural Medicaid Beneficiaries." The researchers looked at Medicaid data from the Oklahoma Health Care Authority for NEMT effects. Adult members with a primary diagnosis of asthma, heart disease, or hypertension were separated into urban and rural areas and those who did or did not use NEMT. For all three conditions, in both urban and rural settings, users of NEMT services had a higher probability of meeting the number of required visits for preventative care.

Regardless of the in-house or broker model, there is value in promoting the use of MATP to Medicaid consumers.

Then in the 2017 *HealthAffairs* article, "Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?" cited "The cost to rural communities of 'foregone medical trips' was estimated to be between \$4.16 and \$6.65 for every dollar spent on transportation." A third study by the *Medical Transportation Access Coalition* (2018) also affirms medical savings if consumers have access to and use NEMT.

These studies highlight the return on investment for states, which provide transportation access to their Medicaid consumers. It is unknown if the same return exists for consumers only using HST. Regardless of the in-house or broker model, there is value in promoting the use of MATP to Medicaid consumers. Section 5 will cover how the change to a broker may affect MATP availability.

Impact on Employment

FTE is a measure of how many employees it might take to perform the work of a project. For MATP administrative work, there are an estimated 150–200 FTEs across the Commonwealth based on

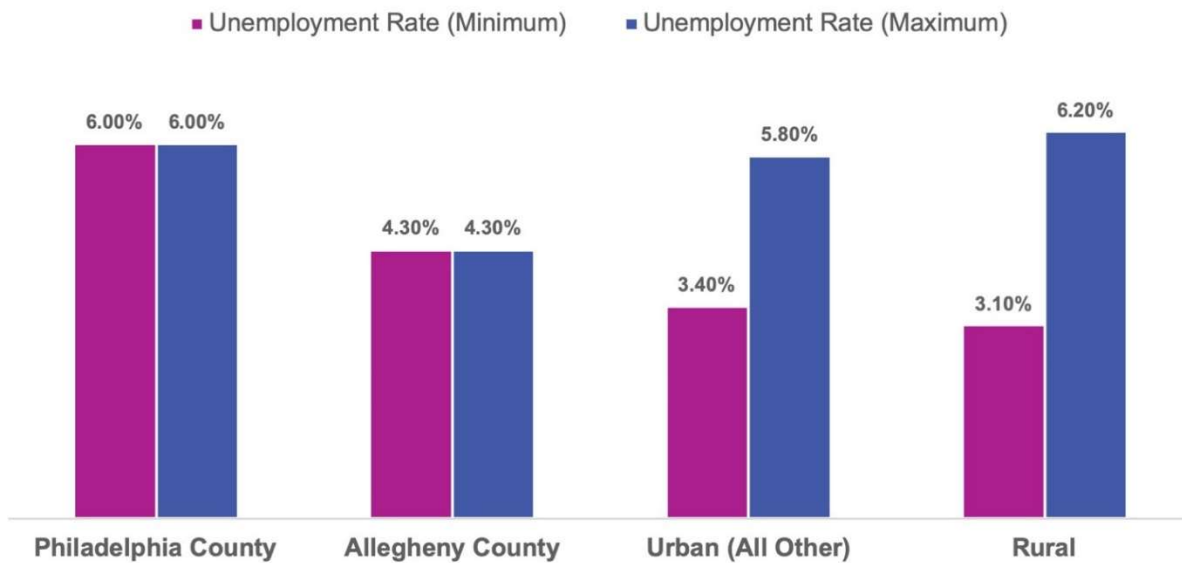
SFY 2017 Key Indicators provided by DHS that show a budgeted estimate of six million for staff wages (excluding benefits). The full impact of the broker model on FTEs is impossible to estimate, and any estimate would need to be based on speculation concerning both the direct impact, as well as the downstream effect of a broker model. With a shift to a broker model, some of these jobs may be eliminated if the worker’s only responsibilities are MATP-related. The broker model may replace some of these positions, but MATP staff may also be HST staff, so that county staffing could remain similar, but without the MATP revenue and work. The FTE estimate does not include the loss of jobs from public or private transportation contractors who may lose business as well.

If a transportation provider has to cut dispatchers and drivers because of lost MATP revenue, there will likely still be demand for those skills. PennDOT has mentioned recent driver shortages in Pennsylvania, and the US Bureau of Labor Statistics (BLS) shows the Commonwealth’s unemployment rate is at a 20-year low as of mid-2019. Therefore, opportunities for employment should exist. As an example, the broker is required to establish a Customer Service Center within their region, creating new job openings. However, the skills of the prior county workers and drivers may or may not translate to the brokers’ or other transportation providers’ positions. Total compensation replacement for impacted workers may or may not be at the same level as in their current positions.

However, the skills of the prior county workers and drivers may or may not translate to the brokers’ or other transportation providers’ positions. Total compensation replacement will likely be short.

This table shows the range of unemployment rates during August 2019, as reported by the BLS.

AUGUST 2019 BLS UNEMPLOYMENT RATES



As noted previously, the full impact of the broker model on FTEs is challenging and speculative to estimate because of the subsequent downstream effects it may have on workloads and budgets. It is near impossible to determine the total impact of a broker model on providers, counties, or the Commonwealth, because of the intertwined and cascading effects of broker engagement with HST, local transit reactions, consumer behavior, secondary-medical effects, and FTE impacts.

We do know there is an estimated \$13.6 million in DHS savings. To demonstrate sensitivity, 24% of the estimated \$57.7 million SFY 2019 non-broker MATP paratransit funding, from the start of this section, is \$13.8 million. While it is unknown if there will be broker disengagement from HST, or how much, this would be an offset to the estimated savings and might lead to a net loss for the Commonwealth based on Fiscal Impact concerns from earlier in this section.

STAKEHOLDER INPUT — GOVERNMENT ENTITIES

An important component of this legislative analysis is stakeholder input from those entities that will directly feel the impact of a change to the delivery model. As discussed in the Introduction Section, Mercer worked closely with the Workgroup to assess and evaluate available information and issues, which could impact both the Commonwealth from an operational perspective, as well as consumers. In addition to Workgroup input, Mercer participated in stakeholder meetings to gain perspective directly from those close to the issue. While the specifics related to the stakeholder engagement are presented in this section of the report, it is important to note that the feedback and insight gained during the stakeholder meetings have helped shape the considerations presented thus far in this analysis. For completeness, in this section, we summarize the Workgroup's interpretation of the discussions. Consumer stakeholder input is in Section 5.

County Commissioners Association of Pennsylvania



On October 3, 2019, a subset of the Workgroup met with the CCAP. Their attendance represented 26 counties. Three primary themes came from our discussion.

First, many commissioners were caught off-guard by the initial Act 40 of 2018 legislation, which required the issuance of a competitive procurement for MATP broker services. All commissioners that shared their opinions believed the passage of Act 40 of 2019 was not based on a thorough review of the program and would ultimately hurt the people of the Commonwealth.

Second, all commissioners who spoke were passionate about the work they have put into what they view as their efficient transportation program, which serves the public, including MATP and HST consumers. There was grave concern about how much MATP funding and ridership might be lost

from their program if a broker model is implemented and the broker disengages from public transit. Commissioners were quoting losses between 40–60% of both.

Lastly, was the theme of local rapport (which will be discussed more in the next section on consumer impacts). The counties' tenure of being the MATP coordinator has built trust with their consumers. Their concern was that a broker would disrupt consumers' care during the program transition and would create continued disengagement from consumers' local needs because the broker is a private company operating at a multicounty level.

Overall, CCAP strongly opposes the broker model.

Pennsylvania Public Transportation Association



On October 8, 2019, a subset of the Workgroup met with PPTA. Their attendance represented mainly those working for or closely with local transportation authorities from around the Commonwealth and other transportation providers. The PPTA had similar concerns as the CCAP over the financial consequences of removing MATP revenue and ridership from local transportation providers. PPTA was quoting losses between 30–60% of both. According to PPTA, the result may be a need to increase fares or limit operations, including shutting down public transportation in some counties. Again, rural counties were the most dependent on the MATP revenue.

The PPTA expects the potential brokers to be shrewd in what options they give consumers, and transportation coordination and quality will decrease. There were concerns that brokers will bifurcate MATP from the rest of HST, which will make it impossible for MATP consumers to one-stop-shop their MATP and non-MATP trips.

The group also explored other states' experiences with broker models, including Texas and South Carolina. The PPTA Executive Director had been part of the Texas transition to an NEMT broker and offered insights from a consumer, provider, and policy perspective about the change, which expanded on the Texas findings in Section 3 of this analysis.

Mercer inquired about staff impacts, as PPTA estimates 800 layoffs from the potential change. Both the CCAP and PPTA have communicated the loyalty of their coordinator and public transportation employees, and feel the broker will lack that type of care and trust towards consumers. Unemployment rates were discussed, but the issue identified wasn't about the employability of laid-off employees, but rather their lacking options for compensation replacement (i.e., employees may not be able to attain similar levels of compensation in new positions).

Overall, PPTA strongly opposes the broker model.



SECTION 4 KEY OBSERVATIONS



- ✓ Some counties have joined together as municipal authorities, or multicounty groups, which balances county independence while sharing resources and synchronizing policies and processes.
- ✓ DHS performs semi-annual compliance monitoring. Converting to a broker system would decrease DHS' oversight load, allowing them to invest in more in-depth reviews.
- ✓ Funding for the in-house MATP comes from the DHS allocations, and each counties' final allocation always matches their final expenditures. This arrangement has little utilization management or accountability of providers, leading to potential overutilization.
- ✓ Funding for a broker is a capitation rate paid per member per month. This arrangement is expected to control costs as brokers will have an incentive to appropriately manage utilization.
- ✓ Due to capitation being a fixed payment, brokers may be tempted to cut corners to save money. Quality measures are essential to any full-risk arrangement to offset this incentive.
- ✓ A regional broker would centralize and consolidate some administrative work. Counties may have overlapping MATP staff and resources with their HST coordination, which would persist without their MATP work.
- ✓ The potential exists for brokers to remove revenue from other public transportation programs, but it is difficult to ascertain to what extent and the effect the removal may have on other HST consumers.
- ✓ The potential costs and savings, to the Commonwealth in total, from transitioning to a broker model cannot fully be quantified due to the tangential impacts and downstream effects (e.g., unknown impact for the employment-related losses, unknown impact for increases in second-order medical costs, and unknown impacts on public transportation programs) that would not be fully understood until potentially years after implementation.



5

POTENTIAL IMPACT ON CONSUMERS, INCLUDING QUALITY AND SERVICE AVAILABILITY



"An analysis of the impact on consumers, including an increase or decrease in quality and service availability."

—Section 443.12 (E)(5)

This section looks at the current quality of the MATP program through the use of survey results, which show generally high satisfaction levels. Consumer complaints indicate most issues are with the drivers and trips themselves and less with the administrative MATP coordinator. Also explored are the potential broker impacts on public transportation.

SATISFACTION OR COMPLAINTS

People perceive quality differently. Some see it as what they receive versus what they paid. Others see it as experience over expectation. The quantification of quality is difficult. One approach is to look at satisfaction or complaint data. These next subsections summarize the experience consumers have had with MATP from different periods, counties, and models. Though it is difficult to draw direct comparisons between the various sources, they do offer varying points of view of the historical MATP. In total, MATP from a consumer standpoint seems to be in a satisfied and stable state, with some expected complaints.

Department of Public Welfare 2010 Survey

In 2010, the Department of Public Welfare (now DHS) sent an MATP survey to approximately 18,000 eligible consumers (excluding those residing in Philadelphia County). Of the respondents (5,126), about 75% were users, and the remaining 25% had not used services but were eligible for rides. Approximately 18% of users had experienced a denied trip. Of the non-users, 60% said they were unaware of MATP. Of the sampled consumers, 86% rated their experience as good or excellent.

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LogistiCare (2016–2018) Reports

LogistiCare is the only broker currently operating in MATP. The Commonwealth provided LogistiCare reports with performance metrics, including complaints and customer satisfaction. The three most recent complete years of data were analyzed (2016–2018). MATP trips in Philadelphia County, based on these reports, are roughly 74% mass transit, 25% paratransit, and 1% mileage reimbursement. For consumers only (over 50,000 a year), the average complaint per 1,000 trips was 1.3 across all MATP trip types. Average customer satisfaction was around 90%. Overall, both complaint and satisfaction trends were flat across time, with some periods of low or high complaints.

Average customer satisfaction was around 90%.

Central Pennsylvania Transit Authority (CPTA) 2018 Survey

CPTA, or rabbittransit, surveyed around 3,000 of their 11,200 current and past consumers in 2018. Note, rabbittransit serves more than MATP consumers. Of their respondents (989), approximately 65% were recent riders, and 35% were former riders. Around 49% of consumers have been riders for more than three years, and 84% of consumers for over one year. Of recent riders, 20% responded as having filed at least one complaint, and of that subset, 81% felt the transit authority resolved their issue. Of the former riders, 3% responded they would not use CPTA's paratransit services again. The demographic majority for both groups were women over the age of 40. Of the recent riders, 94% were satisfied or very satisfied overall.

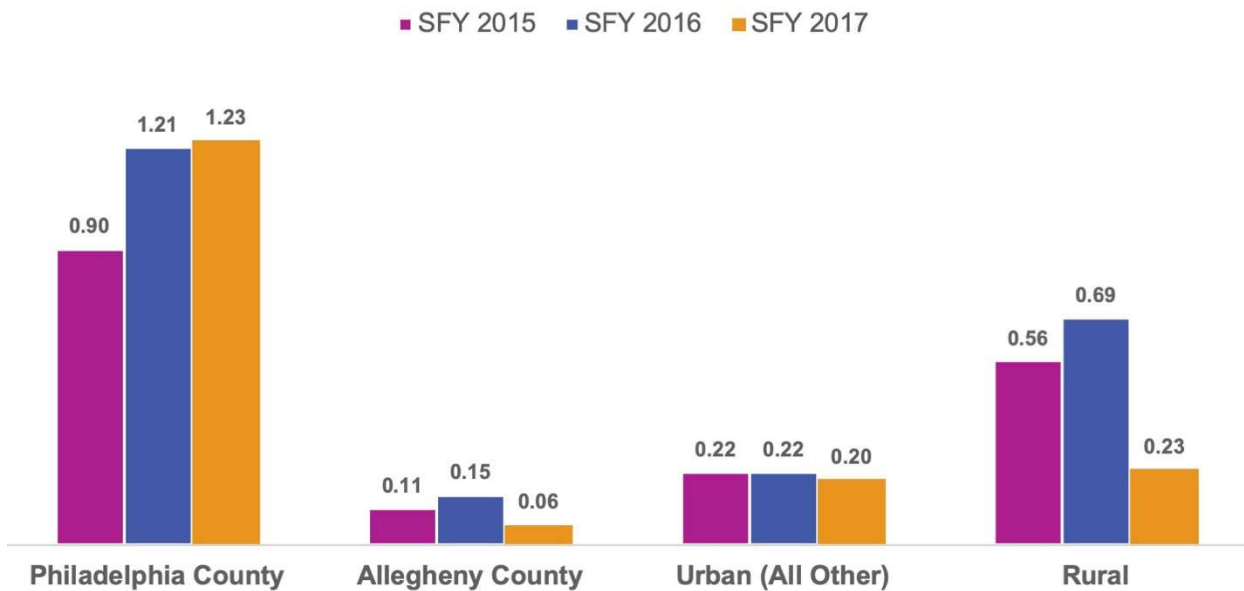
Of the recent riders, 94% were satisfied or very satisfied overall.

Complaints Summary

DHS provided three years of reported complaints for all counties. The MATP Standards and Guidelines, the non-solicitation grants, and DHS's agreement with LogistiCare all have an outlined complaint process that requires written documentation of the complaint, levels of review, and copies of the complaints and responses to the consumer. MATP coordinators send their complaint data to DHS as part of regular reporting.

Mercer removed any complaints MATP coordinators labeled as from drivers about riders (dominated by rider no shows). The following table shows only consumer complaints per 1,000 trips of any transit mode.

CONSUMER COMPLAINTS PER 1,000 TRIPS



Roughly half of the counties reported the nature of their complaints. From that data, the significant theme was late providers, followed by no show providers, and provider behavior (including reckless driving). A smaller set of other complaints included wrong vehicle accommodation, issues with other riders, scheduling hardships, and difficulty getting out of county trips.

The MATP coordinator, whether in-house or broker, has a limited influence on the drivers. By requirement, the coordinator has driver screenings, necessary training, and monitoring. It is likely some mix of consumer expectations for quicker results (as demonstrated by other service industries) mixed with the constraint of transportation resources, which led to the complaint of tardy rides.

USE AND AVAILABILITY

MATP Statistics and Medicaid Expansion

The RFA 28-18 Statewide Databook reflected around 9.3 million MATP trips in 2017. The Databook also offers historical data for 2013 through 2017. Those years of data show on average near-zero growth in trips while the number of eligible consumers continues to grow, leading to an overall reduction in MATP utilization per eligible consumer.

The RFA 28-18 Databook showed the number of MATP trips taken remained flat over 2013 through 2017. That means these members are using MATP as much as, or less than their legacy peers.

With the election of Governor Wolf, the Commonwealth implemented a Medicaid expansion program in 2015 under the ACA. This expansion increased Medicaid eligibility for adults with a

household income of up to 138% of the federal poverty level. In 2019, approximately 700,000 newly eligible consumers enrolled in MA, which also increased the number of available consumers for MATP.⁵⁰ As noted, the RFA 28-18 Databook showed the number of MATP trips taken remained flat over that period of expansion.

Availability Impact

Although the exact effect on public transportation is difficult to ascertain, the switch to a broker has the potential to result in raised public fares, reduced hours, smaller service areas, or fewer fixed-routes for public transportation. The MATP consumer will be insensitive to fare changes for medical trips because Medicaid will pay for these trips. However, same consumer may also use these transportation services for non-MATP trips. In this case, they would be like other non-MATP riders and affected by the higher fares.

The Kaiser Family Foundation has documented several studies where increased medical copays significantly change Medicaid consumers' behavior, mainly by reducing their consumption.

Higher fares can change consumers' behaviors. The Kaiser Family Foundation has documented several studies where increased medical copays significantly change Medicaid consumers' behavior, mainly by reducing their consumption. Higher fares to a Medicaid consumer could have a similar effect as the medical copays because the additional expense can act as a deterrent to service consumption. MATP consumers may take less non-MATP trips, increasing the level of lost revenue for public transportation providers. It is unknown if this phenomenon would materialize, but stakeholders have expressed concerns about this negative feedback loop that could occur.

Under a broker model, MATP consumers will retain access to providers because RFA 28-18 has the same standards of medical access as the current MATP guidelines. MATP consumers have the most flexibility in access if their trip is deemed urgent by the medical provider, which may require the coordinator to negotiate a unique trip with any transportation provider. Non-urgent trips serviced by public transit are within the constraints of the county's public transportation hours. If those hours are reduced as a byproduct of a broker change, then the MATP consumer may experience the limitations on both MATP and non-MATP trips. Currently, if an MATP consumer needs a trip before or after normal hours, the MATP coordinator will accommodate. And if that ride is provided by a public transportation provider and is beyond what is available to the public, it results in a premium trip (which is different from urgent trips, but urgent trips may also result in a premium trip). In some cases, the coordinator may determine that is the most cost-effective option versus a trip provided by a non-public transportation provider. Note, premium trips are defined under the current MATP

⁵⁰ DHS HealthChoices, "Total Number of Individuals in HealthChoices Due to MA Expansion," available at http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_281477.pdf, accessed 30 September 2019.

Standards and Guidelines. With brokers, it is likely transit providers will have similar rate negotiations for uncommon and special circumstance trips.

Similarly, if an MATP consumer needs a trip longer than what is available to the public, then a premium trip occurs. This situation is typical for out of county destinations, but could also occur in the county. In rare cases, the MATP coordinator may deny the trip, but would likely send the consumer to the County Assistance Office for “exceptional transportation.”⁵¹ Complaint data shows some consumers have trouble scheduling out of county trips, but it is an uncommon complaint compared to late and no show drivers. A broker operating within its region would be accommodating because of their consistent presence within the region, but some consumer complications could be experienced.

If MATP consumers are frustrated about MATP scheduling and access (regardless of MATP model), they may forgo their MATP trips to receive preventive medicine. In doing so, their controlled condition becomes unstable, and they could end up hospitalized. Before reaching instability, some MATP consumers may opt to substitute their difficult-to-schedule MATP rides with costly emergency (i.e., 911) ambulance trips.

Point of Contact for Consumers

Consumers in some counties have been able to call one number to coordinate both MATP and non-MATP rides. With a broker, all MATP requests will be a number to the broker, and the county number remains for all other HST. Stakeholders have expressed concerns this change may confuse consumers and require educating them on the update. It should be noted that RFA 28-18 does require consumer education, which would eliminate this issue if successfully implemented. The broker will have a consistent regional presence, which may help in cases of consumers moving between counties within the broker’s region, but less so if they move into a different broker’s region.

One phone number to coordinate both MATP and non-MATP rides may not be feasible under a broker model.

Some confusion exists already with CHC-MCO members who call one number for MATP, and then a separate CHC-MCO number for their non-medical transportation. Stakeholders involved with CHC gave an example that sometimes a member calls both the CHC-MCO and MATP, and then uses the ride that comes first, duplicating services. Moving to a broker would combine the MATP and non-medical call-in numbers but would then split other HST into a separate call.

Local Rapport

Regular consumers of MATP have a routine and an idea of what to expect when calling, seeing their ride come, and interacting with their driver. Stakeholders have expressed concerns that changes to who’s answering the new number, whose logo may be on their new ride, and who their new driver is

⁵¹ DHS, “Medical Services Included in MATP,” available at <http://matp.pa.gov/MATPServices.aspx>, accessed 30 September 2019.

could all be unexpected. If overwhelmed enough, consumers may be discouraged from using MATP as described before. Patients requiring regular treatments to manage chronic conditions are most at risk for any disruption. It could deteriorate their condition, becoming an emergency instead of routine preventative care.⁵² A well-thought-out transition plan must be in place to communicate to consumers the upcoming changes. As noted previously, RFA 28-18 requires the education of consumers and readiness reviews of selected brokers to ensure they can meet the requirements. With a successful transition, these concerns would likely be mitigated. Nonetheless, when exploring the potential impacts on consumers, these issues are important to recognize. The broker may eventually establish new patterns with consumers, but rapport takes time to build. Short or long-term disruptions are difficult to predict.

In discussions with DHS, they mentioned that rabbittransit had been able to take over and transition MATP coordination from counties successfully. One thought was that the successful transition might be due to rabbittransit being a known transportation provider with good branding in the area. PennDOT included that rabbittransit assimilated staff, vehicles, and other county assets over time for a smooth transition. The rabbittransit transitions demonstrate that MATP changes can happen without major disruption.

STAKEHOLDERS — CONSUMERS

Similar to the government entities stakeholder summaries in Section 4, for completeness, Mercer summarizes the Workgroup's interpretation of consumer feedback below. The issues raised by these groups shaped the considerations presented in earlier sections of this analysis.

Pennsylvania Health Law Project (PHLP)



On October 15, 2019, a subset of the Workgroup met with the PHLP. Their clients are Pennsylvania residents who have trouble accessing publicly-funded health care coverage and services. PHLP's Executive Director indicated that the primary areas of concern with the current transportation system are related to standards, accountability, and communication.

One theme was the consumer complaints regarding unpunctual MATP rides. Again, rural areas seem to be the most challenging. PHLP has reports from home health aides of frustrated MATP consumers who forgo MATP rides, and instead, use their aide to drive them to their destination. The Director also suspects MATP consumers who are upset or denied services are not able to obtain full

⁵² Rust G, Ye J, Baltrus P, Daniels E, Adesunloye B, Fryer GE. Practical Barriers to Timely Primary Care Access: Impact on Adult Use of Emergency Department Services. *Arch Intern Med*. 2008.

resolution of their complaints or that consumers may not be aware they can appeal. The hope is that one regional broker will streamline the system and result in a higher level of accountability, regarding both whom consumers can call with complaints, and with better DHS oversight.

PHLP shared feedback that consumers in CHC plans have difficulties identifying whom to call for MATP rides versus non-medical transportation. Combining these two services under the broker may ease that confusion. Besides these two benefits, PHLP hopes brokers can also coordinate any Medicare Advantage NEMT in concert with MATP and non-medical rides. Consumers are also looking for the broker to carefully communicate, educate, and transition consumers into the new model to avoid disruption of care.

Overall, PHLP is hopeful the broker model will bring needed changes to MATP to simplify and streamline transportation services.

Transportation Alliance with Pennsylvania Statewide Independent Living Council (PA SILC)



On November 13, 2019, a subset of the Workgroup met with the Pennsylvania Transportation Alliance on a call hosted by the PA SILC's Public Policy and Outreach Coordinator. Consumers and advocates expressed their concerns about the potential switch to an MATP broker. Over a dozen individuals spoke from counties across the Commonwealth, including urban, suburban, and rural locations. These consumers used a mix of MATP, SSRP, PwD, and ADA Complementary Paratransit, and received assistance from different agencies, with several securing funding from the Office of Long-Term Living. Some individuals were advocates for other groups of consumers, like Voices for Independence, Transitional Paths to Independent Living, and county Centers for Independent Living, among others. Themes from the call included ongoing transportation access, out-of-pocket costs, and driver competency.

Consumers were concerned that a broker might lack network adequacy, that no rides would be available for the days and times they need, and that they would miss medical appointments. They were concerned that missing these would lead to their doctors dismissing them as a patient for too many missed appointments. Other results of ride shortages could be destabilized health conditions because consumers would not get the care they need.

For both MATP and non-MATP users of shared-rides, they were concerned that a broker would cause public transit agencies to have to raise fares. Some consumers shared that they were on fixed incomes and that even a small cost increases in fares or copays would limit their transportation options. Some expressed that their ability to go places was critical to their quality of life.

Last, several consumers expressed concerns about whether the broker would hire and then train transportation providers in how to appropriately work with consumers that had either disabilities, mental health needs, or consumers needing door-to-door service beyond curb-to-curb. A few consumers cited the adverse broker experience in Texas and had concerns that the Commonwealth would have a similar outcome. Despite some challenges in the current MATP, most consumers felt the status quo was better than the unknown complications a broker might bring.

Overall, the Pennsylvania Transportation Alliance is opposed to the broker model.



SECTION 5 KEY OBSERVATIONS



- ✓ Survey and consumer complaint results from various periods and sources indicate generally high satisfaction levels with the current MATP program.
- ✓ Consumer complaints indicate most issues are with the transportation providers themselves and less with the MATP model.
- ✓ The overall number of annual MATP trips taken has remained flat in recent years while the number of eligible consumers continues to grow, leading to an overall reduction in MATP utilization per eligible consumer.
- ✓ MATP consumers would be insensitive to increased fares on medical trips, but would likely be negatively affected if fares rise for non-MATP trips. Any reduced hours of operation would likely impact both types of trips.
- ✓ Stakeholders have expressed concerns that the transition from the current model to a broker model could confuse consumers (different phone numbers, vehicles, and drivers). Frustrated MATP consumers may forgo rides, or substitute them with costly ambulance trips. RFA 28-18 contains requirements for transition and education, as well as the need to have an advisory committee to include consumers, advocates, and providers.



CONCLUSION

The analysis has covered a range of topics. Below are the high-level summary points for consideration:



Federal law allows states considerable flexibility in running their NEMT programs. A number of options with varying requirements and considerations exist for a state to increase its FMAP on NEMT expenses, including direct vendor payment under the State plan, brokerages, or managed care carve-in operated under 1915(b) waiver authority, and State plan brokerage authority. State plan brokerage authority is used in Philadelphia County today.



On a cost basis, the Commonwealth has an efficient NEMT program. Even outside of metropolitan areas, rural counties are keeping trip costs low.

Subject to DHS oversight, each county has the opportunity to vary how they run their MATP. Instead of dozens of county programs, DHS would benefit from the oversight simplification of a few regional brokers. Converting to a broker system and the corresponding decrease in the number of entities would allow DHS to conduct more in-depth reviews. RFA 28-18 would also be a solution to DHS's current use of non-solicitation grant awards.



States that switched to a broker model have had mixed results on savings at the NEMT level but less HST coordination on average. Beyond mixed results, several states have had significant negative issues, including broker terminations initiated from both the state or the broker.



The introduction of a broker risks a reduction in HST coordination. A potential consequence for public transit might be reduced revenue.

Competitively procured brokers will likely create savings for DHS. Partially through the higher FMAP, and partially through the brokers' incentive to

appropriately manage costs because of their capitated arrangement. DHS will transfer utilization risk to the brokers (with some risk mitigation built into RFA 28-18), but there will be new pricing risks as well in how the capitation rate is contracted versus actual outcomes.

Regardless of the model, NEMT is a cost-saving benefit to the Commonwealth. Oversight and quality metrics are critical to curtailing adverse incentives from either model (overutilization from in-house, or unjustified cost-cutting under broker capitation).



Any reduction to HST will likely be followed by negative impacts on MATP and non-MATP consumers. These populations are sensitive to price change and disruption to care.



Rural counties' geography and demographics will amplify most potential impacts discussed. Typically, their transportation budgets depend more on MATP paratransit funding.

In conclusion, the Commonwealth has a respectable MATP NEMT program. DHS, however, has concerns over the long-term viability of the way the program is currently structured and operated, and the broker model within the scope of RFA 28-18 is potentially one solution. Other states' broker experiences have been mixed. The current in-house county models have their advantages and disadvantages, and brokers bring unique advantages and disadvantages as well. From a fiscal perspective, DHS could save money with a broker, but county transit budgets could suffer proportionally to how much brokers disengage with other public transportation programs. Lastly, MATP and HST consumers are a mix of low-income, medically needy, and aged populations. These consumers will probably react poorly to a model change if it is unsuccessfully transitioned from the in-house model. MATP is multi-faceted and requires careful consideration of interconnected regulations, programs, and consumers.

DISCLAIMERS⁵³

Mercer has ongoing rate-setting engagements with DHS for various MA programs and developed a preliminary set of first-year MATP broker capitation rates for use by the Commonwealth before Act 19 of 2019 was enacted.

Act 19 of 2019 required the Workgroup to develop this analysis. The Workgroup asked Mercer to help with that task. The scope of this task is to fulfill the analysis as required by Act 19 of 2019.

This analysis is intended to be relied upon by the Workgroup and Pennsylvania Legislators and should be read in its entirety. Mercer disclaims liability for any reliance on this analysis by third parties.

Data and figures cited come from a variety of sources, including but not limited to, data from DHS, PennDOT, and PDA. Mercer reviewed the data but did not audit it. In our opinion, it is appropriate for the intended purpose. If the data and information are incomplete or inaccurate, the values in this analysis may differ significantly from values that would be obtained with accurate and complete information, which may require a later revision to this analysis. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate.

For the intended audience, if you have questions on any of the information contained in this analysis, please feel free to contact David A. Quinn, FSA, MAAA +1 602 522 6568, who is a member of the American Academy of Actuaries and meets its US qualification standards for issuing the statements of actuarial opinion in this analysis.

⁵³ These disclosures are made in accordance with the Actuarial Standards of Practice on Actuarial Communications available at <http://www.actuarialstandardsboard.org/asops/actuarial-communications/>.

APPENDIX A

ACRONYMS

- ACA — Affordable Care Act
- ADA — Americans with Disabilities Act
- BLS — Bureau of Labor Statistics
- CCAP — County Commissioners Association of Pennsylvania
- CFR — Code of Federal Regulations
- CHC — Community HealthChoices
- CMS — Centers for Medicare & Medicaid Services
- CPTA — Central Pennsylvania Transportation Authority (doing business as “rabbittransit”)
- CY — Calendar Year (January 1, to December 31)
- DHS — Department of Human Services
- FFS — Fee-For-Service
- FMAP — Federal Medical Assistance Percentage
- FTE — Full Time Equivalent
- FWA — Fraud, Waste, and Abuse
- HHSC — Health and Human Services Commission (Texas)
- HST — Human Service Transportation
- IDD — Intellectual and Developmental Disabilities
- LBB — Legislative Budget Board (Texas)
- MA — Medical Assistance
- MATP — Medical Assistance Transportation Program

- MCO — Managed Care Organization
- MH/IDD — Mental Health/Intellectual and Developmental Disabilities
- MTM — Medical Transport Management Inc.
- NEMT — Non-Emergency Medical Transportation
- PA SILC — Pennsylvania Statewide Independent Living Council
- PACAP — Public Assistance Cost Allocation Plan
- PAHP — Prepaid Ambulatory Plan
- PDA — Pennsylvania Department of Aging
- PennDOT — Pennsylvania Department of Transportation
- PPTA — Pennsylvania Public Transportation Association
- PwD — Persons with Disabilities Program
- RFA — Request for Application
- SDOH — Social Determinants of Health
- SFY — State Fiscal Year (July 1, to June 30) (e.g., SFY 2019 is July 2018 through June 2019)
- SPA — State Plan Amendment
- SSRP — Senior Shared-Ride Program

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