MERCER
MAKE TOMORROW, TODAY

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP) PRELIMINARY REPORT

BACKGROUND

The Act of June 22, 2018 (P.L. 258, No. 40) (Act 40), which amended the Human Service Code, required the Department of Human Services (DHS) to issue a solicitation for statewide or regional brokers to provide administrative and operational MATP services while providing the least costly, most appropriate non-emergency medical transportation (NEMT) to Medical Assistance (MA) consumers. DHS solicited applicants through Request for Application (RFA) No. 28-18 issued on December 21, 2018, to comply with Act 40. The three regions proposed are East, West, and Central. While applicants were able to submit an application for all three regions, no more than two regions would be awarded to a single applicant. The MATP broker procurement is currently on hold.

The Human Services Code was again amended by the Act of June 28, 2019 (P.L. 168. No 19) (Act 19), which required DHS, in coordination with the Pennsylvania Department of Transportation (PennDOT) and the Pennsylvania Department of Aging (PDA) to commission an analysis before entering into agreements with a broker or implementing a full-risk brokerage model to administer the MATP. The analysis must, at a minimum, focus on the five major components outlined in the legislation. In addition to an analysis, Act 19 requires DHS, as the lead agency, to submit preliminary and final reports on or before September 28, 2019 and December 28, 2019, respectively. Due to time constraints, DHS was granted an extension; this preliminary report is now due on or before October 28, 2019.

INTRODUCTION

To comply with Act 19, DHS, PennDOT and PDA selected Mercer Government Human Services Consulting (Mercer) to complete the analysis and subsequent reports. Mercer has extensive experience with the Commonwealth in various capacities as well as expertise and knowledge of the MATP.

In conducting its analysis, Mercer has included or will include a review of relevant literature and analysis of readily available information, financial data, studies, and surveys related to the MATP and NEMT brokerage programs. Mercer will also review current federal and state law, regulations and policies governing NEMT and other Pennsylvania human services transportation (HST) as well as a review of other state experiences with both types of transportation. The analysis will be supplemented with stakeholder feedback compiled by the MATP Analysis Workgroup (Workgroup), as well as additional applicable data or information identified by the Workgroup. The information gathered to date will be summarized in this preliminary report and supplemented and expanded upon in the final report, which will identify critical observations for the Commonwealth of Pennsylvania's (Commonwealth) consideration in future decision making.

ACTIVITIESTO DATE

Below is a summary of the efforts thus far in addressing the requirements of Act 19 for an analysis of the MATP. A detailed workplan for the complete required analysis is included with the preliminary report. The key activities completed to date are:

- Development of a MATP Analysis Workgroup.
- Exchange of data and information to inform the MATP analysis.
- Review of pertinent federal and state laws.
- Research of available studies and surveys.
- Initiation of the stakeholder engagement process.
- Development of a preliminary outline and working draft of the final report.

ACT 19 WORKGROUP

In response to the requirements of Act 19, a Workgroup was established, which is comprised of representatives from DHS, including the Offices of Medical Assistance Programs, Long-Term Living and Mental Health and Substance Abuse Services, PennDOT, PDA, the County Commissioners Association of Pennsylvania (CCAP), and Pennsylvania Association of County Human Services Administrators (PACHSA). During the Workgroup's first meeting on July 23, 2019, Mercer was selected as the entity to complete the required legislative analysis and joined the Workgroup on July 30, 2019. The Workgroup meets weekly and its goal is to oversee the analysis and provide relevant information as required by Act 19 and requested by Mercer.

As the lead agency responsible for the analysis, DHS has a weekly status meeting with Mercer. The purpose of these meetings is for Mercer to keep DHS informed of the progress and to seek clarification and for the Workgroup to provide information as necessary. Additionally, on August 13, 2019, PeopleSTAT/Performance Management Office assigned a project manager to assist the Workgroup.

DATA AND INFORMATION EXCHANGE

The Workgroup also identifies information and issues to be addressed in the final report. Since the inception of the Workgroup, a significant amount of information has been shared with Mercer to allow for a better understanding of the coordinated HST in Pennsylvania, as well as to evaluate the potential impact of implementing a regional MATP broker model. The information shared and reviewed to date includes:

- County MATP agency profiles.
- Internal and external PowerPoint presentations on NEMT.
- MATP and PennDOT historical costs.

- Previously issued MATP request for information (RFI).
- Trip counts by modality for PennDOT programs and MATP.
- Utilization metrics for PennDOT programs and MATP.
- MATP complaint and satisfaction information.
- Paratransit revenue sources for PennDOT programs and MATP.
- Statewide paratransit data reflecting funding sources and service type.
- MATP Standards and Guidelines.
- MATP RFA.
- MATP Databook.
- Annual LogistiCare (transportation broker for Philadelphia) reports.
- MATP program and fiscal information from onsite monitoring as well as complaint reports.
- MATP funding and allocation information.
- Human Service Transportation Coordination Study Summary Report.
- Federal and state regulations and policies relevant to MATP and PennDOT programs.

The Workgroup has also participated in many extensive discussions related to the complete HST system and will continue to do so throughout the analysis. The Workgroup continues to identify new issues for discussion and maintain an open exchange of information.

INDEPENDENT MERCER RESEARCH

In addition to the information gathered through the Workgroup, Mercer is conducting independent research to support the requirements outlined in the legislation. Mercer has reviewed numerous studies and surveys related to NEMT brokerage and HST programs and reviewed the current federal and state law, regulations and policies related to all transportation programs. Mercer continues its research to support the analysis based on identified issues, questions, and approaches used in other states.

STAKEHOLDER ENGAGEMENT

Stakeholder input will be an important component for completion of the analysis required by Act 19. As mentioned previously, the Workgroup has representation from CCAP and PACHSA, whose participation has been valuable and insightful in the development of the preliminary report. To provide context of the current structure of MATP, gather feedback regarding the impact to each county's transportation system as

a result of MATP being administered through a broker model and to provide an update of progress on fulfilling the legislative requirements, meetings were held with CCAP on October 3, 2019, Pennsylvania Public Transportation Association (PPTA) on October 8, 2019 and the Pennsylvania Health Law Project (PHLP), including consumers of the MATP on October 15, 2019.

MATP

MATP intersects with other shared ride programs in Pennsylvania and is considered part of the HST system. Other programs served by the coordinated system include PennDOT's Senior Shared Ride Program (SSRP) and Persons with Disabilities (PwD) Program and PDA's Area Agencies on Aging (AAA). Individuals with intellectual disabilities and those receiving mental health services also receive services from the HST system.

Currently, NEMT services are provided to Medical Assistance (MA) consumers who have no other means of getting to and from medical appointments through the MATP. The modes of transportation include public transit systems, mileage reimbursement, and paratransit. The MATP is administered and operated in all 67 counties in the following manner: 38 counties indirectly operate the MATP through contracts with vendors; 7 counties directly operate the program; 9 counties share the responsibility of operating the MATP with a vendor; the Commonwealth has a direct contract with 2 transit agencies to operate in 12 counties and the MATP is operated through a brokerage model in Philadelphia county.

ACT 19 REQUIREMENTS

The following are the five major requirements included in the legislation and information summarizing what will be included in the final analysis:

> "An analysis of current federal and state law, regulations and policies controlling the non-emergency 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)

Depending on the Commonwealth's operational decisions for its NEMT program, different sets of federal regulations and policies may apply. This section of the final report will address the state and federal laws that apply to the MATP currently and those that would apply under a statewide or regional broker model. The section will also address the legal requirements governing other HST programs in the Commonwealth. The analysis of federal or state laws addresses any applicable requirements of procurement, provider type (e.g., non-governmental and governmental), federal match rate, and duration of the federal authority. The relevant laws and regulations to be addressed include 55 Pa. Code Chapter 2070, 67 Pa. Code Chapter 425, Title 74 Pa.C.S §1516, 2 CFR Part 200, 42 CFR § 431.53, 45 CFR Part 75, 49 CFR Part 37, Subpart F, 1915(b) waivers, state plan authority under1902(a)(70),42 CFR §440.170(a)(1) and (4), and federal administrative cost allocation plan requirements.

There are other laws that may apply depending on how a state implements the NEMT benefit. States have significant discretion in how they administer the Medicaid NEMT benefit. This section of the analysis will detail the federal authority for those services including payment methods like fee-for-service (FFS) as an administrative service, contracting with a transportation broker, or contracting with managed care organizations (MCOs).

> "An analysis of the effectiveness and efficiency of the current non-emergency transportation service delivery as it relates to all human service programs in this Commonwealth." — Section 443.12 (E) (2)

The final report will discuss metric statistics from available data sources including the RFA Databook, national surveys, studies of Pennsylvania transportation programs, and data collected and reported by the Commonwealth. The final report will also address key metrics for NEMT effectiveness and efficiency such as cost per trip and rides per hour, and consumer satisfaction. The final report will also include available consumer satisfaction and complaint data from the Department of Public Welfare 2010 Survey, the Central Pennsylvania Transit Authority (CPTA) 2018 Survey, the transportation broker in Philadelphia, as well as county-specific complaint data.

An important part of the analysis will be the cost per trip for NEMT. This is a standard metric for NEMT efficiency. Different sources, such as the Transportation Research Board and the 2014 National NEMT Survey, rank the Commonwealth as having one of the lowest costs per NEMT trip. Between NEMT public transit use and the average cost per trip, there is a modest linear correlation (-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 state fiscal year (SFY) 2019, 71% of all MATP trips in Philadelphia County are on fixed route public transportation, and 61% in Allegheny County. However, removing both counties increases the average unit cost roughly 48%, moving the program's low-cost ranking of third best in the nation to a ranking of seventh; suggesting counties without mass-transit infrastructure are still managing costs down, which may be due to coordinated HST.

> "A review of other states' models of delivering non-emergency 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 of the final report will review the three models state Medicaid programs generally use to deliver NEMT:

- "In-House Management," where a Medicaid program operates its own NEMT program statewide or at the county level.

- "Managed Care," where a state includes NEMT services in its contracts with MCOs.

- "Broker", where NEMT can be operated regionally or statewide on a full-risk (the broker is at financial risk for performing all requirements in the contract with capitated payments) or a shared-risk basis (the broker does not assume all financial risk).

While most state Medicaid programs use just one of these models, several operate hybrid models (i.e., in-house management and a regional broker). Notably, several managed care plans may also subcontract with an NEMT broker to provide contracted NEMT benefits. The Commonwealth operates a hybrid model, principally defined as in-house management at the county level, but Philadelphia County is operated by LogistiCare, a full-risk capitated broker. The following information summarizes NEMT models used by other state Medicaid programs as of 2018.[1]

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. The Commonwealth operates a hybrid model, so it is excluded in this total. Because the in-house management model is generally operated at the county level, this model may allow for greater localization and customization of the NEMT delivery.[1]

In an in-house management model, a state government entity, typically the Medicaid agency, coordinates the NEMT program. The in-house NEMT coordinator has a wide range of responsibilities, which begins with having systems in place to verify consumer eligibility and to schedule and dispatch trips. Coordinators also manage a transportation provider network, which requires fleet maintenance, hiring staff, or negotiating rates with contracted ride vendors. Typically, the arrangements with the vendor are FFS based. There is ongoing monitoring of program integrity, which typically involves obtaining criminal history, and reporting of suspected fraud, waste, and abuse (FWA). The in-house coordinator also submits regularly occurring financial and quality reports to the state government. The Medicaid agency also operates a call center to take incoming requests, inform consumers, or handle member and transportation provider issues.

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 such as LogistiCare or Medical Transport Management Inc. (MTM). The state MCO programs that delegate to an NEMT broker are not distinguished here.

Under a managed care model, an MCO is responsible for managing NEMT services similar to medical benefits. Each MCO operates its NEMT program independently, either negotiating a network of NEMT

---

[1] http://www.trb.org/Main/Blurbs/177842.aspx

providers or contracting with an NEMT broker to provide services. Non-public transport routes, times, and services offered to Medicaid patients may be different between MCOs. It is likely MCOs will not maintain a fleet of vehicles but will use third-party vendors — including public transportation, to provide rides.

MCOs may have incentives to encourage greater use of lower cost transit, like public transportation; therefore, a potential benefit of a managed care model includes lower transportation costs. A managed care model may also have lower administrative costs because it is more centralized than several in-house county coordinators. Additionally, MCOs have access to patients' medical data and care teams. 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.

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 a NEMT broker model. While Philadelphia County uses a broker model, the Commonwealth operates a hybrid MATP model, so it is not counted here.

The broker is usually a specialized third-party vendor contracted by the state Medicaid agency to coordinate NEMT benefits. A broker model is 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 (like the three RFA regions), depending on whether the broker is statewide or regional. As mentioned, the Commonwealth has one broker in Philadelphia County. Due to Philadelphia's unique public transportation infrastructure and urban demographics, it is challenging to extrapolate its broker experience across the Commonwealth.

As described previously, broker models typically operate under a full-risk or shared-risk contract. It is difficult to ascertain the number of states that have a full-risk NEMT contract based on a literature review alone. A state may operate a regional broker differently around the state, with a full-risk contract in one region and a shared-risk in another. Alternatively, such as in the Commonwealth, a state that operates a hybrid NEMT model with a broker may have a full-risk or shared-risk contract. At a minimum, the following states have a full-risk (versus shared-risk) NEMT contract at least in part of its NEMT system: Delaware, District of Columbia, Mississippi, Missouri, Pennsylvania (Philadelphia County), South Carolina, Virginia, West Virginia, and Texas.

For-profit brokers may have a stronger incentive to control costs. However, some states contracting with non-profit entities like public transit authorities as the NEMT broker (described in greater detail later) have reported significant administrative savings and lower per person transportation costs. Many brokers are also national entities, like LogistiCare or MTM, and can leverage their existing assets to administer the program. These may include consumer apps, FWA processes, or administrative reporting units. The competitive bid process could also lead to price competition, which may lower costs on average.

In a broker model, a Medicaid program typically defines the terms of the NEMT contract and gives the state similar control over the expectations, credentialing, and monitoring as it has with the in-house management model.

A 2018 publication from the *National Academic Press*, "Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokers on Transportation Coordination," describes state NEMT experiences from shifting to an NEMT broker model, including the impact on public transportation. A high-level summary of some state experiences will be included in the final report, plus state experiences reported in other literature. In general, several of these states reported that moving to a broker model lowered costs but had the trade-off of less rural access and coordination with other HST rides.

HYBRID

Eleven states (California, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, Oklahoma, Pennsylvania, Virginia, Texas) and the District of the Columbia use a hybrid of the models described above (in-house management, managed care, and broker). This includes the Commonwealth, which operates an in-house and broker hybrid model. These models sometime arise because the state uses MCOs for its managed care population and uses an in-house or broker to manage FFS populations. Other states use a broker for only urban counties, similar to Pennsylvania.

As information becomes available, the final report will address other states' HST and the methods used for providing those services.

"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 of the final report will look at the potential positive and negative impact of maintaining the current NEMT structure versus implementing a full-risk brokerage model to operate the MATP. The impact on funding streams, leveraging of transportation resources, administrative resources, cost incentives (e.g. FFS vs. capitation payments), quality controls of the services delivered, and measurable fiscal implications (e.g. Federal Medical Assistance Percentages or MATP revenue) will also be addressed.

In addition to Pennsylvania's current NEMT model, other areas that will be considered and addressed include:

- Trips and revenue.
- Maintaining coordination of transportation.

- MATP standards.
- Multi-county authorities.
- Administration duplication.
- Procurement.
- Broker reimbursement.
- Transfer risk.
- Broker transition.
- New costs and increased federal share.

"An analysis of the impact on consumers, including an increase or decrease in quality and service availability." — Section 443.12 (E) (5)

This section of the final report will provide additional detail regarding potential changes for consumers under a regional brokerage system. For example, the general day-to-day changes directly affecting consumers under a regional broker system may include:

- Service contact information will change from the county coordinator to the regional broker.
- Options for requesting services will likely change as the broker may introduce its own platforms.

In this analysis, changes to systems utilized by consumers, the tracking and reporting of service quality and how this might change in a regional brokerage system will be explored. For instance, a regional broker system could bring efficiencies to a transportation system, which may include:

- Improving consistency in the administration and coordination of transportation across counties.
- Enhanced monitoring efforts of program quality and member satisfaction.
- Reports with uniform metrics.

Additionally, potential impacts on service availability through a comparison of the current structure to the concept of a regional brokerage system will be explored. Input from the CCAP, PPTA and PHLP, including consumers of the MATP, will be considered in addressing the potential impact of a regional broker system to consumers.

FINAL REPORT

The full legislative analysis report is in progress. Mercer shared a partial working draft of the report with the Workgroup on September 5, 2019 for initial feedback and will continue to summarize critical observations for consideration as additional information and data are compiled and analyzed. As the report progresses and Workgroup feedback is considered, content described in this preliminary report may shift between the five major components outlined in the legislation. Mercer will work with the Workgroup throughout 2019 to develop the final analysis due on December 28, 2019.