2026

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

Broker Study

(Act 46 of 2025)

June 25, 2026

Pennsylvania
Department of Human Services

Commonwealth of Pennsylvania

Commonwealth of Pennsylvania

Table of Contents

Table of Contents 1

Executive Summary 4

KEY FINDINGS 5

1. Pennsylvania's Current HST and MATP Framework 5

2. Statutory and Regulatory Considerations 5

3. Efficiency and Effectiveness of the Current System 5

4. Comparison to Other State NEMT Models 6

5. Projected Impacts of a Broker Model 6

6. Stakeholder Input 7

Introduction 8

CURRENT HUMAN SERVICE TRANSPORTATION BACKGROUND 10

Human Service Transportation Sustainability 12

CURRENT MATP DESIGN 13

County Sole Service Provider Model (8 Counties) 13

County Vendor Model (38 Counties) 13

County Hybrid Model (7 Counties) 14

DHS Broker Model (1 County) 14

DHS Direct Agreement Model (13 Counties) 15

BROKER PROCUREMENTS 15

LEGISLATIVE ANALYSIS 15

1. Statutory and Regulatory Landscape 16

PENNSYLVANIA HUMAN SERVICE TRANSPORTATION PROGRAMS LAWS AND REGULATIONS 16

MATP 16

Senior Shared-Ride Program 17

Area Agencies on Aging 17

ADA Complementary Paratransit 17

Persons with Disabilities Program 17
FEDERAL LAWS 17
2. Efficiency and Effectiveness of Current MATP Model 20
COORDINATION ADVANTAGES IN THE CURRENT SYSTEM 20
Coordination Between MATP and HST 20
Consumer Benefits 21
Cross-County Collaboration 22
COORDINATION CHALLENGES IN THE CURRENT SYSTEM 22
Out of County Trips 22
Varying Standards 23
Disallowance and Procurement Risk 24
3. State Comparisons 26
NEMT DELIVERY MODELS 26
In-House Management (State or County) 27
Broker (Statewide or Regional) 28
Managed Care Carve-In 29
Mixed 30
STATE NEMT EXPERIENCES WITH BROKER MODELS 31
Massachusetts 32
South Carolina 33
Washington 34
Arkansas 35
Texas 35
New Jersey 36
4. Predicted Impacts of a Statewide Broker Model 39
BENEFITS OF A STATEWIDE BROKER MODEL 39
Financial Benefits 39
Service Delivery 40
Administrative Simplicity 41

CONCERNS WITH A STATEWIDE BROKER MODEL 41
Service Delivery 41
Continuity of Operations 42
Financial Impacts 42
Impacts on Transportation Providers 43
Impact on Other HST Programs 43
Impact on Employment 44
STAKEHOLDER INPUT — GOVERNMENT ENTITIES 45
County Commissioners Association of Pennsylvania 46
Pennsylvania Public Transportation Association 46
STAKEHOLDER INPUT — BROKER 48
5. Consumer Experience 50
COMPLAINTS AND SURVEYS 50
MATP Complaint Process Update and Scope 50
PennDOT Shared Ride Survey Results 51
Susquehanna Regional Transportation Authority (CPTASRTA) 2025 Survey 52
Washington County Transportation Authority (Freedom Transit) 2025 Survey 52
USE AND AVAILABILITY 52
MATP Statistics and Medicaid Expansion 52
Availability Impact 53
Point of Contact for Consumers 53
Local Rapport 54
STAKEHOLDERS — CONSUMER ADVOCATE ORGANIZATIONS 54
Pennsylvania Health Law Project (PHLP) 54
Pennsylvania Statewide Independent Living Council (PA SILC) and the Pennsylvania Transportation Alliance (PTA) 55
Conclusion 58
Appendix A: Abbreviations 59
Appendix B: Broker Letter 61
Notes & Sources 69

Commonwealth of Pennsylvania

Executive Summary

The Department of Human Services (DHS), in partnership with PennDOT and the Department of Aging, conducted this analysis to comply with Act 46 of 2025[1], which requires an updated evaluation of the potential impact of transitioning Pennsylvania's Medical Assistance[2] Transportation Program (MATP) to a statewide or regional broker model. This review builds upon the Commonwealth's 2019[3] and 2022[4] Legislative Reports, prior workgroup recommendations, stakeholder feedback, and substantial program improvements that have since been implemented within the in-house, county- administered- structure.

Across Pennsylvania, MATP currently supports essential nonemergency medical transportation (NEMT) for Medicaid consumers who lack other means to travel to medically necessary care. The program is embedded within a broader Human Services Transportation (HST) ecosystem, including the Senior Shared Ride Program (SSRP), Persons with Disabilities (PwD), ADA Complementary Paratransit, Area Agency on Aging (AAA) transportation, and transportation provided through the Medicaid long-term services and supports managed care program. These systems jointly rely on coordinated paratransit resources, shared funding streams, and local administrative expertise.

This analysis concludes that although a statewide broker model may offer theoretical administrative simplification and modest increases in federal financial participation, the measurable fiscal, operational, and consumer risks significantly outweigh the projected benefits. Stakeholder feedback, including from counties, transit agencies, consumer advocates, and disability organizations, is generally opposed to a broker transition due to its potential to destabilize public transportation networks, increase costs, degrade service quality, and create harmful disruptions for the Commonwealth's most vulnerable populations.

Overall, the evidence indicates that Pennsylvania's current county-based model, which has been strengthened through recent reforms, cross-agency alignment, technology investments, and enhanced oversight, continues to be the most effective and sustainable framework for delivering NEMT and coordinating HST services.

KEY FINDINGS

1. Pennsylvania's Current HST and MATP Framework

Pennsylvania operates a nuanced and locally tailored HST system. MATP is delivered through a mix of county-administered (directly, through a vendor, or hybrid), direct agreement, and single-county broker models. These models align with each county's geography, transit availability, and local healthcare utilization patterns.

MATP's integration with other HST programs enables:

- Shared operational infrastructure and scheduling platforms
- Cross-program trip coordination
- Reduced per trip costs through shared rides
- A single point of contact for consumers in many counties
- Community centered service delivery supported by longstanding local relationships
- Counties consistently meet MATP administrative requirements through oversight, time studies, compliance reviews, and multi-agency collaboration.

2. Statutory and Regulatory Considerations

MATP operates within a complex regulatory landscape, with federal and state rules governing NEMT varying by delivery model. While broker models allow NEMT costs to be matched at enhanced FMAP rates, they also introduce federal restrictions—including self-referral prohibitions and extensive reporting requirements—and require complex procurements. There are various operational authorities under which a state may implement an NEMT broker program, each with its own benefits and challenges.

3. Efficiency and Effectiveness of the Current System

The current system offers several advantages:

- **Strong MATP–HST coordination**, particularly in rural areas where shared ride is essential
- **Stable and generally high consumer satisfaction**
- **Improved cross-county collaboration**, supported by DHS and PennDOT's Quarterly Administrator calls
- **Cost efficiencies** driven by local knowledge and consolidated scheduling across funding sources
- **Flexible program delivery** tailored to local needs

Challenges primarily involve long-distance, out-of-county trips and complexities arising from health system consolidation—but these issues exist under any model.

4. Comparison to Other State NEMT Models

States use four general NEMT models: in-house management, broker, MCO carve-in, and some combination of the above models. Experiences in states that transitioned to broker models demonstrate:

- Frequent litigation and procurement delays
- Reduced public transit utilization
- Increased consumer complaints and missed appointments
- Provider network instability, especially in rural areas
- Financial risk tied to capitation misalignment

No state offers a directly comparable landscape to Pennsylvania's, limiting the usefulness of direct analog comparisons.

5. Projected Impacts of a Broker Model

Potential Positives

- Access to higher federal match rates (60.2% vs. 50%)[5]
- More centralized DHS oversight of fewer vendors
- Increased ability to standardize data and reporting

Significant Concerns

- **Financial risk**: Potential net savings of $5.1 million do not account for procurement, transition, litigation, or county level fiscal impacts. Net savings are likely negligible—or negative.
- **Service degradation**: Brokers are paid through capitated arrangements, where DHS pays a fixed per-member-per-month rate to cover all services, including transportation and administrative costs. Brokers are at financial risk in this model: if actual costs are greater than the amount paid, they will incur a loss, but if actual costs are lower than the amount paid, they retain the excess. Therefore, capitated brokers may reduce trip availability, tighten scheduling, and rely heavily on low-cost transportation modes, particularly impacting consumers with complex needs.
- **System disruption**: Transition risks include lost provider capacity, failure to maintain networks, and disruptions in ongoing care.
- **Public transportation destabilization**: Loss of MATP revenue could increase fares, shrink service areas, reduce hours, trigger layoffs, and diminish federal transit funding tied to shared ride volumes.

- **Large-scale employment impacts**: The Pennsylvania Public Transportation Association estimates up to 800 potential job losses among transit agencies and contractors.
- **Consumer experience challenges**: Confusion over new points of contact, longer rides, reduced reliability, and loss of local rapport.

6. Stakeholder Input

Feedback was nearly unanimous in **opposition to a broker transition**, including:

- **County Commissioners Association of Pennsylvania (CCAP)**
- **Pennsylvania Public Transportation Association (PPTA)**
- **Area Agencies on Aging**
- **Public transit providers**
- **County MATP Administrators**
- **Pennsylvania Statewide Independent Living Council**
- **Consumer advocates**

Key concerns include lost coordination, increased costs, service degradation, and harm to vulnerable populations.

Consumer advocates acknowledge MATP's need for ongoing standardization and communication improvements, but do not support a statewide broker as the mechanism to achieve these goals.

One noteworthy departure from the general opposition to a statewide or regional broker model was the feedback received from ModivCare, the vendor who currently serves as the MATP broker for Philadelphia County. ModivCare believes that the concerns noted by other stakeholders could be addressed through proactive contract design to develop standards that would mitigate these adverse impacts.

Introduction

The Act of June 28, 2019 (P.L. 168. No. 19) (Act 19 of 2019) amended the Human Services Code to require the Department of Human Services (DHS) to complete an analysis of the impact of a full-risk broker model on MATP, in collaboration with the Pennsylvania Departments of Transportation (PennDOT) and Aging (PDA). The study, published in December of 2019, explored the same elements required in Act 46 of 2025. As a result of that analysis, the Secretaries of DHS, PennDOT and PDA concluded that a statewide or regional broker model was not in the best interests of the program or its consumers and instead undertook efforts to make improvements to the program through its existing delivery model. This resulted in another report to the legislature published in February of 2022, which detailed the progress made in partnership with key stakeholders and identified additional remaining opportunities for improvement. DHS, in partnership with PennDOT and PDA, has made significant progress toward implementing the improvements identified in the February 2022 report.

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

1. **Statutory and Regulatory Landscape**
2. **Efficiency and Effectiveness of Current MATP Model**
3. **State Comparisons**
4. **Predicted Impacts of Statewide Broker Model**
5. **Consumer Experience**

In response to Act 46 of 2025, DHS leveraged the reports published in 2019 and 2022 and solicited input from members of the workgroups that contributed to those analyses to provide updates. These contributors include staff 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 (PACHSA)

To further inform this analysis, the Department convened two stakeholder listening sessions (March 24 and March 27, 2026) and reviewed follow-up correspondence to clarify and validate key themes. The Department extends sincere thanks to the participants below for their time and input:

- ACCESS Transportation, serving Allegheny County
- Area Transportation Authority (ATA), serving Cameron, Clearfield, Elk, Jefferson, Potter, and McKean Counties
- BeST Transit, serving Bradford, Sullivan, and Tioga Counties
- County Commissioners Association of Pennsylvania (CCAP)
- DaVita Kidney Care
- Pennsylvania Public Transportation Association
- Lehigh and Northampton Transportation Authority (LANTA)
- Pennsylvania Statewide Independent Living Council (PA SILC)
- rabbittransit, serving Adams, Columbia, Cumberland, Dauphin, Franklin, Indiana, Montour, Northumberland, Perry, Snyder, Union and York Counties
- South Central Transit Authority (SCTA), serving Berks and Lancaster Counties
- Representatives from Allegheny, Erie, Fayette, Fulton, and Lebanon Counties

What was heard most consistently in these sessions:

- **Rural county administrators:** Rural administrators were clear that the current, locally integrated model should be kept, noting that a statewide broker approach would add cost and an extra layer of complexity in areas with thin provider networks, potentially worsening service for riders who already travel long distances for care. They also emphasized the importance of maintaining local relationships, particularly for older riders, to support effective coordination and continuity of service.

- **Consumer and independent-living advocates**: Advocates favored keeping the current model rather than moving to a new statewide broker structure to protect access for higher-need riders, including those who must travel across county or state lines. They also emphasized that any refinements to MATP must ensure coordination with Community HealthChoices (CHC) non-medical transportation.

- **Public transit providers:** Transit providers and associations strongly supported keeping the current model, pointing to the improvements made to the county-based system in recent years and warning that a shift to a broker model could create service interruptions and negative downstream impacts to public transit, where the MATP is

often tightly integrated with HST operations, which drives efficiencies across all public transportation services.

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.[6] 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. Trips 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 to the consumer. Rides can be provided through fixed-route public transportation, demand response paratransit, or mileage reimbursement if the consumer has access to a private vehicle but lacks the funds for fuel, parking, or tolls.[7] For paratransit, requests must be made at least one day in advance and up to 14 days in advance of the scheduled medical appointment (or same-day in the case of certain urgent, short-notice trip requests). 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.[8] For state fiscal year (SFY) 2025 (i.e., July 1, 2024, to June 30, 2025), statewide MATP transportation-only costs, estimated from DHS data, are approximately $133.5 million for 4.1 million trips (an average of $32.65 per trip).

Senior Shared-Ride Program (SSRP) allows individuals aged 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.[9] 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 time (30 minutes total). For SFY 2025, PennDOT-provided estimates indicate that approximately $72.8 million in lottery funds (the 85%) supported 2.6 million trips (an average of $28.46 lottery funding per trip, not including rider copay).

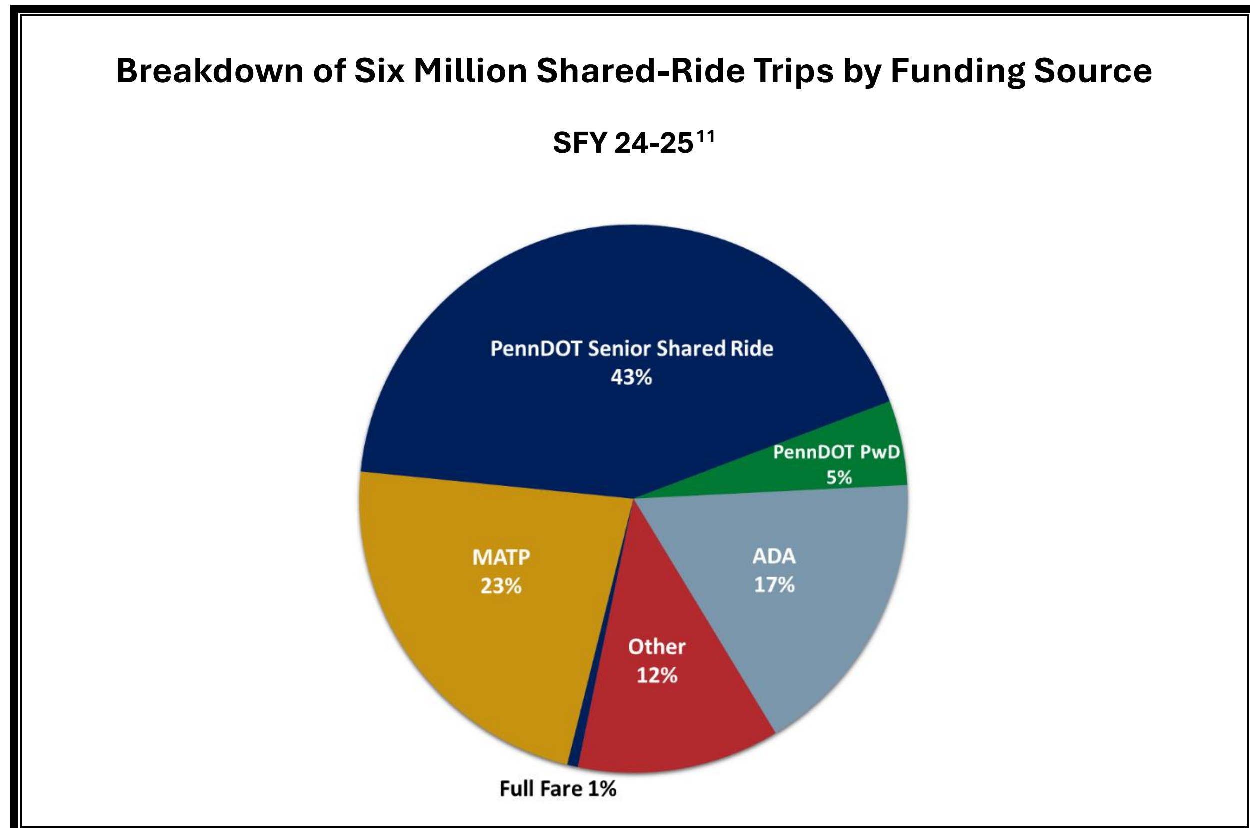
Area Agencies on Aging (AAA) offer alternative transportation programs for seniors. Each AAA has autonomy in determining how it can best serve the seniors of its community. Many choose to offset all or a portion of the SSRP 15% copay to allow seniors to travel at a lower out-of-pocket cost on shared-ride services.

For SFY 2025, PennDOT-provided estimates indicate that approximately $2.9 million was spent on copays for almost 1 million trips (with an average of $3.04 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).[10] For SFY 2025, PennDOT-provided estimates indicate that ADA Complementary Paratransit expenses were approximately $61.7 million supporting 1.1 million trips (an average of $58.53 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 2025, PennDOT-provided estimates indicate that $6.8 million in funding (the 85%) supported 0.3 million trips (an average of $22.63 funding per trip, not including rider copay).

Non-*medical* transportation (different from non-*emergency* medical transportation) 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 managed long-term services and supports Medicaid program called Community HealthChoices (CHC). Therefore, consumers in CHC receive their non-medical transportation through their CHC managed care organizations (MCOs). Individuals with intellectual and developmental disabilities (IDD) are also MATP eligible and may receive non-medical transportation benefits through their Medicaid home- and community-based waiver programs.



Human Service Transportation Sustainability

Serving as the backbone of human service transportation in Pennsylvania, shared-ride service delivers most of the paratransit trips for the programs mentioned above. The statewide availability of this service benefits MATP directly by lowering its NEMT costs while also helping Medicaid beneficiaries and other vulnerable populations satisfy social determinants of health beyond medical care. The funding model in place for shared-ride service dates back over 40 years to the beginning of the Senior Shared-Ride Program. This model increasingly shows its age by constraining transportation providers from effectively covering their service costs with the revenue streams intended to do so.

As a first step in solving this, state agencies and other key stakeholders recently came together to issue the Shared-Ride Transportation Study which outlines the issues with the current funding model and offers several alternative models which could address the issues.[12] The long-term sustainability of shared-ride service and the transportation programs which rely upon it depends on the funding model being reformed.

CURRENT MATP DESIGN

MATP provides NEMT to medical appointments at no cost for Pennsylvanians enrolled in Medicaid who lack other available transportation. Eligibility for MATP services is determined at the County Assistance Office and verified by the local MATP Administrator. 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 regular 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.[13] When applicable, DHS also reviews counties' time studies (county sole source provider and hybrid 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-three counties operate MATP through an in-house county model; however, differences in how the counties operate their programs exist. Some counties either act as a sole service provider or contract with one or more vendors to manage and arrange all or a portion of MATP on behalf of their county.

County Sole Service Provider Model (Eight Counties)

Eight counties operate the program as a sole service provider. This model means the county is the MATP transportation provider 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 or part-time to working on MATP.

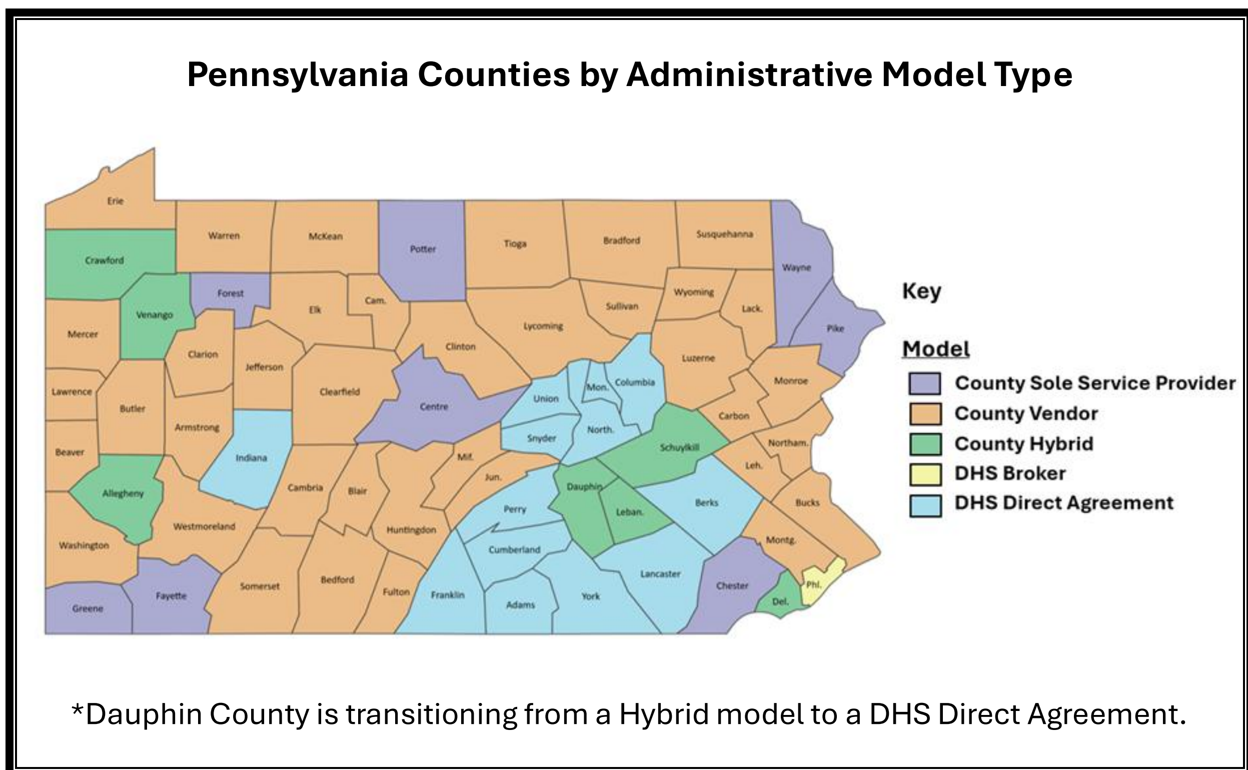
County Vendor Model (38 Counties)

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 are 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 (Seven Counties)

Seven 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 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.



Pennsylvania Counties by Administrative Model Type

*Dauphin County is transitioning from a Hybrid model to a DHS Direct Agreement.

DHS Broker Model (One County)

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

DHS Direct Agreement Model (13 Counties)

Lastly, thirteen 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 Chapter 2 of this analysis.

BROKER PROCUREMENTS

DHS issued RFA 28-18 to procure an MATP broker or regional brokers to serve the entire Commonwealth as a result of a legislative mandate. This procurement was ultimately cancelled, again due to legislative mandate. No statewide or regional broker procurements have been issued since 2018.

DHS has attempted to re-procure the Philadelphia County broker numerous times over the last several years, with RFA 01-23 and RFA 35-21 being cancelled as a result of bid protests. RFA 06-24 is in a stay as of the time of this writing while litigation is pending resolution.

LEGISLATIVE ANALYSIS

The following chapters of this document explore the five major requirements of Act 46 of 2025 in further detail. Key observations for consideration are summarized at the end of each chapter.

1. Statutory and Regulatory Landscape

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

Section 443.12 (g)(1)

This chapter 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.

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.[14] 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.[15]

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 public transit providers are governed broadly by federal regulation 49 CFR Part 37, Subpart F.[16] These regulations prescribe eligibility standards, types of services, and service criteria, among other program operations required of paratransit services.

Persons with Disabilities Program

74 Pa.C.S. § 1516 directs PennDOT to establish the PwD program.[17] The State law authorizes financial assistance to community transportation systems, which provide PwD services "for up to 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 state's federal medical assistance percentage (FMAP), which is 50% for administrative expenses and 50% or higher for medical expenditures.[18] These federal funds are approved by the Center for Medicare & Medicaid Services (CMS), the agency responsible for federal oversight of Medicaid programs.

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 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 in the 2019 Legislative Report, 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 in the 2019 Legislative Report, 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.

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 to self-referral is for a government entity, so long as certain conditions are met.

CHAPTER 1: KEY OBSERVATIONS

The Commonwealth operates several human services transportation programs (MATP, SSRP, PwD, and ADA paratransit), each governed by different state and federal laws with specific eligibility criteria, funding sources, and operational requirements.

Federal law provides four distinct pathways for delivering NEMT services, each with different regulatory requirements, FMAP rates, and operational constraints (e.g., free choice of provider, statewide availability, self-referral prohibitions).

Treating NEMT as an administrative service (50% FMAP) avoids free choice of provider requirements and allows single-provider contracting, while medical service models (higher FMAP) trigger additional federal compliance requirements but offer enhanced federal reimbursement.

The 66 counties operating under non-broker models must comply with federal PACAP requirements (45 CFR part 75, 2 CFR part 200) to claim the 50% administrative match.

Federal regulations (42 CFR § 440.170) prohibit brokers from self-referring unless specific exceptions are met, including an exception for governmental entities under certain conditions.

2

2. Efficiency and Effectiveness of Current MATP Model

> An analysis of the effectiveness and efficiency of the current nonemergency transportation service delivery as it relates to each human service program in this Commonwealth.

Section 443.12 (g)(2)

This chapter 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 varied and nuanced service delivery, procurement, fiscal, and oversight landscapes.

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 Administrator 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. Shared capital and overhead costs drive efficiencies for counties that benefit from coordinated HST.

The 2022 Legislative Report included several recommendations to improve the coordination and communication between DHS and PennDOT, many of which have been implemented by the agencies. In addition to the Quarterly Administrator calls discussed below, the agencies meet at least monthly and are in regular issue-specific communication. Recent work between DHS and PennDOT to align program goals, service standards, reporting requirements, and policies and procedures for all HST programs, including MATP, as recommended by the 2022 Legislative Report, promises to streamline operations, simplify administration, and standardize consumer experience. Now, PennDOT reviews all MATP policy changes prior to implementation to identify potential conflicts with broader HST policy and practice.

This includes a significant undertaking – a full update of the MATP Standards and Guidelines document intended to establish more statewide standards, ensuring clarity and consistency across counties in key areas, while allowing some flexibility for implementation to vary based on factors such as model type, geography, and transportation networks. DHS has endeavored to promote consistency in processes as well as policy, coordinating with PennDOT to develop standard application supplements to gather consumer consent to access protected health information, standard hearings and appeals request templates, and standard referral processes when the MATP Administrator is unable to accommodate a trip request.

Current work between the two state agencies includes development of a new module in PennDOT's Find My Ride system which will allow MATP consumers to submit requests for mileage reimbursement and for Administrators to review those requests online. This is just one of many technology-driven solutions born out of the 2022 Legislative Report.

Research conducted for the 2022 Legislative Report also suggests that expanded collaboration also potentially avoids decreased frequency and availability of service, reduced service areas, and increased fares that could result from conversion to a broker model in areas of Pennsylvania that are currently coordinated.

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).[19] 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. This system also promotes continuity across the lifecycle, since consumers can move among sponsoring programs at different times in their lives.

Cross-County Collaboration

MATP Administrators from different counties benefit from opportunities to share best practices, coordinate long-distance trips, and even share administrative responsibilities. In 2023, DHS and PennDOT began to hold Quarterly Administrator calls where Administrators of all MATP programs across the Commonwealth come together to learn about programmatic updates, discuss shared challenges, and highlight emerging trends. This has catalyzed the development of informal relationships that have improved coordination and moved toward more consistent programs.

As Administrators refine their service areas and update policies and procedures to align with current DHS and PennDOT requirements, their connections to other counties reduce fragmentation and redundancy and expand upon opportunities to provide services across county lines. The 2022 Legislative Report identified several formal administrative county collaborations, and those collaborations have grown in the last several years. This type of collaboration helps MATP Administrators adapt to changing regional healthcare utilization trends driven by consolidation and closure of many rural providers.

Counties with formal or informal relationships decrease their workload by sharing policies and procedures and pooling resources. DHS and PennDOT also benefit from enhanced coordination across counties, as oversight is simplified and reporting becomes more consistent.

COORDINATION CHALLENGES IN THE CURRENT SYSTEM

Out of County Trips

Under federal law, Medicaid beneficiaries must have freedom of choice of healthcare providers and are not limited by their county of residence when it comes to seeking care.[20] In recent years, the pattern of large providers 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-country 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 Administrator 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 24-25 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 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 Administrators 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 are received 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).[21] 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 drive higher costs when programs are not effectively coordinated. Many MATP standards cannot be waived or altered without becoming non-compliant with federal law. Therefore, it is incumbent on other HST programs to adapt to MATP standards to coordinate. DHS and PennDOT have focused extensively in recent years on reconciling variations in policy wherever possible.

Disallowance and Procurement Risk

If an MATP Administrator 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 Chapter 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 District Court.[22] 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. There have been no federal disallowances in the last decade.

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.[23] 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.

There are two non-solicited grants awarded for MATP (i.e., two "Direct Agreements"), and each covers multiple counties.[24,25] Both grants were justified and re-justified as non-solicitation grants. DHS had justified 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.

CHAPTER 2: KEY OBSERVATIONS

Counties have flexibility to coordinate MATP with other HST programs, creating opportunities for shared vehicles, pooled overhead costs, and operational efficiencies.

Collaboration between DHS and PennDOT has improved significantly since 2022, including standardized policies, Quarterly Administrator calls, and technology solutions like the Find My Ride application.

Coordinated models provide consumer benefits: one-stop-shop for multiple programs, trip chaining opportunities, and access to broader social services addressing SDOH.

Healthcare provider consolidation is driving increased demand for out-of-county trips, creating scheduling, cost, and coordination challenges.

Cross-county collaboration is growing through formal and informal relationships, reducing fragmentation and helping counties adapt to rural healthcare consolidation.

Cost allocation requirements remain complex; a 2015 CMS disallowance of $14.5M led to stricter PACAP documentation requirements, and there have been no disallowances since that time.

Transitioning well-coordinated county models to broker models could reduce trip frequency, shrink service coverage, and increase rider fares.

3. State Comparisons

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

Section 443.12 (g)(3)

This chapter describes the main NEMT models used across the nation and some of the advantages and disadvantages of each approach. The model selected by each state depends on many factors, including its Medicaid delivery system for various populations (e.g., managed care vs. fee-for-service), the traditional roles of local government, the availability of public transportation, and other factors that must be considered in determining the most suitable option for the state.

Following the summary information, this chapter provides more detailed descriptions of the experiences of six states that currently or recently utilized a broker model.

NEMT DELIVERY MODELS

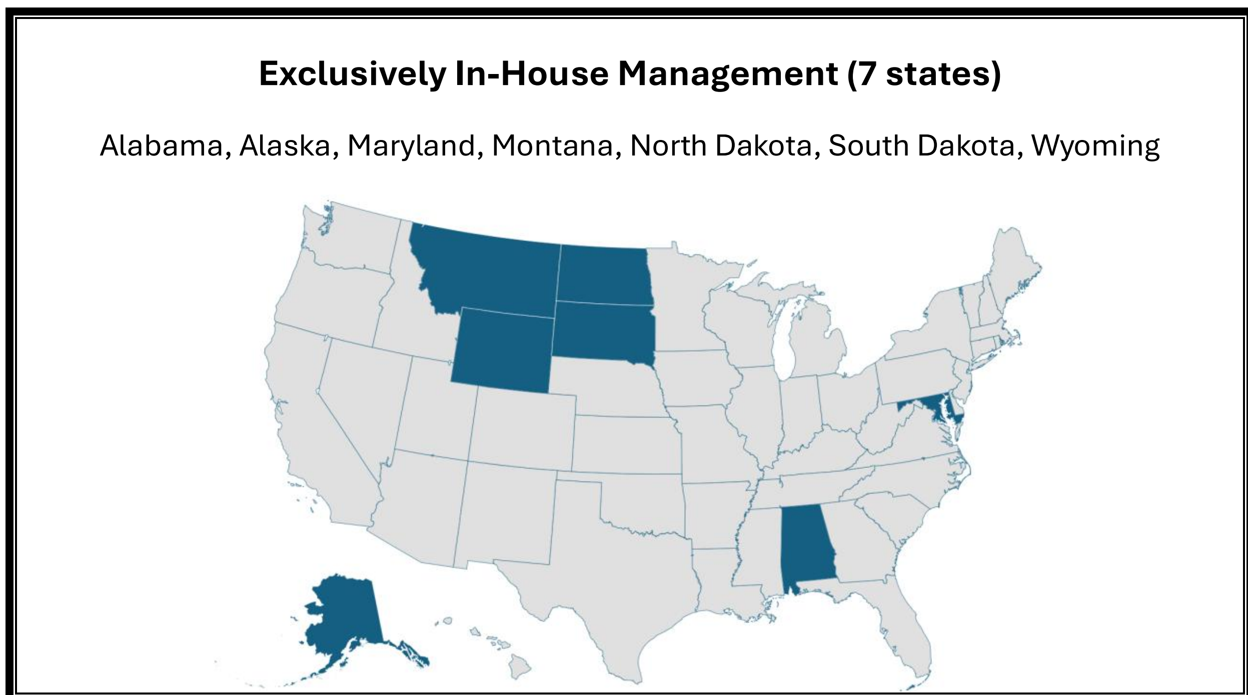
States generally choose from four approaches to assure access to transportation: In-House Management, Broker, Managed Care Carve-In, or a Mixed model that combines elements of the other models. Approaches to NEMT differ across states, reflecting variations in Medicaid delivery systems and operating contexts. Key drivers include the degree to which Medicaid services are delivered through Managed Care Organizations (MCOs) versus fee-for-service (FFS), the role of state versus local government in human services administration, the availability and capacity of public transportation, and other operational considerations. Consistent with this flexibility, states frequently tailor NEMT

program design by subpopulation (e.g., MCO-enrolled vs. FFS, special populations) and may rely on more than one operating model in practice.

The following summarizes the four model types currently being used by states. It also categorizes states by model type utilizing information compiled in Wheels to Care: Navigating NEMT Across America—An NEMT Profile for Each of the 50 States and D.C. (sponsored and funded by the Federal Transit Administration).

In-House Management (State or County)

A state may utilize an in-house management model for some or all of its NEMT needs. This approach is typically used when the state Medicaid agency, or a local designee (e.g., a county or regional entity), intends to retain direct operational and policy control of the system. This model is often used for populations served through Medicaid fee-for-service (FFS) coverage, where the state or local designee directly operates NEMT and reimburses transportation providers under state-defined payment terms.



By utilizing this approach, the state works directly with transportation providers enrolled in the Medicaid program. Trips are generally preauthorized, and providers submit reimbursement claims for payment in accordance with the state's FFS schedule and program requirements. The administering entity typically manages day-to-day functions such as trip authorization, trip scheduling and assignment, provider enrollment and oversight, and claims review and reimbursement for completed trips.

When operated at the county level, this model allows for significant localization and customization of the NEMT delivery.

Broker (Statewide or Regional)

A state may contract with a specialized broker entity to administer NEMT services statewide or for a specific region or county. While states typically contract with a single broker for services within a specific geographic area, states often have contracts with multiple brokers when the broker contract is not statewide.

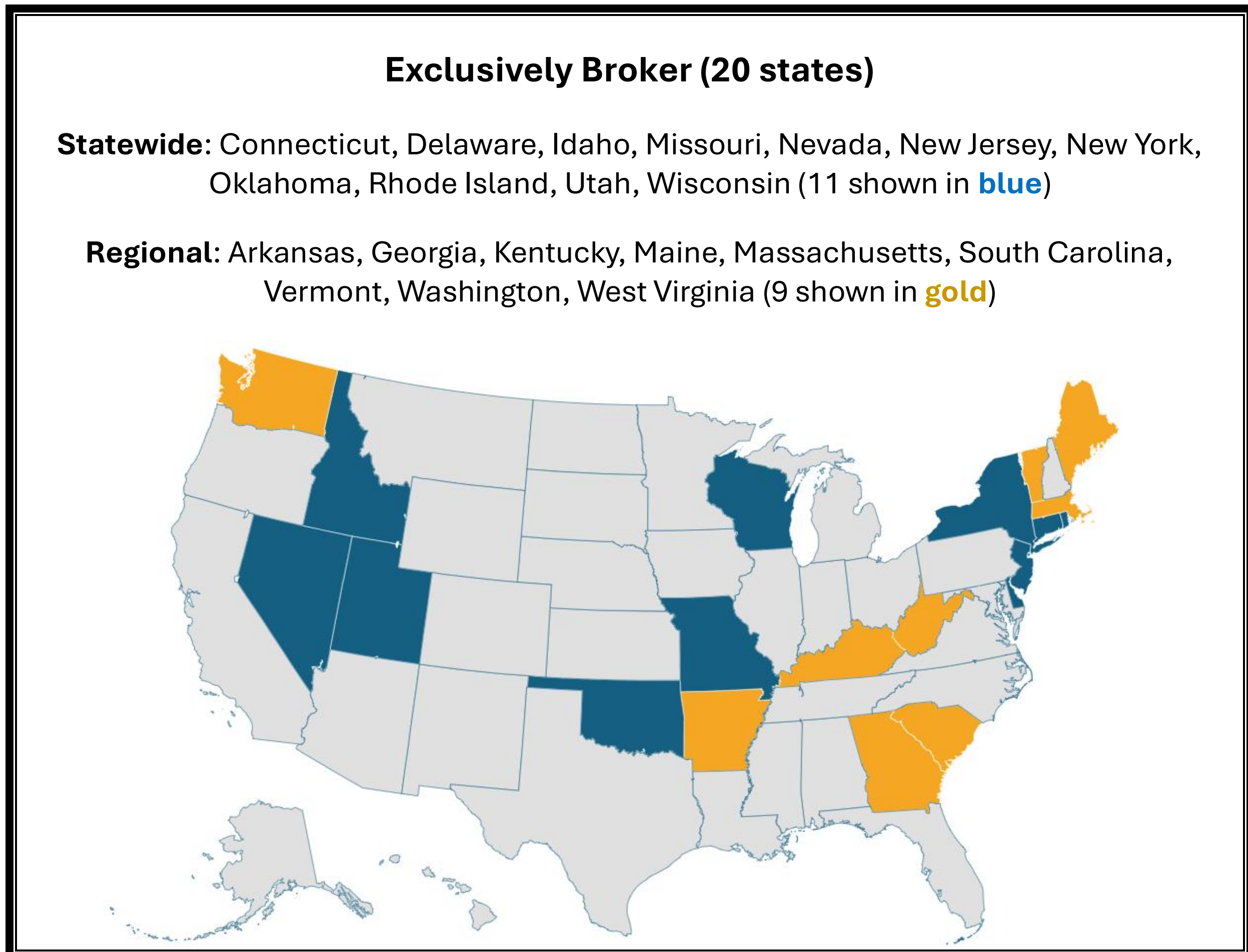
Similar to the in-house management model, a transportation broker is responsible for coordinating all aspects of NEMT, including operating a call center, verifying Medicaid eligibility and authorizing trips, determining the appropriate mode of transportation, scheduling and arranging trips, and contracting with and managing a transportation provider network. The state Medicaid agency is responsible for oversight of the broker to ensure compliance with state and federal regulations and requirements.

Brokers may be compensated through various approaches. One common approach, which is currently used by DHS in Philadelphia County, is using a capitated, per-member-per month (PMPM) rate based on the number of eligible Medicaid recipients in the geographic area. 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. For example, capitation can create an incentive to manage costs and, when appropriate, encourage use of lower-cost modes (e.g., public transportation). However, similar to at-risk MCOs, the incentive to seek the lowest-cost transportation options as a means for cost savings can put pressure on provider systems if states do not sufficiently guard against inappropriate cost controls through their contracts with brokers. Furthermore, when states have procurement processes that include price competition in addition to technical requirements, the competition may lower costs but introduce the risk of a broker underbidding, leading to solvency problems once the contract has commenced. Other forms of broker compensation could include flat payments for administrative activities along with fee-for-service reimbursement for provided trips.

It is difficult to ascertain the number of states using the various broker compensation approaches based on a review of publicly available information. For example, a state that contracts with regional brokers may use a full-risk contract in one region and an administrative payment with trip reimbursement in another.

For additional information about the broker model, including the related federal authorities and procurement requirements, please see the “Federal Laws” section within Section 1,

notably the subsections entitled “Brokerage Option Under the Section 1915(b) Waiver” and “State Plan Brokerage Authority Through 1902(a)(70) of the Social Security Act.”



Managed Care Carve-In

A state that enrolls some or all Medicaid beneficiaries in managed care organizations (MCOs) may include NEMT as a covered benefit. Under this “carve-in” approach, MCOs are responsible for administering NEMT for enrolled members and typically pay for the service with revenue received through their contracted arrangements with the state.

MCOs may administer NEMT directly, including managing and arranging trips and contracting directly with transportation providers. Alternatively, states may allow MCOs to subcontract day-to-day administration to a transportation broker, which typically manages the call center and ride scheduling and builds and oversees the transportation provider network, in the same manner as a broker that is contracted directly with a state. In either case, members initiate ride requests through health plan-provided contact information, which is used to route the request to the appropriate transportation provider.

The state Medicaid agency maintains oversight of NEMT performance through the MCO contracts by defining contractual and performance expectations, reviewing required reporting, and using contractual enforcement measures when warranted.

It is important to note that a state's use of managed care to provide NEMT services can be nuanced, which frequently leads to states that utilize an MCO carve-in to be characterized as having "mixed" models. This is often due to underlying Medicaid programmatic decisions regarding which Medicaid beneficiaries are enrolled in MCOs, as well as variations regarding the delivery of NEMT benefits between separate managed care programs within a state.

Because an NEMT MCO carve-in only applies to individuals enrolled in an MCO, states often need a parallel NEMT option for individuals who are not enrolled in an MCO, such as eligibility groups excluded from MCO enrollment (i.e., served through fee-for-service) or are included but awaiting enrollment. As a result, these NEMT models commonly appear "mixed" in practice, with most NEMT delivered through managed care and the remaining population served through an in-house management or broker arrangement.

Additionally, states that provide Medicaid services through multiple managed care programs might vary the approach to NEMT between programs. For example, a state might carve out NEMT for a general managed care program while carving in NEMT for a specialized managed care program that already provides a significant amount of transportation to enrollees related to specialty benefits (e.g., transportation to Social Adult Day Care).

In such instances, the "mixed" model structure frequently results from the underlying delivery system used for various populations rather than a decisive NEMT model choice.

Mixed

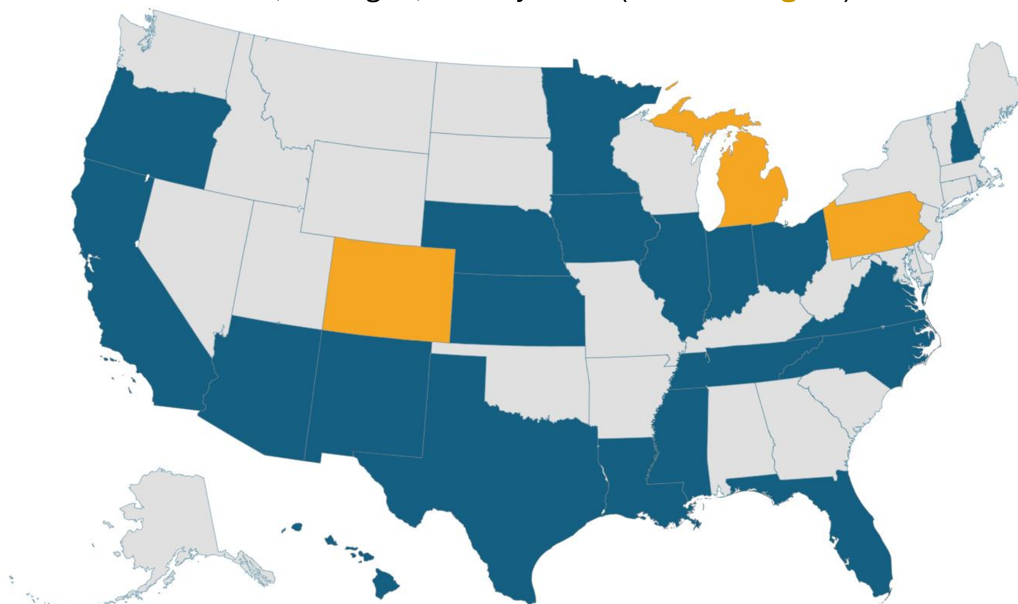
Any state that operates a combination of MCO Carve-In, Directly Operated In-House, or State-Contracted Broker models is classified as a Mixed model for the purposes of this report.

Other: Non-exclusively in-house or non-exclusively broker (23 states and the District of Columbia)

MCO Carve-In (using MCO-contracted brokers) and either Directly Operated In-House or State-Contracted Broker for Non-MCO Carve-In populations*:

Arizona, California, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Texas, Virginia (21 shown in **blue**)

Directly Operated In-House & Regional Transportation Brokers contracted by State: Colorado, Michigan, Pennsylvania (3 shown in **gold**)



*This could include populations served by FFS, either upon initial Medicaid enrollment or on an ongoing basis, or by an MCO program that does not cover NEMT.

STATE NEMT EXPERIENCES WITH BROKER MODELS

Just as states have wide discretion in shaping their Medicaid programs, federal requirements of NEMT give states significant flexibility in how they design and deliver the service. Given this autonomy and differences in the structure and capacity of state and local public transit systems, other states' experiences with brokerage models (positive or negative) are not readily transferable to the Commonwealth. This chapter includes summaries of the NEMT models and experiences of six states based on a review of available information, including state and federal government websites, published studies, and news reports. These states – Massachusetts, South Carolina, Washington, Arkansas, Texas, and New Jersey – were featured in the 2019 Legislative Report. Note that the

conclusions and findings are based on the information reviewed and do not reflect DHS's opinions or conclusions. In addition, this analysis did not evaluate specific broker contract requirements and broker performance beyond the insights captured in the research.

Massachusetts

The Massachusetts Medicaid program (MassHealth) provides NEMT through a regional brokerage structure that is carved out of managed care and overseen by the Executive Office of Health and Human Services' (EOHHS) Human Service Transportation (HST) Office, which coordinates transportation across MassHealth and multiple EOHHS agencies and programs.[26]

In July 2021, Massachusetts moved from its prior six-broker arrangement to contracts under which two Regional Transit Authorities serve as transportation brokers.[27] Each broker is responsible for arranging through its contracted network of transportation providers to deliver NEMT to and from medically necessary MassHealth covered services for members in the broker's contractually designated service area. Brokers may not directly provide NEMT and may not refer or subcontract to a transportation provider if the broker has a direct or indirect relationship with the provider. In addition, brokers may be held liable for costs stemming from prohibited relationships or referrals.[28]

To increase efficiency, officials also consolidated the service areas from nine regions to three (Western, Northern, including the metropolitan Boston area, and Southeastern Massachusetts). They explained that a significant portion of the Medicaid population travels eastward to Boston for medical visits, with NEMT providers currently passing through multiple NEMT regions.[29]

Under the brokerage contracts, payments are designed to promote cost-effectiveness by requiring brokers to competitively procure and manage a network of transportation providers and use competitive trip and route assignment methods. Brokers must schedule each trip with the lowest-cost qualified provider, with the state reimbursing brokers at cost for provider payments.[30]

Brokers are paid a broker-specific average monthly cost per eligible trip.[31] For demand-response trips, this is calculated as the broker's total monthly demand-response spending divided by the number of demand-response trips that month. For program-based trips, route-level average monthly trip rates are calculated first and then combined into an overall average trip rate for the broker.[32]

Brokers may also earn a shared-ride incentive for meeting the target rate of shared ambulatory trips. In addition, brokers receive a fixed monthly management fee, claimed as an administrative expense and negotiated based on the broker's reasonable management-function costs, excluding direct transportation costs.[33]

Massachusetts' experience may be minimally instructive for Pennsylvania due to the significant differences in size and population, geography, healthcare utilization patterns, and transportation provider availability.

South Carolina

South Carolina has long administered Medicaid NEMT through a transportation broker model. In 2007, South Carolina transitioned from an in-house NEMT model to a full-risk, regional broker model under Section 1902(a)(70) State Plan authority, with three regions.[34] The state initially selected two national brokers, but by 2011 there was only one statewide broker covering all three regions. Implementation was initially controversial, and the state faced challenges, including the loss of potential NEMT bidders. Consumer complaints increased, but injuries decreased (SFY 2016–2017). The South Carolina Department of Health and Human Services (SCDHHS) required a corrective action plan from the broker due to performance issues and attempted to switch brokers, but the proposal was canceled because the new contract did not meet certain criteria.[35] [36]

Currently, South Carolina's NEMT program operates as a broker fee-for-service (FFS) model, in which the broker arranges transportation and is reimbursed based on services delivered (e.g., trips), rather than a fixed prospective amount, resulting in limited downside risk to the broker for total program cost. Through the January 1, 2025, South Carolina Division of Procurement Services solicitation (RFP 5400027781), the state outlined a planned shift to a risk-based capitated model, in which the broker would receive a prospective per-member-per-month (PMPM) payment and would be at risk for managing utilization, provider network performance, and total cost while meeting defined access and quality requirements. The solicitation states that the transition from FFS to risk-based capitation payments is intended to:

1. address shortcomings with the current model, such as lack of risk for the broker and inability to introduce value-based programs;
2. improve current operational challenges, such as inadequate network due to administrative challenges, implementing cost-reduction and quality improvement initiatives, and monitoring end-to-end program performance and quality; and,
3. increase healthcare access opportunities by the completion of approved trips, and mandating and utilizing improved performance measures and monitoring.[37]

The 2025 procurement was subsequently protested by the current broker ModivCare Solutions, LLC, after Medical Transportation Management, Inc. (MTM) was ranked higher and identified as the awardee. On October 2, 2025, the ModivCare protest was sustained by the Chief Procurement Officer, and the contract was not issued. MTM objected to the decision and appealed to the South Carolina Procurement Review Panel (Panel Case No. 2025-4), with deliberations held on January 6, 2026. The Procurement Review Panel affirmed the decision on January 16, 2026. 38 As of the date of this writing, the contract has not been awarded, and ModivCare remains the statewide broker. Of note, Pennsylvania

finds itself in a similar scenario with respect to its current efforts to re-procure the MATP broker serving Philadelphia County.

Washington

Washington's Medicaid program provides NEMT through the Washington State Health Care Authority (HCA). The Washington State Non-Emergency Medical Transportation (WANEMT) program operates through a state-run regional brokerage model authorized by 42 CFR 440.170(a)(4), and Washington includes NEMT in its Medicaid State Plan as a medical service rather than an administrative activity.[39] According to an HCA report to the legislature in 2024, the approach requires greater oversight but also "reduces risk to the Medicaid agency and the state."[40] The brokerage model dates to 1989.[41]

HCA oversees broker performance through contracts and utilization-based monitoring. To support that oversight, HCA requires brokers to submit approximately 20 monthly reports, which program staff use to assess contract compliance, identify service issues, and develop corrective actions.[42] Washington also relies heavily on program data to manage WANEMT and presents that approach as a contributor to the program's cost effectiveness.[43]

HCA contracts with six transportation brokers to coordinate NEMT across 13 geographic regions covering all 39 counties. The brokers, which include five nonprofit community organizations and one Area Agency on Aging, arrange transportation for eligible clients within their assigned service areas.[44] Riders contact the broker serving their county of residence to request trips, and the program emphasizes use of the least costly transportation mode appropriate to the individual's needs and condition.[45]

HCA's legislative report explains that WANEMT separates administrative payments from payments for transportation services. The administrative rate is negotiated and cannot be changed without legislative action; payments for transportation services are passed through in full to transportation providers. As a result, brokers do not retain a share of trip-service payments. The report indicates this payment approach ensures there is "no incentive to run up costs to increase profitability." The report also states that "no broker is a for-profit organization so their sole focus is on service."[46]

Broker contracts also include incentives to reduce costs and increase use of lower-cost modes such as public transit, mileage reimbursement, fuel vouchers, and volunteer drivers, with any earned incentive funds reinvested in the brokerage.[47] Rather than using a single statewide NEMT fee schedule, Washington allows each broker to negotiate trip rates directly with its transportation providers based on regional market conditions.[48]

Arkansas

The Arkansas Department of Human Services, Division of Medical Services has operated a regional NEMT broker program under the authority of a 1915(b)(4) freedom of choice waiver since 1998.[49] It allows the state to mandatorily enroll Medicaid beneficiaries into the single regional NEMT broker – technically, a Prepaid Ambulatory Health Plan (PAHP) – that the state competitively selected to serve beneficiaries residing in the region, without offering them a choice between at least two brokers. Additionally, the 1915(b)(4) waiver authority enables Arkansas' regional brokers to provide trips directly rather than only through subcontracted transportation providers.[50] Direct provision of services by NEMT brokers is generally prohibited under the State Plan broker authority provided under section 1902(a)(70) of the Social Security Act.[51]

While the Arkansas NEMT model and the authority under which it operates has remained consistent for decades, Arkansas has continued to modify its program over time. Most recently, Arkansas reprocured its program in 2025 using the same seven regions it has had in place since reducing from eleven regions in 2018.[52,53] The Invitation for Bid was open to bidders that met certain qualifications, including a minimum experience of five years as a broker, and that offered the lowest PMPM bid within an actuarial spread range established by the state.[54] After three out-of-state entities challenged in all seven regions, Georgia-based Verida retained four of its five regions, and two local brokers retained each of their respective regions. ModivCare replaced Verida in the Little Rock-area region after an established coin-flip process between the lowest cost out-of-state bidders.[55]

Notably, Arkansas uses a full-risk PMPM model with a component that requires brokers, when applicable, to remit to the state "an amount equal to the amount of the actual service cost PMPM that falls below the 95% targeted service cost PMPM multiplied by the contracted period member months."[56] While a broker's margin is essentially capped, their losses are not.

Texas

Prior to June 2021, Texas delivered NEMT through contracts with regional transportation brokers. Effective June 1, 2021, House Bill 1576 shifted Texas to a managed care "carve-in" model, under which NEMT is administered as a covered benefit by state-contracted MCOs.[57] In this model, MCOs are accountable for NEMT administration and coordination, and typically subcontract operational functions such as trip intake, scheduling, assignment, and fulfillment to transportation brokers and other transportation vendors. For recipients who are Medicaid eligible but not yet enrolled in an MCO, the Texas Health and Human Services Commission (HHSC) contracts with a statewide fee-for-service (FFS)

broker to provide NEMT during the interim period prior to managed care enrollment.[58] The model change was intended to strengthen continuity of care, reduce administrative burden at HHSC, improve access and utilization, lower costs, and clarify performance accountability.[59]

In 2019, Texas adopted policy changes aimed at strengthening the transportation network by expanding the available driver pool through legislation that allowed transportation network companies (e.g., Uber and Lyft) to provide NEMT and receive Medicaid reimbursement. As a result, TNC drivers generally interact with NEMT trips in a manner similar to standard rideshare trips.[60]

In March 2025, a study published by the Episcopal Health Foundation assessed current levels of Texas NEMT utilization and identified barriers consumers face in accessing the benefit. The study covered more than 65,000 unique Medicaid consumers and more than 2.7 million trips from June 2021 through May 2024. The report notes that the carve-in model clarified accountability for administering and coordinating the benefit, but stakeholder feedback indicated the transition was implemented relatively quickly and created confusion, frustration, and an administrative burden for members, transportation providers, and healthcare providers. The report describes frequent users shifting from familiar local to new enrollment and scheduling processes, and it describes transportation providers navigating new broker contracts and requirements that made participation unfeasible for some smaller companies and rural transportation agencies.[61] While utilization remains low (23.1 members served per 1,000 enrollees), it has increased modestly each year since 2021, suggesting incremental stabilization as stakeholders align with the model and MCOs to strengthen NEMT programs and member communications.[62]

New Jersey

New Jersey administers Medicaid through the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), and delivers most medical benefits through MCOs. NEMT is carved out and administered through a single statewide transportation broker, currently ModivCare. New Jersey has utilized the same statewide broker since 2009. Consumers request and schedule rides through the broker (including urgent/same-day, subject to medical-necessity verification), and the broker fulfills trips through its contracted transportation provider network (with public transit fare options, where appropriate).[63]

New Jersey generally applies a closest-provider policy for members who make regular trips to medical facilities outside their immediate area when equivalent services are available locally. Exceptions apply for certain specialists or for consumers who are mid-course in

treatment, such as for chemotherapy or surgical evaluation and treatment, in which case NEMT may be provided without a mileage limit.[64]

The broker model has faced scrutiny tied to oversight and performance concerns.[65] Assembly Bill No. 2878 (2022–2023 session) would have created a "Medicaid Transportation Brokerage Program Oversight and Accountability Act" to strengthen oversight of the state's broker. The proposal focused on clearer broker and transportation-provider standards, regular performance reviews, complaint and grievance processes, recordkeeping requirements, liquidated damages for nonperformance, and an option for DHS to add a second broker if needed to ensure service coverage and reliability.[66] A similar proposal, Assembly Bill No. 5032 (2024–2025 session), was introduced with a similar intent and structure to reinforce standards, reporting, evaluations, and accountability mechanisms for the brokerage program.[67]

CHAPTER 3: KEY OBSERVATIONS

State Medicaid programs use a range of NEMT delivery approaches, often combining models to reflect differences in Medicaid delivery (managed care vs. fee-for-service), local human services administration, and transportation market capacity.

NEMT delivery models vary, and "mixed" approaches are common.

States generally choose from four approaches to assure access to NEMT: In-House Management, Broker, Managed Care Carve-In, or a Mixed model combining elements of the other approaches.

In practice, many states tailor NEMT operations by subpopulation (e.g., MCO-enrolled vs. FFS, special populations), which is a key reason "mixed" structures emerge.

In the context of this analysis, the model choices of the 50 states and D.C. can be summarized as follows:

- Seven states exclusively use an In-House Management model, either at the state or local level.
- Twenty states exclusively use a state-contracted Broker model, either statewide or regionally.
- The remaining 23 states and D.C. use other approaches that frequently incorporate an MCO Carve-In (using MCO-contracted brokers) and either In-House Management or a state-contracted Broker for non-MCO Carve-In populations. Pennsylvania and two other states combine In-House Management and state-contracted brokers.

State experiences with broker models are inconsistent. States that have shifted toward a broker model report varied outcomes:

Potential benefits cited: better cost control, improved quality and safety oversight, preserved access, and increased operational standardization (particularly in more urban markets).

Common challenges cited: increased consumer complaints and wait times, reduced coordination with other HST programs, weaker network participation in rural areas, and in some cases higher costs.

Rural impact can be amplified: smaller member volumes, longer distances, and thinner provider networks can make it harder to maintain timely service and robust coverage.

4. Predicted Impacts of a Statewide Broker Model

> An analysis of the positive and negative impact of maintaining the current transportation delivery model versus implementing a brokerage model as it relates to the state and local government entities, including financial impact.

Section 443.12 (g)(4)

This chapter provides an analysis of maintaining the in-house county models versus implementing a regional broker model. The fiscal impact analysis estimates the potential impacts on different programs resulting from a switch.

BENEFITS OF A STATEWIDE BROKER MODEL

Financial Benefits

Funding in a broker model would use a fixed per-member-per-month payment for all MATP-eligible individuals, regardless of service use. Because payments do not increase with trip volume, the broker assumes financial risk and is incentivized to control costs, reduce unnecessary or high-cost trips, and centralize administration. This structure transfers financial and operational risk away from counties, but outcomes would remain highly dependent on local transportation availability and existing county coordination, which may limit the effectiveness of a regional broker.

However, as evidenced with the COVID-19 pandemic, the per-member-per-month capitation rate can result in a broker continuing to be paid when, in fact, little to no service is being provided.

Brokers are incentivized to control costs, using cost-effective fixed-route public transportation for their consumers whenever possible, which likely would continue to

contribute that portion of revenue to public transit systems. However, the availability of fixed-route service is limited outside of urban centers in the Commonwealth so the portion of revenue to transit systems is less impactful in rural counties.

Currently, with the in-house model, the number of trips and the amount reimbursed to the Administrator from DHS are one-to-one. If the provider makes more trips, the county reports more trips, which DHS pays for. Using a full-risk broker transfers that risk from DHS to the broker since the broker would not be paid for more trips. The number of trips and the amount of reimbursement from DHS are now independent for the rating period. Any unnecessary trip comes out of the broker's bottom line, which is a strong incentive to prevent them. Note that this can result in stricter trip approvals and tighter scheduling, leading to longer rides, less flexibility, and potential service disruptions for consumers, especially those with complex needs or in rural areas. The number of trips that do happen during the rating period would then be used to inform the capitation payment for future rating periods, with a greater number of trips resulting in higher future payments. This may offset the incentive to control the number of trips inherently generated by a downside risk model.

Additionally, as mentioned previously, a capitated rate could result in the broker being paid when little to no service is provided, as it did during the COVID-19 pandemic.

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 60.2% (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.

A transition to a statewide broker model is estimated to generate $9.2 million in DHS savings attributable to increased federal participation. However, there is also estimated to be an increase in administrative costs, driving the net projected savings down to $5.1 million. Critically, these estimates do not include procurement costs (including legal fees), transition and implementation costs (including start-up costs for new vendors), or impacts to county budgets as discussed below. Because of this, actual net savings are expected to be much lower, and possibly negative.

Service Delivery

One of the most frequently cited challenges with the current structure of the MATP program is the difficulty traveling outside of the county. With a statewide broker, this could become

easier as long as local transportation providers in the broker's network are willing to travel longer distances. This is not guaranteed.

Administrative Simplicity

The oversight experience for Commonwealth staff would be much more straightforward in a statewide or regional broker model due to a significantly decreased number of MATP Administrators to oversee. DHS performs regular 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 of the various entities to review has made oversight more complex. Converting to a broker system would significantly decrease the number of Administrators that DHS would have to directly monitor. Consistent processes within a broker, even though it may cover several counties and require more depth, would likely make oversight easier through uniformity and fewer points of contact, although problems, when discovered, would be larger.

Data sharing may also improve as a result of a transition to a broker model. Data sharing with the current broker in Philadelphia County is simpler and requires less manual review than the data submitted by county partners.

A regional broker can centralize and consolidate its administrative work, which may generate 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.

CONCERNS WITH A STATEWIDE BROKER MODEL

Service Delivery

A statewide, or even regional, broker model would not be able to account for local dynamics to the extent the current model does; what works in Lackawanna County does not work in Tioga County. Large-scale broker models also lack the community-based vested interest in ensuring consumers receive high-quality services. County staff are inherently more incentivized to ensure their neighbors and friends receive the best service possible. Particularly in areas where there is only one transportation provider available, a broker only serves as an unnecessary additional layer of bureaucracy that further removes consumers from those held accountable for service provision. Additionally, 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 behavior. If the broker covers a multicounty area, aggregate regional statistics may overlook quality subtleties in a specific county or demographic. Brokers may also look solely at cost

savings, rather than access to health care or measurable functional limitations of consumers, in determining appropriate mode of service. This could ultimately impact positive health care outcomes and usage of MATP. Finally, when there are performance issues, they have the potential to impact broad swaths of the state, rather than a localized area. Notably, Texas's transition to a broker led to an increase in missed appointment rates.

Continuity of Operations

Operational risk centers on how effectively MATP transitions from county-run programs to a regional broker model. Key issues include continuity of already scheduled rides, system readiness, and the broker's ability to establish and maintain a reliable provider network at startup. Any breakdown during implementation could disrupt transportation access for consumers, particularly during the initial transition period. Procurement of MATP broker services has proven extremely difficult and riddled with legal challenges, resulting in lengthy, expensive, and inefficient implementation. DHS has also contended with a dearth of interested and qualified vendors resulting in minimal competition to provide services.

Operational risk also includes the possibility that a broker fails to meet its contractual obligations over time. While in-house county programs also carry performance risk, broker failure would affect an entire region rather than a single county. Additionally, a broker's exit would likely result in widespread and immediate service disruptions for consumers across the region.

Financial Impacts

As discussed previously, there is pricing risk related to broker models due to the capitation rate being based on projections, which can at times result in overpaying compared to the fee-for-service style financing arrangement in the current model. The reverse can also be true; insufficient rates can threaten a broker's solvency and ability to provide services.

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 may submit a revised budget to DHS for review. At the end of the fiscal year, the county submits a Grantee Cost Report that reflects actual MATP expenditures. If DHS approves the revision, DHS will adjust the county's allocation to reconcile any remaining differences.

Other states discussed in Chapter 3 of this report have experienced adverse financial impacts, such as Texas's increased per-rider costs.

Impacts on Transportation Providers

A broker's continued use of public paratransit is difficult to gauge and will be influenced by its availability. The experience in other states indicates that brokers typically contract with agencies in some but not all instances, leading to a reduction in both the number of agencies providing this service and the number of rides among agencies that continue to participate. Agencies also face potential challenges with the financial and legal terms imposed by the broker and may not be able to secure a contract that covers program costs in the same manner as the current reimbursement structure.

Agencies participating with the broker are also not assured of being selected to deliver trips in a given area. Trip assignment is at the discretion of the broker, who has incentives to seek to lowest-cost option, which may be a different provider. The combination of these factors has led to significant losses in Medicaid NEMT rides for public transit agencies with the switch to a broker model in states such as Texas and New Jersey.

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 the transit authority to refuse all contracts with the broker. In New Jersey, there were many instances of transportation providers and agencies no longer willing to participate in the NEMT program due to the need to work with the broker.

Through the Community HealthChoices (CHC) program, brokers attempted to negotiate contracts with public transit agencies throughout the Commonwealth for paratransit services. Although some transit agencies negotiated contracts with brokers for CHC trips, most of those contracts did not prove to be viable as CHC trips never materialized from the brokers.

Impact on Other HST Programs

Coordinating MATP service with other HST programs improves overall productivity and provides a lower cost per passenger trip. If brokers remove revenue from public transportation, the fares of other HST consumers have to rise to cover the lost funding, resulting in both consumers and third-party sponsors, such as Area Agencies on Aging, paying more for services. If fares are not increased, access to service will be reduced proportionally to compensate for lost revenue. Decreased trip volume would result in a loss

of federal transit funds for the Commonwealth because of appropriation formulas correlated with factors such as trip volumes.

Paratransit providers earn funding from many sources, the two largest being MATP and the SSRP. From SFY 2025 data provided from the statewide shared-ride scheduling software (excluding Allegheny and Philadelphia County because they use different scheduling systems), MATP was approximately 34% of trips and 30% of all fare revenue for the shared-ride public transportation service.

MATP expenditures on paratransit outside Philadelphia County totaled $64.8 million in SFY 2025. The impact on public transportation revenue if a broker were used would be proportional to how engaged the broker stays in HST coordination.

Pennsylvania's HST funding model entails transportation providers charging per trip fares intended to cover the full cost of delivering the service. With MATP trips representing roughly a third of all trips paying the HST fares across the state, any significant shifting of its trips away from the coordinated service will severely impact the cost recovery of the local HST providers. Most HST providers already charge less than needed to cover their costs, due to the constraints explored in the Shared-Ride Transportation Study[68], so any loss of fare revenue from a reduction in trips cannot be absorbed without additional funding from other sources or service cuts.

While the full extent of broker disengagement from HST cannot be known in advance, the CHC program's transportation mandate can be looked to as an example of statewide brokered service in Pennsylvania. To date, the brokers responsible for CHC transportation service have delivered most of it on parallel transportation networks outside of coordinated HST. Were MATP to shift to a statewide brokered model and follow the same pattern, the financial impact to HST providers would likely far exceed, and therefore offset, the estimated $5.1 million in state savings to MATP.

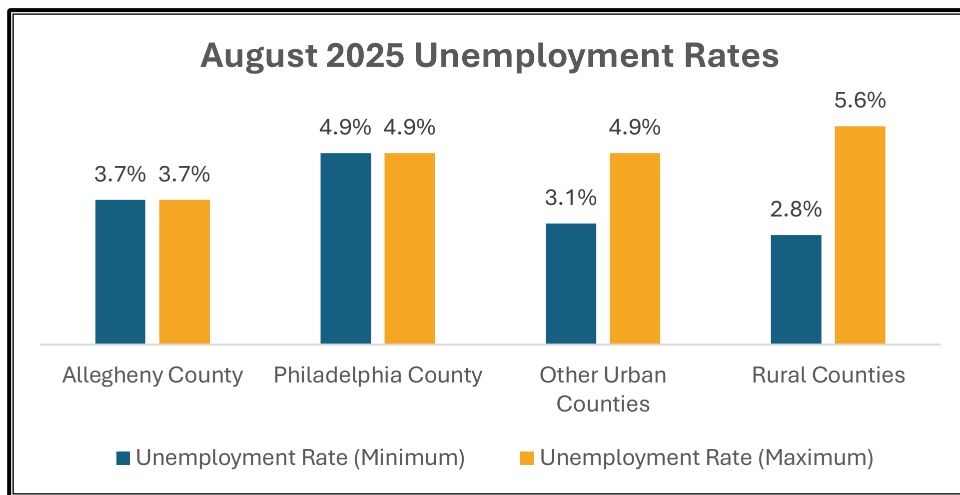
Impact on Employment

Full Time Employee (FTE) is a measure of how many employees it might take to perform the work on a project. For MATP administrative work, there are approximately 70 FTEs across the Commonwealth based on SFY 2025 fiscal reports provided by DHS that show $1.3 million for staff wages (excluding benefits). The full impact of the broker model on FTEs is impossible to estimate, but the Pennsylvania Public Transportation Association (PPTA) believes there could be as many as 800 layoffs statewide as a result of this change. 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 may 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 has continued to remain low. The labor market, particularly for drivers, has changed substantially since the 2019 Legislative Report, with the potential for neither existing nor new providers of MATP services and other demand-responsive programs being able to staff appropriately.

This table shows the range of unemployment rates during August 2025 using seasonally adjusted Bureau of Labor Statistics data, as reported by the Pennsylvania Department of Labor & Industry:



STAKEHOLDER INPUT — GOVERNMENT ENTITIES

An important component of this legislative analysis is stakeholder input from those entities that would directly feel the impact of a change to the delivery model. As discussed in the Introduction, feedback and input were solicited from impacted stakeholder groups and incorporated into the analysis presented in this study. Stakeholder perspectives on the feasibility and desirability of a statewide broker model were nearly universally opposed, as further detailed below. Several counties and groups, such as public transportation providers, the Pennsylvania Public Transportation Association (PPTA), and CCAP continue to oppose the use of regional or statewide broker models for MATP, just as they were opposed in 2019.[69, 70, 71, 72, 73, 74, 75 76]

County Commissioners Association of Pennsylvania

Counties have always opposed proposals to move MATP to a regional broker model, emphasizing the risks associated with shifting a locally administered program to a centralized, private structure. Commissioners note that MATP, as locally administered, operates efficiently and responsively, and that major changes should be approached with caution given the program's direct impact on vulnerable consumers.

Counties have invested heavily in coordinated transportation systems that serve both MATP and Human Services Transportation consumers. Shifting MATP to a broker risks diverting funding and ridership away from public transit providers, weakening local systems, and reducing access, particularly in rural areas. Commissioners warn that these losses could significantly undermine service availability.

Local trust and accountability are central to MATP's success. Counties have built strong relationships with consumers, providers, and community partners that cannot be replicated by a private, multicounty broker. CCAP remains opposed to a broker model and continues to advocate for approaches that protect consumers, preserve local control, and strengthen existing transportation networks rather than destabilize them.

Overall, CCAP strongly opposes the broker model.

Pennsylvania Public Transportation Association

Coordinating MATP service with other human services transportation improves overall productivity and provides a lower cost per passenger trip.

In 2019, PPTA commissioned Econsult Solutions, Inc. (ESI) and the Texas A&M Transportation Institute (TTI) to prepare an independent analysis of the topics set forth in Act 19 of 2019. This analysis used a “cost-benefit” framework to evaluate the overall impact to the state and local governments of the proposed brokerage model, relative to the current service delivery model for human services transportation.

The ESI-TTI analysis concluded that transitioning to a brokerage has the potential to increase annual costs borne by the state for human services transportation programs by $17.3 million, reduce annual Federal Transit Administration (FTA) apportionments to Pennsylvania’s transit agencies by $5.0 million and increase annual state Medicaid costs by $31.3 million through degraded health outcomes, an aggregate cost of $53.6 million annually. Including the potential annual benefit of $15.2 million in federal MATP matching funds, potential net costs to the state and its transit agencies total $38.4 million annually.

According to PPTA, if a brokerage model is implemented, the result may be a need to substantially increase fares for other human service transportation services at an increased cost to the state and consumers or limit operations, including shutting down public transportation in some counties. Again, rural counties are 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 are 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. Trip assignment is at the discretion of the broker, who has incentives to seek the lowest cost option, which may be a different provider. The combination of these factors has led to significant losses in Medicaid NEMT rides for public transit agencies with the switch to a broker model in states such as Texas and New Jersey.

PPTA estimates 800 layoffs from the potential change. Potential cuts to the transit agency workforce are significant on a number of dimensions. From a broader economic standpoint, some or all of this activity may be replaced through increased demand and employment from other providers delivering the transportation services in place of existing entities. However, this disruption may have material implications for workers. First, compensation through public agencies includes a living wage and benefits, and generally increase with the number of years of experience. Positions with private providers replacing this activity may not adhere to the same pay scale and benefits, and may not reflect the advances in seniority that agency workers have accrued.

This combination of factors suggests that this displacement could lead to material decreases in employee earnings, even if total transportation activity is shifted rather than reduced. If significant enough, this decrease could have downstream impacts on the state through reduced household earnings and spending (impacting various tax bases) and potentially an increased reliance on state benefit programs.

In addition, shared ride vehicle miles are a component of the federal funding allocation formula for urban transit agencies administered by the FTA. A reduction in service provision through MATP would lead to reductions in these allocations, leading to federal dollars flowing to other states rather than Pennsylvania and reducing available operating funds for agencies.

Overall, PPTA strongly opposes the broker model.

STAKEHOLDER INPUT — BROKER

ModivCare has served for several years as the vendor providing MATP broker services in Philadelphia County and has experience nationally operating NEMT broker programs. It is ModivCare's view that a statewide broker model can be effectively implemented in Pennsylvania through thoughtful contract design, local partnership requirements, and phased operational safeguards that directly address the concerns identified in DHS' analysis. ModivCare's recommendations can be summarized as follows, with full details available in Appendix B of this study:

1. Proactive Contract Design: DHS should aim to develop broker contracts that address the concerns outlined in the analysis and protect the benefits of the current system.

2. Public Transit Funding Protections: DHS should require brokers to set fair rates with public transit providers and include contractual provisions that brokers look to public transit providers as a primary source of MATP rides.

3. Robust Performance Management and Oversight: DHS should hold brokers to standard performance requirements monitored through regular reporting.

4. Local Partnerships: DHS should require brokers to leverage partnerships with local organizations across Pennsylvania to encourage brokers to invest in and tailor services to Pennsylvania's diverse communities.

5. Rural Service Planning: DHS should require brokers to develop plans, policies, and procedures to operate differently in rural areas to best serve rural communities.

CHAPTER 4: KEY OBSERVATIONS

Broker model shifts financial risk to vendors through capitated payments, potentially generating $5.1M in net savings from increased federal match (60.2% vs 50%), though actual savings likely lower or negative after factoring in procurement, transition, and implementation costs.

Capitation incentivizes cost control but can result in paying brokers when little service is provided (as during COVID-19) and may lead to stricter trip approvals, longer rides, and reduced consumer flexibility.

Converting to a broker system would significantly decrease the number of Administrators that DHS would have to directly monitor, but regional problems would impact larger populations and lack local accountability and community relationships.

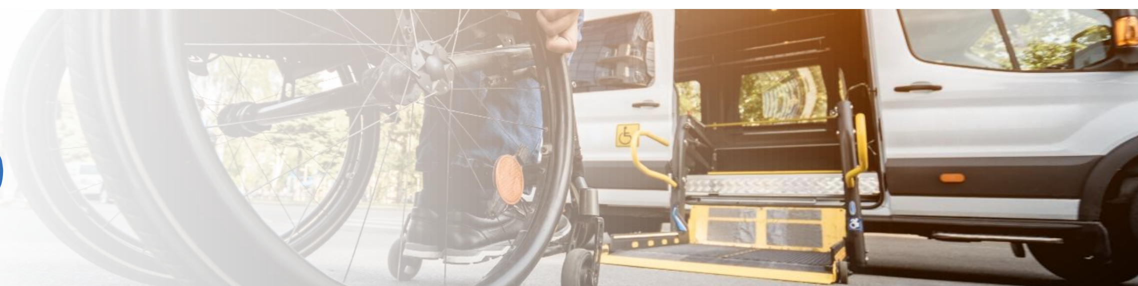
Approximately $64.8M in annual MATP paratransit funding outside Philadelphia is at risk; broker disengagement from HST coordination could increase fares for other programs, reduce service access, and decrease federal transit formula funding.

Transition risks include procurement challenges, service disruptions during implementation, and broker failure affecting entire regions rather than single counties.

There could be an estimated 800 potential job losses statewide as counties and transit providers lose MATP work; reduced trip volumes would also decrease federal transit funding allocations to Pennsylvania.

PPTA-commissioned study found a potential net cost of $38.4M annually to state and transit agencies, contrasting with DHS estimate of $5.1M in savings.

CCAP and PPTA strongly oppose broker model, citing risks to local control, service coordination, public transit viability, and consumer access—particularly in rural areas.



5. Consumer Experience

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

Section 443.12 (g)(5)

This chapter 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 managing and arranging of their services. Also explored are the potential broker impacts on public transportation.

COMPLAINTS AND SURVEYS

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. In total, MATP from a consumer standpoint seems to be in a satisfied and stable state, with some expected complaints.

MATP Complaint Process Update and Scope

There has been a concerted effort to enhance the MATP complaint process. Within that framework, MATP has recently established an updated reporting structure for all MATP Administrators, except the broker. The updated process requires written documentation for each complaint and defined levels of review, with copies of both the complaint and the response sent to the consumer. MATP Administrators submit complaint data to DHS as part of routine reporting.

Because this process was only recently redefined, the complaint metrics summarized here are limited to the Commonwealth's broker region serving Philadelphia County. While the

broker data provides useful directional insights, results should not be treated as representative of statewide performance given Philadelphia County's distinct population size, utilization patterns, and model type.

Philadelphia County Trends

Under Commonwealth reporting requirements, ModivCare submits performance data, including complaint and customer satisfaction information, for its broker services in Philadelphia County.

This study analyzed complaint data from calendar years 2023 to 2025. As shown in the table below, the nature of complaints shifted over time, with fewer no-show complaints and greater concerns related to timeliness and the ride experience itself.

Consumer Complaints – Philadelphia County
Calendar Years 2023 – 2025

CY	Average Complaints (per 1000 trips)	Distribution of Complaints by Type				
		Provider No-Show	Timeliness	Transportation Provider	Injury	Miscellaneous
2023	2.08	51.91%	8.96%	15.95%	0.58%	22.60%
2024	1.76	42.50%	17.60%	20.05%	1.17%	18.69%
2025	1.82	26.58%	19.12%	28.42%	0.95%	24.92%

ModivCare's complaint rate in Philadelphia County remained relatively stable over the period, ranging from 1.76 to 2.08 complaints per 1,000 trips and averaging about 1.9 complaints per 1,000 trips overall. That overall rate is higher than the average of 1.3 complaints per 1,000 trips cited in the 2019 Legislative Report for calendar years 2016 through 2018.[77] It is important to note that the distribution of trips by mode also varied between the 2016-2018 and 2023-2025 periods, with public transit decreasing from 74% to 59%, paratransit increasing from 25% to 40%, and mileage reimbursement steady at 1%. Average customer satisfaction also decreased between the two periods, from around 90% to 82%.

PennDOT Shared Ride Survey Results

Since 2018, PennDOT has been providing assistance to transit agencies to conduct rider surveys for the shared ride service. Although many of the transit agencies serve more than MATP consumers, the survey provides valuable insight into how consumers rate the transit agencies' performance. The results of two recent examples of these surveys conducted for

transit systems who provide MATP are described below. Both surveyed MATP providers out-performed the Philadelphia broker in terms of consumer satisfaction.

Susquehanna Regional Transportation Authority (CPTASRTA) 2025 Survey

SRTA, or rabbittransit, randomly surveyed 381 consumers in 2025. The survey results indicate a high level of overall satisfaction with 92% of respondents indicating their overall satisfaction as very satisfied or satisfied. Drivers received a 95% satisfaction rating for being safe, skilled and friendly. As it relates to service improvements, respondents were most dissatisfied with the timeliness within which phone calls are answered and the wait time for return trip, with 26% of respondents indicating they were dissatisfied or very dissatisfied.

Washington County Transportation Authority (Freedom Transit) 2025 Survey

In 2025, Freedom Transit randomly surveyed around 300 consumers of more than 2,700 who had ridden in the prior six months. Of the respondents, 51% have been riders on the shared ride system for more than three years. The survey reflected 51% of respondents reported using shared ride service as they have no other transportation options. An overall satisfaction rate of 96% was reported as respondents said they were “satisfied” or “very satisfied” with the service. The service improvement request with the highest ranking was to shorten return-trip wait times with 30% of respondents rating it as most important.

USE AND AVAILABILITY

MATP Statistics and Medicaid Expansion

DHS data indicate approximately 4.1 million MATP trips in FY 2025. Trip volumes increased from FY 2021 through FY 2023, followed by a decline from FY 2023 through FY 2025. Overall MA enrollment exhibited a comparable pattern, resulting in a generally stable utilization rate per eligible consumer over the period.

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.[78] As noted, the Databook showed the number of MATP trips taken remained flat over that period of expansion.

Availability Impact

While it is difficult to predict the exact impact on public transportation, switching to a broker would have the potential to result in raised public fares, reduced hours, smaller service areas, or fewer fixed routes for public transportation.

With revenues fixed through a capitated payment, profitability for a private broker would be a function of minimizing transportation costs, either through the decreases in "per unit" delivery costs or through reductions in the number of trips to medical services. The financial disincentive to increase the use of their services provided by brokers is in opposition to the traditional dynamic in competitive consumer markets.

The set of incentives may encourage the use of low-cost providers at the expense of consumer safety or experience considerations. In addition, it may discourage the provision of high-quality customer service in processing and scheduling rides and addressing complaints. Evidence from other states implementing a private broker model document issues with safety monitoring, service provision, and customer complaints that align with the expectations dictated by this problematic incentive structure.

The MATP consumer will likely be insensitive to fare changes for medical trips because Medicaid will pay for these trips. However, the 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.

Higher fares can change consumers' behaviors. Based on historical performance among public transit agencies in Pennsylvania whose ridership has been negatively impacted after instituting a large fare increase.

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 would be directed 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.

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.

Some consumers may choose not to call the broker for their MATP trip and instead elect to utilize the HST at their own expense. Without coordinated HST, determining payer of last resort could be difficult to manage resulting in a cost shift back to public transit.

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 is answering the new number, whose logo may be on their new ride, and who their new driver is 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.[79] A well-thought-out transition plan must be in place to communicate to consumers the upcoming changes. The broker may eventually establish new patterns with consumers, but rapport takes time to build. Short or long-term disruptions are difficult to predict.

STAKEHOLDERS — CONSUMER ADVOCATE ORGANIZATIONS

Similar to the government entity stakeholder summaries in Chapter 4, a summary of consumer advocate feedback is provided below. The issues raised by these groups also shaped the considerations presented in earlier chapters of this analysis.

Pennsylvania Health Law Project (PHLP)

PHLP clients are Pennsylvania residents who have trouble accessing publicly funded health care coverage and services.

As of 2026, PHLP does not have a position on the appropriateness of converting to a statewide MATP broker model for Medicaid recipients and Pennsylvanian communities. Informed by our client's experiences navigating MATP and non-medical transportation services in the years since this interview was conducted, PHLP continues to believe the current MATP system needs more consistent standards, improved capacity, better

accountability, clearer communication, and better coordination with Medicaid managed care- and Medicare-funded transportation. However, we are not confident that a single vendor will resolve, or is necessary to resolve, those issues. Moreover, we are concerned that disrupting the current MATP model, which is financially intertwined with other transportation systems, may negatively impact Pennsylvanians who rely on those systems to get medical care as well as attend work, school, and community activities.

Pennsylvania Statewide Independent Living Council (PA SILC) and the Pennsylvania Transportation Alliance (PTA)

The Pennsylvania Statewide Independent Living Council (PA SILC) and the Pennsylvania Transportation Alliance (PTA) both point to Pennsylvania's diversity regarding topography, population trends, increasing demographic diversity, and local county governments. Pennsylvania's unique mix of rural, urban, and suburban settings differs from most states and renders comparison challenging. Any model designed to meet the needs of one area of the Commonwealth or another small state with vastly different indicators should not serve as the basis for deciding to transition to a broker model.

They also acknowledge the changes that have taken place since the 2019 Legislative Report was finalized, and the impact those changes have had on HST:

- The COVID-19 public health emergency had a significant and lasting impact on utilization trends for public transit.
- Pennsylvania's population is aging, and many counties are seeing increased rates of people with disabilities who use MATP.
- Service provision costs, including fleet maintenance and employee salaries, have risen drastically since the original report.

If DHS were to change to a statewide or regional broker model, it would be critically important to meaningfully consult with and inform MATP consumers in advance, especially people with disabilities of all ages who utilize the program. This could be done through a dedicated committee or forum to address consumer complaints or solicit public feedback,

as a supplement to the Quarterly Administrator calls. Even if a statewide broker model is not adopted, continued coordination among all offices of DHS, PDA, and PennDOT is critical due to the overlap of issues and the nature of consumers transitioning between and among various publicly funded or subsidized transportation programs.

In addition, they have identified the following concerns that would need to be addressed in order for a statewide broker to sufficiently serve their membership:

- There must be an adequate mechanism for health and wellness concerns of the consumers to be addressed by the broker.
- There must be assurances that there will be enough participating transportation providers in the broker's network to meet the needs of consumers, including those with mobility needs.
- Any changes to the operational model would be needed to ensure that quality of services is not sacrificed in exchange for cost containment.
- The broker(s) will need to be able to address any concerns about fraud, waste, and abuse raised by policymakers at the state and federal levels.
- Transportation should be coordinated between the MATP broker and local transportation providers, including providers of other HST trips for non-MATP consumers.
- Transportation should be coordinated with county mental health and intellectual disability program staff for consumers who receive services through those systems
- Consumer experiences with non-medical transportation provided through the Community HealthChoices program that uses a broker model should be taken into consideration and lessons learned from that program should be leveraged to best serve individuals with physical disabilities.
- The unique needs and abilities of all Pennsylvanians, including children, youth, and parents with disabilities, should be accounted for to help ensure continued access to needed healthcare services.

Overall, the Pennsylvania Statewide Independent Living Council and the Pennsylvania Transportation Alliance remain opposed to the broker model.

CHAPTER 5: KEY OBSERVATIONS

Current MATP model shows generally high consumer satisfaction; surveyed in-house providers (rabbittransit 92%, Freedom Transit 96%) outperformed Philadelphia broker model (82% satisfaction, 1.9 complaints per 1,000 trips).

Broker capitation creates a financial incentive to minimize trips and costs rather than maximize access, potentially encouraging use of lowest-cost providers at expense of safety, quality, or consumer experience.

Transition to broker would eliminate one-stop-shop coordination in counties currently offering combined MATP and HST scheduling, potentially confusing consumers and discouraging MATP use.

Loss of local rapport and established routines with coordinators and drivers poses risks, especially for patients with chronic conditions requiring regular treatments; disruptions could escalate preventative care needs into emergencies.

Consumer advocates (PHLP, PA SILC) express concern about disrupting current system's financial interdependence with other transportation programs and emphasize need for meaningful consumer consultation, adequate provider networks, and quality assurances before any model change.

Pennsylvania's unique geographic and demographic diversity makes comparisons to other states challenging and requires locally responsive solutions.

Conclusion

After extensive review, the analysis finds that converting MATP to a statewide or regional full risk broker model would introduce substantial fiscal, operational, and service delivery risks, with limited proven benefit. The current county-administered structure—strengthened by ongoing DHS and PennDOT reforms—continues to provide a coordinated, community-focused, and cost-effective approach to meeting the transportation needs of Medicaid consumers across the Commonwealth.

Given the potential for disruption to consumers, public transportation providers, local governments, and the broader HST ecosystem, and considering stakeholder consensus, the evidence strongly supports continuing MATP under the improved in-house county delivery model rather than implementing a full risk broker system.

Appendix A: Abbreviations

- 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
- DHS — Department of Human Services
- FFS — Fee-For-Service
- FMAP — Federal Medical Assistance Percentage
- HST — Human Service Transportation
- IDD — Intellectual and Developmental Disabilities
- MA — Medical Assistance
- MATP — Medical Assistance Transportation Program
- MCO — Managed Care Organization
- NEMT — Non-Emergency Medical Transportation
- 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
- PTA — Pennsylvania Transportation Alliance
- PwD — Persons with Disabilities Program
- RFA — Request for Application
- SFY — State Fiscal Year (July 1, to June 30) (e.g., SFY 2026 is July 2025 through June 2026)
- SPA — State Plan Amendment
- SSRP — Senior Shared-Ride Program

Appendix B: Broker Letter

Via Email

April 16, 2026

To: Gwendolyn Zander
Kristen Figueroa
Rebekah Leiphart
Amy Brandt

CC: Dr. Val Arkoosh
Sally Kozak

Pennsylvania Department of Human Services
P.O. Box 2675
Harrisburg, PA 17120

Re: PA DHS Medical Transportation Assistance Program Broker Analysis Draft for Discussion

Dear Dr. Arkoosh:

Modivcare respectfully submits feedback on Pennsylvania Department of Human Services' Medical Transportation Assistance Program (MATP) draft for discussion regarding implementing a regional or statewide MATP broker.

ModivCare[1] is transforming healthcare by connecting people with the care they need, wherever they are. Modivcare serves a diverse array of patient populations, from children to older adults, delivering reliable, high-quality care to people living in communities ranging from large, densely populated urban areas to sparsely populated rural communities. The Company's value-based solutions ensure members receive the essential care they need, helping its members manage risks, reduce costs, and improve health outcomes. ModivCare is a leading provider of non-emergency transportation, personal care services, and monitoring solutions. To learn more about ModivCare, please visit www.modivcare.com.

ModivCare's comments focus on the assumptions at the foundation of the analysis. It is ModivCare's view that a statewide broker model can be effectively implemented in Pennsylvania through thoughtful contract design, local partnership requirements, and

[1] ModivCare refers to ModivCare Topco, LLC, a Delaware limited liability company, that provides healthcare services under its licensed and credentialed entities.

phased operational safeguards that directly address the concerns identified in DHS' analysis.

Recommendations Regarding an Effective MATP Statewide Broker Model

ModivCare recommends the following design elements as Pennsylvania considers the advantages of a statewide transportation broker model for MATP:

1. Proactive Contract Design: DHS should aim to develop broker contracts that address the concerns outlined in the analysis and protect the benefits of the current system.
2. Public Transit Funding Protections: DHS should require brokers to set fair rates with public transit providers and include contractual provisions that brokers look to public transit providers as a primary source of MATP rides.
3. Robust Performance Management and Oversight: DHS should hold brokers to standard performance requirements monitored through regular reporting.
4. Local Partnerships: DHS should require brokers to leverage partnerships with local organizations around Pennsylvania to encourage brokers to invest in and tailor services to Pennsylvania's diverse communities.
5. Rural Service Planning: DHS should require brokers to develop plans, policies, and procedures to operate differently in rural areas to best serve rural communities.

Through these strategies, DHS can protect against the concerns cited in its analysis such as:
1. Potential transit agency funding losses.
2. Workforce displacement.
3. Broker performance.
4. Consumer confusion.
5. Rural access.

The following provides context supporting these recommendations and demonstrates how DHS may consider a statewide broker model that addresses and shifts the assumptions in its analysis.

<u>Proactive Contract Design:</u> DHS cites several concerns with a statewide broker model that it could mitigate through prescriptive contracting. Brokers' contracts could be structured to protect the State against financial risk, subpar service provision, and public transit agency losses. DHS should consider the following contract elements that would alleviate some of its fundamental concerns:
1. Set rate floors for payments to public transit providers contracting with brokers.
2. Require brokers to look to public transit providers as a primary source of rides, demonstrated through standard reporting on public transit rides as a portion of total rides and compared to previous data.

3. Reimburse brokers for services at capitated rates to allow DHS to predict costs, regularly review capitations to ensure fair rates, and control costs through utilization management pressures.
4. Require annual capitated rate reviews to protect against overpayment to brokers during periods of unexpected, sharp decreases in utilization.
5. Include a clawback provision if a situation like COVID-19 reduces utilization to extremely low levels while brokers continue to be paid their capitated rate.
6. Require brokers to meet quality standards; levy financial penalties on brokers that do not meet the quality standards.

A key element of a broker model is the opportunity to predict and potentially control program costs through actuarially sound capitation rate-setting.

DHS references Texas as a cautionary example of increased spending following a transition to a broker model. However, Texas and Pennsylvania operate materially different transportation delivery systems, serve different populations, and have used multiple payment structures over time, including fee-for-service brokerage, capitated brokerage, and managed care carve-in approaches. As a result, Texas' experience should be interpreted cautiously and may not serve as a direct analog for Pennsylvania's proposed MATP structure. Texas has also opted to change their program structure in several instances, moving towards a capitated rate broker model in 2015 and then choosing to transition to a managed care carve-in that became effective in 2022. Throughout the 7 years Texas administered the broker model, costs steadily decreased to generate overall cost reductions in SFY 2020 following a sharp increase in costs attributed to the system stress of shifting program models. Now, the managed care administered program varies greatly from the broker model that DHS is considering. While Texas' Fee-for-Service Medicaid participants do still receive medical transportation through a broker model, the participants exempted from managed care enrollment often have the highest acuity of Texas' Medicaid population. Since the customers served through the broker model generally have greater medical needs, the cost of transporting these individuals is also higher, artificially raising the average member cost for that population relative to others.

<u>Public Transit Funding Protections:</u> DHS cited concerns regarding the financial impact that a statewide broker model would have on public transit agencies. Beyond the public transit-related contractual provisions recommended above, as a broker, ModivCare has demonstrated a commitment to public transit as a primary source of member rides.

Protecting public transit use in the MATP program and federal / state funds affected by MATP public transit use is, in ModivCare's view, an important element of a statewide broker model. Doing so will support transit agencies while also protecting the jobs within those agencies. ModivCare recognizes the importance of public transit across Pennsylvania and is a proud partner of the Southeastern Pennsylvania Transit Authority in the Philadelphia area. In a statewide broker arrangement, ModivCare would look to expand

public transit partnerships beyond SEPTA, working with other county and regional transit agencies such as Rabbit Transit in the Capital Region, Pittsburgh Regional Transit, and smaller agencies throughout Pennsylvania. Public transit agencies are a key resource and partner for ModivCare in metropolitan Philadelphia and across the country. ModivCare believes that supporting those agencies in maintaining their financial sustainability is essential for its own mission and goals.

ModivCare also believes that it is well positioned to provide actuarially sound rates to public transit organizations as a good steward of State Medicaid and Federal funds. In the current system, MATP administrators have limited pressures to constrain the rates paid to public transportation agencies to ensure their alignment with service delivery cost. In the current political and regulatory environment, it is critical that all protections against fraud, waste, and abuse are in place to demonstrate MATP's responsible use of Medicaid funds. A statewide broker model would preserve MATP reimbursement to public transit agencies while also protecting against scrutiny through actuarial assessments and fairly determined rates, which we encourage should be reviewed and reset annually. Before Texas' program transitioned to a broker model, the US HHS Office of the Inspector General reported that Texas' program relying heavily on public transportation agencies did not always properly submit claims for reimbursement or charge fair rates. The Capital Areas Rural Transportation System often received overpayments for services that were then used to support its non-Medicaid programing. As a closely scrutinized program, it is imperative that Medicaid programs and their important components like MATP are structured to be beyond the suggestion of reproach when delivering and paying for services. A statewide broker model would introduce safeguards and rate setting pressures that continue to uphold the integrity of the program and prevent the appearance of any fraud, waste, and abuse within MATP through its payments to public transportation agencies.

<u>Robust Performance Management and Oversight:</u> ModivCare is committed to providing excellent service to its members and understands the central role MATP plays in supporting the health and welfare of Pennsylvanians. With a statewide broker model, DHS would have an opportunity to closely monitor contracted brokers and develop tailored plans to ensure high-quality performance and service delivery. In the current system, DHS' resources are spread across the state, addressing service concerns with 57 agencies. A statewide broker model would garner efficiencies in DHS' oversight responsibilities, allowing staff to home in on areas for improvement with a limited number of brokers.

ModivCare also believes that a robust, standardized performance measure reporting and monitoring system would create additional opportunities for early and frequent identification and resolution of brokers' performance challenges. In its work in New Jersey, South Carolina, Maine, and Philadelphia, ModivCare has demonstrated its commitment to cooperation with regulators and organizational improvement to improve member experience. ModivCare has undergone substantial efforts in recent years to improve its operations and service delivery.

CARING • COLLABORATIVE • DEDICATED • PURPOSEFUL 4

Maine's statewide broker model demonstrates how a centralized structure can drive strong, measurable operational performance while improving consistency for members, providers, and regulators. Under the current model, members and caregivers benefit from a single statewide mileage reimbursement policy and standardized forms, including the highest mileage reimbursement rate among the state's former broker regions, currently 70 cents per mile, alongside more modern reimbursement tools such as a reloadable debit card and mobile app functionality.

The statewide model also supports stronger oversight through a consistent call center experience statewide, including standardized messaging, ride-request instructions, and non-English language services. On the provider side, all contracted transporters operate under uniform statewide performance requirements, standardized contract terms, monthly report cards, and a common dispatching framework, enabling clearer accountability and more effective regulatory monitoring. These operational features demonstrate how a statewide broker structure can improve service quality while simplifying oversight responsibilities for the state.

ModivCare is consistently improving and committed to supporting its members in maintaining their health. Studies commissioned by organizations like the PA Public Transportation Association reflect those organizations' own interests in maintaining the status quo. They do not account for the safeguards creative contracting would create. The study DHS referenced makes claims of spurious correlation, predicting health outcome degradation if Pennsylvania transitions to a broker model. ModivCare's priority will always be the welfare of its members; its service delivery and operations would reflect that.

DHS cites a 2025 complaint rate of 1.9 per 1,000 trips from Modivcare's members in Philadelphia. This metric reflects stronger performance relative to peer benchmarks in other states and is closely aligned with the statewide complaint rate of 1.82 complaints per 1,000 trips. The similarity between the statewide rate and Modivcare's rate in Philadelphia indicates similar member satisfaction between individuals served by the current county-based model and Philadelphia's broker model.

Lastly, DHS noted concerns with the potential for increased administrative costs associated with overseeing a statewide brokerage model while also noting concerns with as many as 70 current system administrators being laid off due to the change. It is ModivCare's view that staff currently overseeing the county-based model would be well positioned to transition into oversight roles for the statewide broker model. Their experience serving Pennsylvania's diverse communities would benefit the brokers DHS would contract with. Additionally, reducing the number of MATP models will reduce the pressure to oversee a highly diverse program portfolio, driving down oversight costs while allowing for more focused oversight.

Local Partnerships: ModivCare takes pride in working as a close partner with local organizations to best serve communities and their unique needs. It understands that programs are at their strongest and most effective when they have substantial input from the individual communities they serve.

Maine offers a strong example of how a statewide broker can preserve local responsiveness while improving consistency. Under the consolidated model, ModivCare established one statewide website, standardized facility ride-request procedures, and a uniform hospital discharge transportation process, making it easier for providers, discharge planners, and local organizations to navigate the system regardless of geography.

At the same time, ModivCare strengthened coordination with transportation providers by implementing consistent contract requirements, shared performance standards, and a common approach to dispatching across all regions, enabling stronger relationships with local transportation partners while reducing administrative burden.

ModivCare works to develop a high-touch experience for members that tailor service to their needs and situations. It operates through a "Member First" approach that is relationship driven and backed through analytics highlighting the solutions to best serve each member. The platform is dependent on partnerships with local transportation providers and learning as much as possible about the communities it serves. ModivCare was built with the goal of making a difference in access to healthcare and providing best-in-class service to communities. An effective broker for Pennsylvania must demonstrate an understanding and willingness to get close to Pennsylvania's communities, creating a vested interest in high-quality service delivery. Through that mission and close partnerships with local officials, providers, and organizations like Area Agencies on Aging, a statewide broker can stay engaged in local concerns through local accountability and relationships.

Brokers' local relationships must include developing a strong relationship with administrators in each of Pennsylvania's Human Services Transportation (HST) programs. A successful statewide broker would seamlessly direct customers where needed to receive services through programs other than MATP. It would leverage its working knowledge of each HST program to connect customers with the most appropriate resource when required. ModivCare understands that being served through several providers when an individual participates in several HST programs can be intimidating. It is the role of the broker to minimize any friction members may experience when looking for transportation. An effective statewide broker must be able to also serve as a navigator, helping members connect with the resources they need even if the provider they need to access is not the broker.

Rural Service Planning: Pennsylvania's current MATP model places administrative authority closest to communities to encourage local accountability and locally tailored

program features. This sort of planning is most important in rural communities where transportation providers may be limited, travel times may be longer, and access to healthcare services may be strained. ModivCare is experienced in servicing rural communities and believes that they need unique operational mechanisms for effective service.

Maine's statewide broker model offers a strong example of how a consolidated structure can improve service in rural communities by removing artificial geographic barriers between broker territories. Under the statewide approach, transporters can be utilized more efficiently across the state without the regional boundaries that previously constrained trip assignment. This flexibility strengthens network resiliency in low-density areas, allows providers to be deployed where they are most needed, and supports more reliable access for rural members traveling longer distances for care. The model also benefits from a consistent statewide approach to out-of-state travel requirements, which is particularly important for rural populations who may need to cross state lines for specialty services.

A strong statewide broker would embed themselves in rural communities to encourage local tailoring and accountability similar to Pennsylvania's current model. What works in Potter County will not be how ModivCare operates in Philadelphia County. A statewide broker will have a responsibility to conduct targeted outreach in rural communities to understand the needs of locals and develop operations in line with the knowledge of local partners. For example, DHS noted that in situations where a member may only be able to be served by one provider, accessing transportation through a broker may feel like an unnecessary bureaucratic step. ModivCare understands and agrees with DHS' perspective. In such a situation, an effective broker would alter their operations for those communities to expedite approval processes and provider matching. ModivCare would address this challenge by targeting communities with similar circumstances, working with providers individually to understand their experiences, and tailoring members' ride assignment experiences to the functionalities of provider partners.

ModivCare adapts its services to rural communities' needs and has advocated for Rural Health Transformation Program funding targeted towards improving NEMT. For example, ModivCare supports an initiative to cover no-load miles when no member is present in the vehicle, increasing providers' opportunities to deliver transportation to and from remote locations. ModivCare has worked to identify the unique barriers to NEMT and medical services more broadly in rural communities and developed internal operational plans to address those barriers and deliver positive member experiences.

Conclusion

ModivCare appreciates DHS' thoughtful identification of the operational and policy considerations associated with a potential statewide or regional MATP broker model.

However, ModivCare views the assumptions guiding DHS' analysis as worst-case situations that can be addressed through thoughtful and proactive program design. ModivCare sees the enormous administrative, financial, and service delivery benefits that a consolidated model could have for MATP administrators and members. Through careful planning and lessons learned from other states' programs, ModivCare believes that Pennsylvania can further improve the success of their already strong MATP program through a transition to a statewide or regional broker model. ModivCare hopes to work as a partner with DHS as it considers the next steps for its MATP program.

Thank you for considering our comments. Please feel free to reach out to me at [redacted] with any questions.

Sincerely,

[redacted]

Faisal Khan
Senior Vice President, General Counsel and Secretary
Modivcare Topco, LLC

Notes & Sources

[1] Pennsylvania General Assembly, "Act 46 of 2025," accessed April 1, 2026, https://www.palegis.us/statutes/unconsolidated/law-information?sessYr=2025&sessInd=0&actNum=46.

[2] In Pennsylvania, the Medicaid Program is known as the Medical Assistance (MA) Program, accessed March 18, 2026, https://www.pa.gov/agencies/dhs/resources/medicaid.

[3] Pennsylvania Department of Human Services, et al., *Medical Assistance Transportation Program (MATP) Legislative Analysis*, (December 27, 2019), accessed March 18, 2026, http://matp.pa.gov/PDF/Final%20MATP%20Legislative%20Analysis%20v20191227.pdf.

[4] Pennsylvania Department of Human Services, *Medical Assistance Transportation Program Stakeholder Input and Options Analysis Workgroup Summary Report*, (February 2022), accessed March 18, 2026, http://matp.pa.gov/PDF/MATP%20Legislative%20Report%20_Final_February%202022.pdf.

[5] Broker models can be matched at the Federal Medical Assistance Percentage (FMAP) associated with medical services. Therefore, 60.2% is the current estimate of the "effective" FMAP rate for using a broker beyond Philadelphia County, which contrasts with the 50% federal matching rate on administrative expenditures.

[6] Pennsylvania Department of Transportation et al., *Human Service Transportation Coordination Study Summary Report* (July 17, 2009), accessed March 18, 2026, https://www.pa.gov/agencies/penndot/programs-and-doing-business/public-transportation/reports/studies.

[7] In rare instances, volunteers are also used according to guidelines established by DHS.

[8] Pennsylvania Department of Human Services, *Medical Assistance Transportation Program Standards & Guidelines*, (November 2016), accessed March 18, 2026, http://matp.pa.gov/PDF/MATPStandardsGuidelines.pdf.

[9] 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.

[10] National Archives, "Code of Federal Regulations, 49 CFR § 37.131," accessed March 18, 2026, https://www.ecfr.gov/current/title-49/subtitle-A/part-37/subpart-F/section-37.131.

[11] John Taylor (Pennsylvania Department of Transportation), email to Department of Human Services, April 1, 2026, providing funding-source data and a chart for "Breakdown of Six Million Shared-Ride Trips by Funding Source (SFY 24–25)"; chart adapted by the author.

[12] Pennsylvania Department of Transportation, *Shared-Ride Transportation Study*, (March 2025), accessed March 18, 2026, https://www.pa.gov/agencies/penndot/programs-and-doing-business/public-transportation/reports/studies.

[13] Pennsylvania Department of Human Services, *Medical Assistance Transportation Program Standards & Guidelines*.

[14] The Pennsylvania Code, "Chapter 2070. Eligibility for Services Funded Through the Public Assistance Transportation Block Grant," accessed March 18, 2026, https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter2070/chap2070toc.html.

[15] Pennsylvania State Lottery Law (P.L. 351, No. 91), Section 904, accessed March 18, 2026, https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/1971/0/0091..PDF.

[16] National Archives, "Code of Federal Regulations, 49 CFR. §§ 37.121-37.155," accessed March 18, 2026, https://www.ecfr.gov/current/title-49/subtitle-A/part-37/subpart-F/section-37.121.

[17] Pennsylvania General Assembly, "Title 74 Chapter 15 Sustainable Mobility Options," accessed March 18, 2026, https://www.palegis.us/statutes/consolidated/view-statute?txtType=HTM&ttl=74&div=0&chapter=15.

[18] Congressional Research Service, "Medicaid's Federal Medical Assistance Percentage (FMAP)," accessed March 18, 2026, https://www.congress.gov/crs-product/R43847.

[19] Pennsylvania Newsroom, "Shapiro Administration Launches PA Navigate, A New Online Tool to Better Connect Pennsylvanians with Food, Housing, Childcare and More," (January 23, 2024), accessed March 18, 2026, https://www.pa.gov/agencies/dhs/newsroom/shapiro-administration-launches-pa-navigate-a-new-online-tool-to-better-connect-pennsylvanians-with-food-housing-childcare-and-more-.

[20] While federal NEMT regulations generally require states to ensure the availability of transportation to the nearest qualified provider, regulations also require "nearest" to be interpreted broadly to ensure consumer freedom of choice and timely access to care.

[21] Federal Transit Administration, "Grant Programs," accessed April 22, 2026, https://www.transit.dot.gov/grants.

[22] United States District Court, M.D. Pennsylvania, "DEPT. OF HUMAN SERV'S v. U.S. DEPT. OF HEALTH," accessed March 18, 2026, https://www.leagle.com/decision/infdco20181002c90.

[23] 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.

[24] Pennsylvania Department of Human Services, Division of Procurement and Contract Management and South Central Transit Authority, *Contract Agreement*, (April 29, 2019), accessed March 18, 2026, https://contracts.patreasury.gov/Admin/Upload/495853_410081368%20RNEW%205-13-19.pdf.

[25] Pennsylvania Department of Human Services, Division of Procurement and Contract Management and Central PA Transportation Authority DBA rabbittransit DBA York Co Trans Aut, *Contract Agreement*, (April 11, 2019), accessed March 18, 2026, https://contracts.patreasury.gov/Admin/Upload/495852_4100081366%20RNEW%205-13-19.pdf.

[26] Massachusetts Executive Office of Health and Human Services, Human Service Transportation Office materials, accessed March 18, 2026, https://www.mass.gov/info-details/learn-about-non-emergency-medical-transportation-for-masshealth-members.

[27] Sharon Silow-Carroll, Kathy Gifford, Carrie Rosenzweig, Kathy Ryland, and Anh Pham, Health Management Associates, *Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends,*

Challenges, and Innovations, Prepared for the Medicaid and CHIP Payment and Access Commission (MACPAC), (August 2021), accessed March 18, 2026, https://www.healthmanagement.com/wp-content/uploads/HMA_NEMT_Report_MACPAC_Aug-21.pdf.

[28] Massachusetts State Plan Amendment MA-21-0030, Attachment 3.1-A, pp. 9–9a, accessed March 18, 2026, https://www.medicaid.gov/Medicaid/spa/downloads/MA-21-0030.

[29]Sharon Silow-Carroll, Kathy Gifford, Carrie Rosenzweig, Kathy Ryland, and Anh Pham, Health Management Associates, *Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends, Challenges, and Innovations, Prepared for the Medicaid and CHIP Payment and Access Commission (MACPAC)*, (August 2021), accessed March 18, 2026, https://www.healthmanagement.com/wp-content/uploads/HMA_NEMT_Report_MACPAC_Aug-21.pdf.

[30] Massachusetts State Plan Amendment MA-21-0030, Attachment 3.1-A, pp. 9a, accessed March 18, 2026, https://www.medicaid.gov/Medicaid/spa/downloads/MA-21-0030.

[31] Massachusetts State Plan Amendment MA-21-0030, Attachment 3.1-A, pp. 9a, accessed March 18, 2026, https://www.medicaid.gov/Medicaid/spa/downloads/MA-21-0030.

[32] Massachusetts State Plan Amendment MA-21-0030, Attachment 3.1-A, pp. 9a-9b, accessed March 18, 2026, https://www.medicaid.gov/Medicaid/spa/downloads/MA-21-0030.

[33] Massachusetts State Plan Amendment MA-21-0030, Attachment 3.1-A, pp. 9b, accessed March 18, 2026, https://www.medicaid.gov/Medicaid/spa/downloads/MA-21-0030.

[34] South Carolina General Assembly Legislative Audit Council, "A Review of the Non-Emergency Medical Transportation Program of the Department of Health and Human Services," (March 2009), accessed March 18, 2026, https://lac.sc.gov/reports/reports-agency-a-k/dhhs-2009.

[35] South Carolina Department of Health and human Services Transportation Advisory Committee, "Quarterly Meeting Agenda," (December 8, 2016), accessed March 10, 2026, https://www.scstatehouse.gov/reports/DHHS/TAC12.8.16.pdf.

[36] Pennsylvania Department of Human Services, et al., *Medical Assistance Transportation Program (MATP) Legislative Analysis*, (December 27, 2019), accessed March 18, 2026, http://matp.pa.gov/PDF/Final%20MATP%20Legislative%20Analysis%20v20191227.pdf.

[37] South Carolina State Fiscal Accountability Authority, Office of State Procurement, *Non-Emergency Medical Transportation Coordinator Services (NEMT) Solicitation No. 5400027781*, (January 24, 2025), accessed March 18, 2026, https://apps.sceis.sc.gov/SCSolicitationWeb/attachmentDisplay.do?attachName=Solicitation+Document&attachType=DOCX&phioClass=BBP_P_DOC&phioObject=005056AC75401EEFB6D26AF0837DAC65&type=S&solicitNumber=5400027781&dateModified=01%2F24%2F2025+04%3A02%3A20+PM.

[38] South Carolina Procurement Review Panel, "Public Notices: Appeal by Medical Transportation Management, Inc. Panel Case No. 2025-4," (January 16, 2026), accessed March 17, 2026, https://prp.sc.gov/index.php/public-notices.

[39] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, (December 1, 2024), accessed March 18, 2026, https://www.hca.wa.gov/assets/program/nemt-leg-report-20241201.pdf, 7.

[40] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, 7.

[41] Washington State Health Care Authority, Transportation services (nonemergency), accessed April 21, 2026, https://www.hca.wa.gov/billers-providers-partners/program-information-providers/transportation-services-nonemergency.

[42] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, 8.

[43] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, 8.

[44] Washington State Health Care Authority*, Non-Emergency Medical Transportation (NEMT): An introduction to the NEMT program and Washington State Apple Health*, (July 19, 2017), accessed March 18, 2026 https://www.hca.wa.gov/assets/billers-and-providers/NEMT101.pdf, 1.

[45] Washington State Health Care Authority*, Non-Emergency Medical Transportation (NEMT): An introduction to the NEMT program and Washington State Apple Health*, 2.

[46] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, 7.

[47] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, 7.

[48] Washington State Health Care Authority, *Non-Emergency Medical Transportation (NEMT) Overview and Gap Analysis*, 8.

[49] Arkansas Department of Human Services, *Non-Emergency Transportation 1915(b)(4) Waiver Renewal*, (October 1, 2020), accessed March 18, 2026, Arkansas 1915(b)(4) waiver document, 3. [Note: Although the state's Invitation for Bid document refers on page 18 to the "1915(b) Waiver for NET services AR.0003.R03.00 - Apr 01, 2023," only this "R02" version is available on the CMS website.]

[50] Arkansas Department of Human Services, Office of Procurement, *Invitation for Bid*, (June 5, 2025), accessed March 18, 2026, https://humanservices.arkansas.gov/wp-content/uploads/710-25-049-Solicitation-Revision-2-Clean-Version.pdf, 14. As stated in the IFB, "The Broker may operate as a sole provider, or as the prime contractor/broker with subcontractors as transportation providers as part of their network, as long as NET services remain sufficient to provide quality services for all qualified Beneficiaries residing in the region(s) served by the Broker."

[51] Social Security Act §1902(a)(70) requires states exercising this option to contract with a broker that "(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate)," 42 CFR 440.170(a)(4)(ii)(B) provides for certain exceptions.

[52] Arkansas Department of Human Services, *Office of Procurement, Invitation for Bid*.

[53] Arkansas Non-Emergency Transportation 1915(b)(4) Waiver Renewal, October 1, 2020, Arkansas 1915(b)(4) waiver document, 3.

[54] Arkansas Department of Human Services, *Office of Procurement, Invitation for Bid*, 13. The IFB states, “The Broker shall have a minimum of five (5) years of experience in non-emergency medical transportation. Subcontractor experience shall not substitute for Broker experience.”

[55] The coin flip process is used in Arkansas procurement to decide between tied bidders when there is not a tied in-state bidder to award. (Note that the two in-state brokers retained their respective regions after tying as lowest bidder, which made the coin flip unnecessary.) For more information on the 2025 Arkansas procurement, including the coin-flip process that was used in all seven regions, refer to Arkansas Department of Transformation and Shared Services, *State of Arkansas Procurement Laws and Rules*, (December 4, 2023), accessed March 19, 2026, https://sas.arkansas.gov/wp-content/uploads/Laws-and-Rules-updated-Dec-2023.pdf, 40.

[56] Arkansas Department of Human Services, *Office of Procurement, Invitation for Bid*, 50.

[57] Centers for Medicare & Medicaid Services, approval letter for Texas State Plan Amendment TX-21-0003, May 25, 2021, effective June 1, 2021, accessed April 21, 2026, https://www.medicaid.gov/medicaid/spa/downloads/TX-21-0003.pdf.

[58] Texas A&M Transportation Institute & RLS and Associates, Inc., *Wheels to Care: Navigating NEMT Across America: An NEMT Profile for Each of the 50 States and D.C.*, prepared for Community Transportation Association of America & National Center for Mobility Management, (April 2025), accessed March 19, 2026, https://www.ccam-tac.org/wp-content/uploads/2024/12/NEMT-State-by-State-Profiles-December-2024-Final-1.pdf, 44.

[59] Episcopal Health Foundation & Working Partner, *Texas' Non-Emergency Transportation Medical Benefit: Utilization and Barriers to Use*, (March 2025), accessed March 19, 2026, https://www.episcopalhealth.org/wp-content/uploads/2025/03/Texas-NEMT-Utilization-and-Barriers-Report.pdf, 13.

[60] Episcopal Health Foundation & Working Partner, *Texas' Non-Emergency Transportation Medical Benefit: Utilization and Barriers to Use*, 8.

[61] Episcopal Health Foundation & Working Partner, *Texas' Non-Emergency Transportation Medical Benefit: Utilization and Barriers to Use*, 7.

[62] Episcopal Health Foundation & Working Partner, *Texas' Non-Emergency Transportation Medical Benefit: Utilization and Barriers to Use*, 1.

[63] Coordinating Council on Access and Mobility Technical Assistance Center (CCAM-TAC), *State-by-State Profiles for the Research and Update: NEMT and Public Transportation Project* (December 2024), “New Jersey” (profile updated September 2024), https://www.ccam-tac.org/nemt-state-by-state-profiles/#elementor-toc__heading-anchor-35.

[64] Coordinating Council on Access and Mobility Technical Assistance Center (CCAM-TAC), *State-by-State Profiles for the Research and Update: NEMT and Public Transportation Project*.

[65] Office of Inspector General, U.S. Department of Health and Human Services, “New Jersey Did Not Adequately Oversee Its Medicaid Nonemergency Medical Transportation Brokerage Program,” report no. A-02-14-01001, (July 5, 2016), accessed February 25, 2026, https://oig.hhs.gov/reports/all/2016/new-jersey-did-not-adequately-oversee-its-medicaid-nonemergency-medical-transportation-brokerage-program/.

[66] New Jersey Legislature, *Assembly Bill No. 2878,* (August 15, 2023), accessed February 25, 2026, https://pub.njleg.gov/Bills/2022/A3000/2878_E1.PDF.

[67] New Jersey Legislature, *Assembly Bill No. 5032*, (January 8, 2026), accessed February 25, 2026, https://www.njleg.state.nj.us/bill-search/2024/S5032/bill-text?f=S5500&n=5032_S1.

[68] Pennsylvania Department of Transportation, *Shared-Ride Transportation Study*, (March 2025), accessed April 1, 2026, https://www.pa.gov/content/dam/copapwp-pagov/en/penndot/documents/programs-and-doing-business/transit/informationandreports/studies/shared-ride-transportation-study/shared-ride-transportation-study-phase-1-report-2025.pdf.

[69] Judith Higgins, "OP-ED: Put Brakes On Public Transit Plan," (July 1, 2019), accessed March 19, 2026, https://www.ydr.com/story/opinion/contributors/2019/07/01/op-ed-put-brakes-dismantling-public-transit-plan/1616571001/.

[70] Jeff Eggleston, "Stop The Privatization of MATP in PA," accessed March19, 2026, https://www.change.org/p/tom-wolf-stop-the-privatization-of-medical-assistance-transportation-programs-matp-in-pa.

[71] Kristina Shalhoup, "Lackawanna County and COLTS Taking A Stand Against Privatizing MATP," (April 30, 2019), accessed March 19, 2026, https://www.2822news.com/news/lackawanna-county-and-colts-taking-a-stand-against-privatizing-matp/.

[72] Sarah Cassi, "Change Is Coming For People Who Need Riders To Medical Appoints, And LANTA Is Worried," (February 10, 2019), accessed March 19, 2026, https://www.lehighvalleylive.com/news/2019/02/change-is-coming-for-people-who-need-rides-to-medical-appointments-and-lanta-is-worried.html.

[73] Richard Farr, "Rabbittransit Fears State Change Will Result In Less Service While Costing The State More," (April 22, 2019), accessed March 19, 2026, https://www.ydr.com/story/opinion/2019/04/22/rabbittransit-fears-state-change-mean-less-service-higher-costs/3541521002/.

[74] PPTA, *Impact of Brokerage of Medical Assistance Transportation Program*, https://ppta.net/wp-content/uploads/2026/01/PPTA-NEMT-Executive-Summary.pdf, accessed February 26, 2026.

[75] Jeff Eggleston, "Stop the Privatization of MATP in PA."

[76] PPTA, *Pennsylvania MATP: Brokerage Model Impact, Updated Findings and Implications for Pennsylvania's Shared-Ride System,* https://ppta.net/wp-content/uploads/2026/04/Evaluating-MATP-Service-Models-Impacts-on-Riders-and-Transit-Providers.pdf, accessed May 14, 2026.

[77] Pennsylvania Department of Human Services, et al., *Medical Assistance Transportation Program (MATP) Legislative Analysis*, (December 27, 2019), accessed April 22, 2026, http://matp.pa.gov/PDF/Final%20MATP%20Legislative%20Analysis%20v20191227.pdf.

[78] DHS Data Dashboards and Reports, "Medicaid Information," accessed March 19, 2026, https://www.pa.gov/agencies/dhs/resources/data-reports.

[79] George Rush, Jiali Ye, Peter Baltrus, Elvan Daniels, Bamidele Adesunloye, George Edward Fryer, *Practical Barriers to Timely Primary Care Access: Impact on Adult Use of Emergency Department Services*, (August 11, 2008), accessed March 19, 2026, https://pubmed.ncbi.nlm.nih.gov/18695087/.