

## **Health and Human Services Recommendations for Legislative Action/Review Gaining Efficiencies and Decreasing Administrative Burden**

### **1. System Consistency and Standardization**

- a. Across DHS:
  - i. Require that standards are made consistent across DHS departments (specific examples in sections below).
- b. Across BH-MCOs/Primary Contractors and CHC-MCOs:
  - i. Create increased consistency in standards and requirements across different behavioral health contracts.
- c. Across Counties:
  - i. Need consistent language and standards for Early Intervention.

### **2. Substance Use Disorder Treatment System**

- a. In instances where the Commonwealth has developed or directed specific programs within the system or standards for the overall system, establish *one process for auditing* that must be followed by the oversight body, entity, or organizations responsible for the auditing, thereby reducing inconsistency in interpretation, implementation, and enforcement as well as reducing resulting burden on the provider system. Although guidelines and audit tools exist, there is great variation in how they are interpreted and used by the various overseers. Specifically, those instances include:
  - i. Multiple quality audits conducted by multiple behavioral health managed care organizations (BH-MCOs) of the same organization or facility;
  - ii. Audits of providers to determine alignment with the criteria used to assess, plan, and provide addiction treatment (i.e., ASAM Criteria), and specifically the intent to implement redundant and costly ambulatory reviews/audits in January 2026; and
  - iii. The guidelines used for the Commonwealth's approximately 300 Opioid Use Disorder Centers of Excellence to ensure adherence to specific standards and best practices.

### **3. Mental Health: Medicaid Payment for Telehealth & Outpatient Psychiatric Burden**

- a. This spring, the House passed HB 1590, a bill designed to address the Medicaid payment requirements for the delivery of telehealth by practitioners outside the physical "Four Walls" of community-based clinics, for both mental health and substance use disorder (SUD) services. This would also allow recipients of telehealth services to be outside the clinic as well. In June, CMS approved the DHS State Plan Amendment (SPA), which addressed the practice application of delivering these services for both behavioral and physical health outside the "Four Walls." If passed, this would satisfy the federal "Four Walls" requirements for the delivery of telehealth services.
- b. Passing of a mental health psychiatric outpatient bill would address the current waiver condition that allows the advanced practice professionals (APP), certified registered nurse practitioners (CRNP), and physician assistants (PA) with a mental health certificate to fulfill the required 50% psychiatric time requirements for psychiatrists in the clinics under the 55 Chapter 5200 Psychiatric Outpatient Requirements 5200.22. This provision would also allow for the use of telehealth to meet supervision standards.

#### **4. Intellectual and Developmental Disabilities**

- a. Allow unit rounding of non-residential services: Align ODP with other DHS program standards in adopting the OLTL approach to unit rounding, which would simplify billing and documentation for providers. This alignment reduces administrative burden and increases efficiency across systems without impacting service quality.
- b. Reduce redundant administrative licensing and oversight: Consolidating overlapping licensing and monitoring requirements across regulatory chapters would ease provider workload and free up resources for quality improvement. A centralized documentation system would eliminate repetitive submissions and allow licensing staff to focus on meaningful oversight rather than paperwork.
- c. Redefine Community Participation Support (CPS) billing standards for increased flexibility: Updating CPS guidelines in the [ODP ISP Manual](#) — such as removing restrictions on the number of individuals allowed in a community setting — would support person-centered planning and improve staff utilization. Greater flexibility enhances community access while maintaining quality and safety.

#### **5. Long-Term Living**

- a. Direct care workforce (DCW) Health/TB Testing: Move OLTL to ODP standard of testing on hire.

#### **6. Brain Injury**

- a. Funding request of \$13M to be allocated to Brain Injury (BI) residential habilitation providers, with a federal match to increase this amount to \$30M. These funds will allow BI residential habilitation providers to offer competitive wages to direct support professionals, aiding in recruiting and retaining adequate staff to support individuals who have experienced brain injury. The inability to offer critically needed services to these individuals often results in them being incarcerated, unhoused, residing in skilled nursing facilities (SNFs), or at home with no services with friends and relatives attempting to offer care.
- b. As mandated by the PA legislature, implement the process of rate studies to be conducted every three years for services in the Community HealthChoices (CHC) Waiver – similar to what exists for ODP.
- c. Reduce redundant administrative licensing and oversight: Consolidate overlapping licensing and monitoring requirements across regulatory chapters.