

# **Department of Human Services**

## **HealthChoices Physical Health Services**

### **Request for Information (RFI)**

**26-RFI-20476**



**Date: October 6, 2026**

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## **PART 1. General Information**

### **1.1 Purpose of this Request for Information**

The Pennsylvania Department of Human Services (“Department”), Bureau of Procurement & Contract Management issues this Request for Information (“RFI”) to gather input and information concerning the development of a Request for Applications (“RFA”) for a HealthChoices Physical Health services procurement the Department intends to release in the future as well as ideas and strategies for improvements to the Department’s mandatory managed care program.

Specifically, this RFI seeks information to assist the Department in reprocurring managed care organizations to administer the delivery of physical health services to Medical Assistance (“MA”) beneficiaries and optimizing the design and requirements of the HealthChoices Physical Health agreement and program to continuously improve healthcare quality and access while stabilizing Pennsylvania’s Medical Assistance spending.

Through this RFI, the Department hopes to become aware of and knowledgeable about the most promising models supported by evidence to promote the health of MA beneficiaries, including but not limited to:

- Medicaid managed care program design and priorities;
- Targeted community and population health initiatives;
- Programs to address health equity and Health-Related Social Needs (“HRSN”);
- Value-based purchasing and alternative payment models;
- Quality measures and performance standards that focus on outcomes;
- Partnerships with healthcare providers and community-based organizations;
- Information Technology, Systems, and Data; and
- Program Integrity.

As the HealthChoices Physical Health Program approaches its thirtieth anniversary, the Department is carefully evaluating the progress made over the last three decades and setting the course for the future. The Department is interested in gathering input to identify leading-edge approaches to structuring and overseeing Medicaid managed care programs that focus on rewarding outcomes rather than process measures. The Department has identified three specific priority areas on which it proposes to focus in the future. These areas were selected based on the following factors: the scope of impacted beneficiaries; the proportion of program spending; and opportunity for improved outcomes and decreased disparities. The proposed areas of focus are:

1. Poorly Controlled Chronic Conditions
2. Perinatal and Child Health
3. Children with Complex Health Needs

The Department encourages vendors and other interested parties to provide feedback in response to this RFI or any part thereof. A vendor may respond to all or any of the specific questions or topics included in this RFI.

## **1.2 Request for Information Timeline**

| <b>Event</b>             | <b>Date</b>       |
|--------------------------|-------------------|
| Release RFI              | October 6, 2026   |
| Vendor RFI Responses Due | November 20, 2026 |

The Department is requesting that all responses to this RFI be submitted by 12:00 p.m. on the due date. Responses must be submitted electronically to the following email account with “HealthChoices Physical Health Program RFI” in the email subject line: [RA-PWRFICOMMENTS@PA.GOV](mailto:RA-PWRFICOMMENTS@PA.GOV).

While the Department does not intend to respond to questions or clarifications during the RFI response period, vendors may submit administrative questions related to this RFI electronically to: [RA-PWRFICOMMENTS@PA.GOV](mailto:RA-PWRFICOMMENTS@PA.GOV) using “HealthChoices Physical Health Program RFI” question” in the email subject line. The Department may or may not respond based on the nature of the question. The Department will post all answers provided online at: <http://www.emarketplace.state.pa.us>.

## **1.3 Disclaimers**

The Department is not liable for any costs or expenses incurred by vendors in the preparation of responses related to this RFI.

This RFI is issued for information and planning purposes only and does not constitute a solicitation for future business, an offer for procurement, or any other type of current or future procurement action, and is only intended to gather information and input. The Department will not award an agreement on the basis of this RFI or otherwise pay for any of the information received.

The Department may use the information gathered through this process in the development of future procurement documents; however, the Department does not guarantee that this will occur. The Department will not return responses to this RFI. Respondents will not be notified of the result of the review, nor will they be provided copies of it. If the Department issues a procurement document, no vendor will be selected, pre-qualified, or exempted based on its participation in this RFI process.

Respondents should be aware that the responses to this RFI will be public information and that no claims of confidentiality will be honored. The Department is not requesting, and does not require, confidential, proprietary information, or other competitively sensitive information to be included as part of the RFI submission. Ownership of all data, material and documentation

originated, prepared, and provided to the Department during this RFI process will belong exclusively to the Department.

## **PART 2. Background**

### **2.1 Background Information – HealthChoices Overview**

HealthChoices is the name of Pennsylvania's statewide mandatory managed care program for certain MA recipients, which includes a Physical Health and a Behavioral Health component.

Through Physical Health Managed Care Organizations (“PH-MCOs”), MA recipients receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Department’s Office of Medical Assistance Programs oversees the Physical Health component of the HealthChoices Program.

Through Behavioral Health Managed Care Organizations (“BH-MCOs”), MA recipients receive quality medical care and timely access to appropriate mental health and drug and alcohol services. This component is overseen by the Department’s Office of Mental Health and Substance Abuse Services.

The HealthChoices Program has three primary goals:

- To improve access to health care services for Medical Assistance recipients.
- To improve the quality of health care available to Medical Assistance recipients.
- To stabilize Pennsylvania's Medical Assistance spending.

As set forth in Pennsylvania’s [Managed Care Quality Strategy](#) submitted to the Center for Medicare and Medicaid Services, under each goal the Department has identified related objectives and metrics to assess whether the state is making progress on the goals and objectives, including statewide baseline measurements and performance targets.

The Department has established themes, or domains, that link priorities across the goals: increasing value, supporting health equity, and addressing HRSN. A focus on value is designed to ensure the highest quality of care is delivered for the lowest cost. This priority is reflected in the Department’s value based purchasing (“VBP”) initiatives, designed to ensure beneficiaries receive the right care, in the right setting, at the right time, and providers receive the right financial incentive to support improved recipient health. Key to high-value health care is a focus on health equity, but neither are possible without addressing underlying HRSN that affect recipient health outcomes. Therefore, the Department systematically integrates measures that address HRSN into its healthcare system, its initiatives, goals and objectives.

As of July 2026, the HealthChoices Physical Health Program currently serves about 2.3 million recipients on a statewide basis in the following zones:

- i. Southeast – Bucks, Chester, Delaware, Montgomery, and Philadelphia counties
- ii. Southwest – Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Green, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties
- iii. Lehigh/Capital – Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties
- iv. New West – Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren counties
- v. New East – Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming counties

Additional information about the HealthChoices program may be found at the following locations:

- <https://www.pa.gov/agencies/dhs/resources/medicaid/hc>
- [www.enrollnow.net](http://www.enrollnow.net)

## **2.2 HealthChoices Standard MCO Program Agreement**

Please view Pennsylvania's HealthChoices program agreement:

<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/managed-care-information/2026-healthchoices-agreement-including-exhibits-and-non-rate-financial-appendices-draft.pdf>

## **PART 3. Request for Information Submission Format**

Through this RFI, the Department is soliciting information and comments regarding optimizing the design and requirements of the HealthChoices Physical Health agreement and program and reprocurring managed care organizations to administer the delivery of physical health services to MA beneficiaries. All interested vendors are asked to respond in writing to this RFI, per the items outlined below.

### **3.1 Response Submission**

Please prepare responses simply, providing straightforward and concise language and descriptions. All responses should be produced in 12 point Serif or Sans-Serif font. Please limit your response to no more than 20 pages, not including the cover letter or attachments. Please refrain from sending marketing materials to the Department.

### **3.2 Cover Letter**

Please include a cover letter with the following information:

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1. An introduction to the respondent's organization, background, and interest in Medicaid managed care.
2. General information about the respondent and respondent's organization, to include an address and a point of contact along with a telephone number and an e-mail address.

### **3.3 Conceptual Solutions and Strategies Response**

The following provides a suggested structure for a response to this RFI. This structure is intended to minimize the effort required to develop and analyze submitted responses. Please address the following:

#### **3.3.1. General Program Design**

- a. What, if any, adjustments should the Department make to its priority areas for outcomes-based contracting? (Poorly Controlled Chronic Conditions, Perinatal-Child Health, and Children with Complex Health Needs)
- b. Should MCOs be required to operate statewide, or should the zone structure be maintained? How many MCOs should operate in HealthChoices? Should there be a maximum or minimum number (other than required choice of two under the Federal waiver) and what criteria should determine the number?
- c. Should the Department require MCOs to carve in or carve out any of the benefits managers, such as pharmacy, dental, and vision? Should the Department consider carving non-emergency medical transportation into the HealthChoices program?
- d. Which aspects of the current HealthChoices Program design are important to preserve in order to ensure quality of care and fiscal stewardship?
- e. Would an enrollment lock-in be required to achieve outcomes for any or all of the three priority areas? Why?
- f. What regulatory changes would be required to support this work? Are there any current regulatory barriers that prevent MCOs from operationalizing initiatives that would advance the Department's goals?
- g. How should Physical Health and Behavioral Health MCOs be required to coordinate to serve shared members?
- h. The current HC PH Agreement uses geographic zone and county-based provider network access standards and travel times, appropriate for most services that require the consumer to travel. How should Network Access standards be determined for provider types and specialties that primarily deliver products or services to consumers' homes, such as (but not limited to) Durable Medical Equipment, Shift Care (Home Health Aides, Skilled Nursing), and in-home therapies?
- i. What updates should be made to prior authorization to avoid delays in access to services that have been determined to be medically necessary by a provider? Are there services that should no longer require prior authorization or administrative or technical updates that can be made to modernize and streamline the process? Should these changes be made

for all providers, or only for certain groups, such as those that are low-risk, those with the highest quality outcomes, or those that opt into value-based payment arrangements?

### **3.3.2. Outcomes Measures**

- a. Should the Department define the outcome metrics to which MCOs will be held or allow each MCO to propose its own metrics? Would allowing each MCO to establish its own focus and metrics impede progress toward improving statewide population health?
- b. If the Department should define a set of metrics, what should those metrics be for:
  1. Poorly controlled chronic conditions
  2. Perinatal and child health
  3. Complex Pediatric Cases

If you propose alternative priority areas, what metrics should be used for these?

- c. How should the department evaluate applications from MCOs with differing metrics, populations of focus, and timelines for implementation? Should priority scoring be awarded for certain metrics, outcomes thresholds, populations, or timelines?
- d. What are the most promising models supported by evidence to promote community and population health that could be incorporated into the HealthChoices Program? Should DHS require MCOs to use or support any specific chronic disease management and community-based prevention programs? What metrics should be used to determine the success or return on investment of these programs?
- e. How can the Department monitor and oversee MCO performance to understand whether outcomes are being achieved without micro-managing the program design and implementation and allowing for flexibility? How often should the Department evaluate outcomes?
- f. How much time should the Department allow MCOs to scale their initiatives before beginning to hold them accountable for outcomes? Would two to four years be sufficient? How can MCOs be held accountable during the phase-in? For example, should the Department develop a hybrid monitoring approach that includes both performance-based and outcomes-based compliance, using real-time measures that are not tied to an annual performance measure cycle?

### **3.3.3. Financing and Value Based Payment**

- a. What payment or incentive structure would best allow MCOs sufficient time to implement their proposed initiatives? Should incentive payments made during the implementation phase be tied to achieving key milestones or benchmarks? After implementation has occurred, what timeline would be appropriate for the Department to evaluate outcomes for the purposes of determining whether an MCO has earned an incentive payment?
- b. What financing structure would work best for the Department to fund the MCOs?
  1. Risk Corridor?

- i. If so, what is the correct percentage of excess revenue or losses to allow?
- 2. Withholds?
  - ii. If so, what percentage of capitation revenue should be withheld for failure to achieve an agreed-upon outcome?
- 3. Something else?
- c. How should MCOs begin the process of moving away from the Department's Fee For Service Program's fee schedule as the basis for provider payment rates for services or initiatives and establishing their own well publicized fee schedules or payment models?
- d. Which of the Centers for Medicare and Medicaid Innovation's (CMMI) Alternative Payment Models should the Department require or give preference to when evaluating applications?

#### **3.3.4. Initiative Development**

- a. What processes should MCOs use when designing and selecting initiatives to implement, including populations served and geographic areas covered? How should the Department determine when to allow or require MCOs to propose new initiatives? How should Members and Providers be included in the process of developing initiatives?
- b. What threshold should the Department require in terms of number or percentage of members or geographic communities served by proposed initiatives? Should the Department require or accept initiatives that serve entire zones, counties, or more focused geographic areas?
- c. How should the Department's evaluation of proposals for urban versus rural areas differ?
- d. How should MCOs be required to work together, or at least not duplicate or contradict one another's efforts?

#### **3.3.5. Partnerships**

- a. What types of partnerships with hospitals, primary care providers (including Patient Centered Medical Homes and Federally Qualified Health Centers/Rural Health Centers) and specialists, and county human service agencies should the Department require to improve outcomes?
- b. What level and type of engagement and funding should the Department require for Community-Based Organizations?

#### **3.3.6. Poorly Controlled Chronic Conditions**

- a. For initiatives to address poorly controlled chronic conditions and decrease potentially preventable admissions and inappropriate emergency department utilization, which

clinical conditions should the Department prioritize, based on available medical literature and utilization data pertaining to current HealthChoices enrollment and expenditures?

1. Which community-based and clinically based interventions would be best to address each of those conditions?
- b. Do interventions and approaches differ for those patients with a history of hospitalizations and those who are at risk of hospitalization?
- c. What is the best way for a hospital to coordinate with a patient's Primary Care Provider to arrange for follow-up services, plan discharges, and to facilitate transitions of care?
- d. How should the Department continue to expand access to care through non-traditional ancillary provider types in the managed care delivery system? How should the Department and MCOs encourage appropriate utilization of these providers? What steps should MCOs take to integrate these providers into clinical and payment models?

### **3.3.7. Perinatal and Child Health**

- a. How should the Department define dyadic models of care?
- b. Which components of the Commonwealth's Maternal Health Strategic Plan and Rural Health Transformation Plan are most critical to sustain through the HealthChoices program?
- c. What lessons should the Department learn from its current maternal home visiting program, and how can this program be improved?
- d. Should the Department continue to require the Obstetric Needs Assessment Form? Should revisions be made to the information it collects, the way it is shared between providers, MCOs, and the Department, or the purposes for which it is used?
- e. Which approaches and techniques are most successful in serving maternity care deserts?
- f. Which of the leading causes of maternal mortality (Opioid Use Disorder, preeclampsia, and sepsis) are MCOs best positioned to affect?

### **3.3.8. Children with Complex Health Needs**

- a. Should the Department carve medically complex children and/or children with intellectual and developmental disabilities and autism ("I/DD/A") out of the Physical Health HealthChoices program and pursue and procure a single specialized MCO to serve this population? If so, should this be done statewide or in a specific region?
- b. What does an ideal Pediatric Extended Care Center look like?
- c. What services are not currently covered through the HealthChoices program that would benefit medically complex children and children with I/DD/A and their families?
- d. Which elements of CMS's Accelerating State Pediatric Innovation Readiness and Effectiveness ("ASPIRE") Model are most important to incorporate into the HealthChoices program?

- e. Which aspects of CMS's Integrated Care for Kids ("InCK") Model are most important for the Department to incorporate into the HealthChoices program?
- f. How can MCOs support transitions for youth among various levels of care and settings, such as acute care, residential treatment facilities, and residential pediatric complex care facilities?
- g. How can MCOs support transitions for youth who are approaching their twenty-first birthday and will be aging out of coverage under Early Periodic Screening, Diagnosis and Treatment ("EPSDT") and who are aging out of the foster care system?

### **3.3.9. Technology and Data**

- a. How can the Pennsylvania Patient and Provider Network ("P3N") be better leveraged in the HealthChoices program?
- b. In what areas does the Department need to prioritize modernization of IT systems and processes to support innovation and emerging practices?
- c. What data would MCOs need from the Department to support their work?
- d. What are the best software or systems for MCOs to use to identify and deter fraud, waste, and abuse?
- e. In addition to the federal requirement to post overall prior authorization approval rates, how should MCOs improve transparency regarding prior authorization approval rates for specific conditions or services such as pediatric shift care, dental services, or pharmacy?

### **3.3.10. Program Integrity**

- a. What methods of fraud, waste, and abuse ("FWA") prevention should MCOs apply to these program initiatives to ensure compliance and continuity of care?
- b. What methods should the MCO implement to increase timeliness and accuracy of FWA reporting?