**July 7, 2026**

**RCPA Response to Community HealthChoices Request For Information**

The recommendations in this response are informed primarily by RCPA members who serve older adults and individuals with physical disabilities participating in Community HealthChoices. RCPA will provide separate comments on Brain Injury services to ensure that those unique service-delivery considerations receive focused attention during the procurement process.

**3.3.1 Program Requirements**

**Service Coordination, Authorizations, and Person-Centered Planning**

Nearly a decade after implementation, Community HealthChoices has demonstrated the value of coordinated, person-centered services, but service coordination remains inconsistent across managed care organizations.

RCPA members report significant variation among CHC-MCOs in assessments, authorizations, care planning, and communications. These differences create confusion, increase administrative burden, and delay access to services. While participants may have similar needs, the process for obtaining services can vary considerably depending upon the managed care organization involved.

Providers are often the first to recognize changes in participant needs. Home care staff, service coordinators, therapists, and other community-based professionals are often the first to identify changes in health status, caregiver availability, housing stability, functional limitations, or social support needs. Yet provider input is not always incorporated consistently into service planning and authorization decisions. When provider expertise is excluded from care-planning discussions, opportunities to prevent crises, avoid hospitalizations, and preserve participants' independence can be missed.

DHS should require greater standardization across CHC-MCOs for assessments, reassessments, authorization requirements, and care planning expectations. Greater provider participation in person-centered planning would improve communication, reduce delays, and strengthen participant outcomes. The next procurement presents an opportunity to reinforce the principle that person-centered planning is not simply a documentation requirement. Still, a collaborative process is needed, focusing on preserving participant independence, supporting family caregivers, and helping individuals remain successfully engaged in community life.

The procurement should also establish minimum statewide standards for provider information sharing. Providers responsible for implementing authorized services should consistently receive the information necessary to safely deliver care, including diagnoses, functional limitations, authorized services, significant care transitions, and other recurring services that materially affect care coordination.

The Commonwealth's investment in community living depends on responsive, consistent service coordination. Administrative variation among CHC-MCOs should never delay participant access to services.

**Housing, Home Modifications, Assistive Technology, and Community Supports**
Personal Assistance Services (PAS) remain the cornerstone of Community HealthChoices and should be prioritized throughout the procurement. Home modifications, assistive technology, and housing-related supports are important enabling services. Still, they should be evaluated primarily for how they strengthen PAS delivery, reduce caregiver burden, and prevent unnecessary institutional care. DHS should streamline authorization processes for these supports and improve coordination so they complement, rather than delay, timely access to PAS.

**Self-Direction, Employment, and Complex Participant Needs**
RCPA supports preserving participant choice by maintaining both participant-directed and agency-delivered service models within Community HealthChoices. Pennsylvania has long recognized self-direction as an important option for individuals who wish to recruit, direct, and manage their own workforce. At the same time, experience over the past decade demonstrates that many participants and families continue to choose agency-delivered PAS, because they value professional oversight, caregiver recruitment, workforce training, scheduling, backup staffing, and quality management. Maintaining both models ensures participants can choose the approach that best fits their needs and preferences.

Agency-delivered PAS also provides important safeguards that support participant health, safety, and program integrity. Agency providers maintain comprehensive screening, supervision, training, compliance, and quality management programs while ensuring continuity of care when caregivers are unavailable. These capabilities become increasingly important as participant acuity rises and more individuals require coordinated support across physical and behavioral health, as well as long-term services and supports.

Consistent with federal person-centered planning requirements, participant education should present all available service delivery models without preference. Standardized, Department-approved educational materials would promote informed participant choice while ensuring participants understand the roles, responsibilities, benefits, and limitations associated with each model.

### 3.3.1.2 Appendix B – Financial Requirements

**Provider Sustainability and Workforce Capacity**
Provider sustainability represents one of the most significant issues facing Community HealthChoices today and one of the most important determinants of participant access to services.

Across Pennsylvania, providers continue to face workforce shortages, rising labor costs, increasing regulatory requirements, growing participant acuity, and expanding administrative responsibilities. These challenges affect organizations of all sizes and increasingly limit provider capacity to accept referrals, expand services, and meet participant demand.

The direct care workforce, nurses, therapists, service coordinators, and other frontline professionals are the foundation upon which Community HealthChoices is built. Every vacant position reduces participant choice. Every provider that limits admissions due to workforce shortages reduces access to services.

Workforce stability should therefore be viewed as a participant outcome measure rather than solely a provider concern. Without a sufficient workforce, participants cannot access services regardless of the benefits available through the CHC program. Network adequacy is not simply a matter of signed provider contracts; it is a question of whether participants can obtain services when and where they need them.

RCPA recommends greater transparency in CHC-MCO reimbursement methodologies, stronger oversight of provider network sustainability, and increased accountability to ensure reimbursement supports workforce recruitment and retention. The procurement also presents an opportunity to establish meaningful measures related to provider capacity, workforce stability, referral acceptance rates, and service availability.

Pennsylvania's success in promoting community living depends upon maintaining a provider network that is adequately funded, operationally sustainable, and capable of meeting participant needs throughout the Commonwealth.

Financial stability also depends on payment certainty. Providers routinely verify participant eligibility and rely on CHC-MCO authorizations before delivering services, yet may later be required to repay claims because of retroactive eligibility changes that were not visible at the time services were rendered. The next CHC agreement should clarify that providers acting in good faith based on verified eligibility and valid service authorizations should not bear the financial risk of retroactive administrative eligibility changes outside their control.

**Value-Based Purchasing**

RCPA strongly supports expanding value-based purchasing (VBP) as a central component of the next Community HealthChoices procurement. Future models should move beyond limited pay-for-performance arrangements and establish long-term, collaborative partnerships between CHC-MCOs and providers. These relationships should align financial incentives around improving participant outcomes, strengthening the direct care workforce, and expanding access to high-quality PAS, which remain the foundation of community-based long-term services and supports.

Successful VBP arrangements should reward measurable improvements in participant independence, timely initiation and continuity of PAS, reduced avoidable hospitalizations and emergency department utilization, successful transitions from institutional settings to the community, caregiver stability, participant satisfaction, and workforce retention. Performance measures should be clinically meaningful, risk-adjusted to reflect participant complexity, and developed collaboratively with providers to ensure they are achievable and directly influence participant outcomes.

It is advised that DHS require each CHC-MCO to offer meaningful advanced VBP opportunities supported by transparent methodologies, timely performance reporting, and multi-year agreements that justify provider investment in workforce development, technology, care coordination, and quality improvement. Providers should receive actionable performance data throughout the year so quality improvement becomes a continuous process rather than a retrospective reporting exercise.

Advanced VBP should reward investments in workforce development, predictive analytics, responsible AI, and operational improvements that strengthen service delivery while reducing administrative burden. By supporting sustained investments in PAS capacity and coordinated community-based care, these models can improve participant outcomes while reducing the total cost of care.

VBP will be most effective when core quality measures, reporting expectations, and performance methodologies are aligned across CHC-MCOs. Greater consistency would reduce administrative complexity, encourage broader provider participation, and allow organizations to focus their resources on delivering measurable improvements in participant care rather than managing multiple payment methodologies.

**Artificial Intelligence**

DHS should encourage the responsible use of artificial intelligence to reduce administrative burden, strengthen care coordination, identify service gaps, improve documentation, and generate actionable population health insights. AI should augment—not replace—professional judgment. Decisions involving medical necessity, service authorization, appeals, and participant rights must remain subject to qualified human oversight. DHS should encourage responsible innovation through clear expectations for transparency, security, algorithmic accountability, and provider engagement.