July 10, 2026

RCPA Response to Community HealthChoices Request For Information

Appendix A

The BI providers recommend the following:

- Designate acquired BI participants as a special needs group with funding based upon acuity, similar to an SNF funding methodology.
- Specialized training standards for service coordinators and complex care coordinators serving participants with acquired brain injury.
- Enhanced identification of specialty brain injury providers within CHC provider networks via CARF accreditation for proper referral coordination.
- Expanded access to cognitive rehabilitation therapy and other evidence-based neurorehabilitation services, via an accurate network of providers who are actively engaged and providing these services (not just marked as credentialed to do so).
- Develop a group to evaluate the qualifications necessary to provide cognitive rehabilitation therapy.
- Outcome measures focused on community integration and functional independence.
- Greater emphasis on maintenance and safety, in addition to rehabilitation outcomes and compensatory skills.

IV. FINANCIAL REQUIREMENTS (APPENDIX B)

Rate Adequacy

RCPA encourages DHS to establish a transparent methodology for:

- Annual rate rebasing;
- Workforce cost analysis;
- Inflation adjustments;
- Evaluation of provider sustainability; and
- Consideration of participant acuity.

Without a sustainable provider network, participant choice and access to services have diminished, as providers close programs or cease serving CHC waiver participants due to financial and operational challenges.

Residential Capacity Preservation (Bed-Hold Policy)

RCPA recommends that DHS evaluate and implement a bed hold policy similar to what is afforded to skilled nursing facility programs.

A limited bed-hold mechanism could:

- Promote continuity of care and support successful community integration;
- Preserve community-based placements and prevent unnecessary disruption to participants;
- Reduce unnecessary institutionalization or extended facility stays;
- Protect specialized residential rehabilitation capacity;
- Improve participant outcomes;
- Support provider network stability; and
- Reduce system costs associated with discharge delays, placement searches, and loss of community-based housing options.

V. REPORTING AND TRANSPARENCY (APPENDIX C)

Relevant Provision: Appendix C – Reporting Requirements.
Support strong reporting and oversight requirements that promote accountability and continuous quality improvement. The substantial amount of data currently collected through CHC presents opportunities for improved transparency and more meaningful performance evaluation.

Meaningful Access Reporting

DHS should utilize existing reporting structures to evaluate and publish:

- Access to cognitive rehabilitation therapy;
- Access to specialty brain injury providers;
- Service wait times;
- Provider capacity;
- Workforce shortages; and
- Percent of claims processed within 30 days by service.

Enforcement of timelines and policies as presently outlined in the CHC Waiver

These measures may provide a more accurate picture of participant access than provider directory data alone.

Administrative Simplification and Oversight Coordination

The brain injury providers support ongoing efforts to:

- Reduce duplicative reporting, documentation, and oversight requirements across OLTL, CHC-MCOs, QMET, CARF, DOH, and other reviewing entities.
- Improve interoperability and information sharing among OLTL, CHC-MCOs, QMET, CARF, DOH, and other oversight agencies to minimize repetitive requests for information already available in other systems.
- Leverage existing claims and encounter, licensure, accreditation, and review data whenever possible rather than requiring providers to submit the same documentation to multiple entities.
- Standardize administrative processes, forms, and review expectations to promote consistency and efficiency across all oversight bodies.
- Coordinate oversight activities to reduce disruption to provider operations while maintaining accountability and quality standards.

While we recognize that certain regulatory requirements are mandated and cannot be modified, the greatest opportunity for meaningful administrative savings lies not in reducing oversight, but in better aligning and coordinating it. Specifically, we encourage consideration of:

- Cross Portal Access and Data Sharing: Expand access of existing electronic portals and explore cross-portal access to create mechanisms for secure information sharing between OLTL, CHC-MCOs, QMET, CARF, and DOH to utilize information that has already been submitted and reviewed, to avoid requiring documentation multiple times.
- Alignment of Review Schedules: Coordinate licensing revalidation through OLTL, CHC-MCOs, QMET, CARF, DOH, and other oversight reviews whenever possible. Aligning review schedules would reduce provider preparation time, limit operational disruption, and improve efficiency for both reviewing entities and providers.

- Reduction of Redundant Site Visits: Where appropriate, utilize existing review findings, accreditation surveys, and documentation reviews to avoid multiple visits evaluating the same standards. This could include consideration of extending review intervals following successful CARF accreditation or other comprehensive evaluations.
- Standardized Review Tools and Forms: Develop common review instruments, documentation requests, and corrective action processes across agencies and MCOs to improve consistency and reduce administrative work.
- Enhanced Information Coordination: Allow findings, corrective actions, and compliance determinations from one oversight entity to be recognized by others whenever appropriate, reduce duplicate reviews and follow-up requests.

Reducing administrative burden allows providers to redirect resources toward participant care, workforce development, recruitment and retention efforts, and quality improvement initiatives. The greatest opportunity for cost savings lies not in reducing oversight, but in improving coordination, reducing duplication, and strengthening information sharing across reviewing entities while maintaining quality and accountability.

See Attachment I (dated October 31, 2025) for additional information

VI. IN LIEU OF SERVICES (APPENDIX E)

Relevant Provision: Appendix E – Assisted Living as an In Lieu of Service (ILOS).

We support the Department's efforts to create alternatives to nursing facility placement and recognize the value of assisted living residences (ALR) as a community-based option.

However, DHS should evaluate whether the current ILOS framework creates an unintended disparity between assisted living residences and personal care homes.

Currently, assisted living residences may serve as an approved ILOS alternative to nursing facility placement. Comparable opportunities do not exist for many personal care homes serving similar participant populations.

Participant Choice

This distinction may unintentionally limit participant choice and reduce access to specialized residential rehabilitation environments.

Participants should have access to the most clinically appropriate setting capable of meeting their needs, regardless of whether that setting is licensed as an assisted living residence or personal care home.

Specialized Brain Injury Providers

This issue is particularly relevant for providers specializing in acquired brain injury rehabilitation.

In some cases, personal care homes operated in conjunction with CARF-accredited rehabilitation programs may possess greater expertise in serving individuals with acquired brain injury than traditional assisted living settings.

Despite this expertise, current policies may limit access to these specialized residential environments, which are available to non-CHC waiver funded individuals.

Recommendation

We recommend that DHS evaluate whether personal care homes meeting specified quality, staffing, and rehabilitation standards should be eligible for consideration as an approved ILOS alternative to nursing facility placement.

At a minimum, DHS should examine whether current policies unintentionally reduce participant choice and create unequal treatment among residential providers capable of safely serving Nursing Facility Clinically Eligible individuals in community-based settings.

Grievances & Grievance Committee for Providers

Recommendation:

RCPA recommends implementation of the Provider Dispute Resolution Process (Section T).
RCPA recommends DHS be involved and have oversight and enforcement of this process.

III. NETWORK ADEQUACY AND ACCESS (EXHIBIT T)

Relevant Provision: Exhibit T – Provider Network Composition and Service Access.
Future procurements should place greater emphasis on meaningful access rather than solely measuring provider counts and geographic access standards.

Network Availability Versus Network Accessibility

A provider's inclusion within a network directory does not necessarily mean participants can obtain services from that provider.

Future network adequacy evaluations should consider:

- Provider specialization;
- Provider capacity;
- Workforce stability;
- Wait times for services;
- Acceptance of new referrals; and
- Participant access to specialty services.

This distinction is particularly important for individuals with acquired brain injury, who often require providers with specialized expertise rather than simply any provider offering a particular service category.

These measures may provide a more accurate picture of participant access than provider directory data alone.

Specialty Provider Networks

DHS should evaluate whether participants have meaningful access to providers specializing in:

- Brain injury rehabilitation;
- Cognitive rehabilitation;
- Neurobehavioral rehabilitation;
- Community integration;
- Vocational rehabilitation; and
- Physical rehabilitation.

Network adequacy should reflect the quality and specialization of available services, not merely the number of contracted providers.

VII. ARTIFICIAL INTELLIGENCE

AI should support, not replace, professional clinical judgment, treatment, or person-centered decision making.

Additional Comments:

Regarding the next phase of Community HealthChoices (CHC), RCPA recommends that there is a statewide rollout of the CHC-MCOs, rather than a regional designation. Providers should not be limited to one specific CHC-MCO. RCPA and their members will work collaboratively with the CHC-MCOs chosen to implement the CHC Waiver.