November 20, 2026

Department of Human Services | Bureau of Procurement and Contract Management

Pennsylvania Department of Human Services Office of Medical Assistance Programs
Re: HealthChoices Physical Health Services RFI 26-RFI-20476

Dear Department of Human Services Review Team:

With more than 400 members, the majority of who serve over two million Pennsylvanians annually, Rehabilitation and Community Providers Association (RCPA) is among the largest and most diverse state health and human services trade associations in the nation. RCPA advocates for those in need, works to advance effective state and federal public policies, serves as a forum for the exchange of information and experience, and provides professional support to members. RCPA provider members offer mental health, substance use disorder, intellectual and developmental disabilities, children and youth, criminal and juvenile justice, brain injury, medical and pediatric rehabilitation, and physical disabilities and aging services, across all settings and levels of care.

The Rehabilitation and Community Providers Association (RCPA) appreciates the opportunity to comment on the future of Physical HealthChoices. Our members serve people with behavioral health needs, substance use disorders, intellectual and developmental disabilities and autism, brain injury, physical disabilities, rehabilitation needs, and complex pediatric conditions. We approach this RFI with a clear interest in ensuring that people can obtain the treatment and supports they need to live in their communities.

We recognize the fiscal pressures facing the Commonwealth. Addressing those pressures will require a greater focus on how care is delivered and where community services can improve outcomes and reduce avoidable spending. Providers need the workforce and resources to deliver that care, and managed care organizations must be accountable for making coordination work.

Existing agreements already require coordination among physical health, behavioral health, and long-term services and supports. The next step is consistent enforcement and full participation by community providers. Their services can help prevent hospitalizations and emergency department visits and manage the total cost of care. When their work produces savings, they should be able to share those savings. This principle runs through our comments.

RCPA appreciates the opportunity to offer these recommendations and looks forward to continuing to work with DHS, the Office of Medical Assistance Programs, providers, managed care organizations, participants, and other stakeholders. We share the Commonwealth's interest in preserving choice, improving outcomes, and using public resources responsibly while strengthening the services that make community living possible.

Respectfully submitted,



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General Program Design
RFI Section 3.3.1(a), (b), (d), (e), (g), and (h)

RCPA supports the Department's focus on chronic conditions, perinatal and child health, and children with complex health needs. Within each priority, the program must account for people whose medical needs overlap with disability, behavioral health, developmental, and rehabilitation needs. Our interest is in a sustainable program that supports community living, delivers quality services, uses technology effectively, and addresses the workforce realities facing providers. These comments concern Physical HealthChoices and its coordination with other programs. We are not proposing that the benefits of those programs be moved into Physical HealthChoices.

Under Section 3.3.1(g), the issue is follow-through. Existing managed care agreements establish coordination responsibilities between physical health MCOs (PH-MCOs) and behavioral health MCOs (BH-MCOs), with related requirements for long-term services and supports (LTSS).

RCPA is concerned that these obligations are not consistently enforced. DHS should verify that shared planning and information exchange actually occur and require corrective action when they do not. Coordination must preserve the expertise and accountability of the respective systems while making care work for the person receiving it.

Community providers are central to that work. They support people between medical appointments, recognize changes in daily functioning, and help carry out care plans after a hospital discharge. Behavioral health, substance use, disability, rehabilitation, and home- and community-based services can help prevent avoidable hospitalizations and emergency department visits. MCOs should include these providers in planning and follow-up, with the individual's participation and appropriate consent. DHS should also ensure that handoffs between Physical HealthChoices, Community HealthChoices, and other applicable systems are completed and that providers have the information and payment needed to fulfill their responsibilities.

For Sections 3.3.1(b), (d), and (e), decisions about statewide or regional MCOs should be grounded in local capacity, consumer choice, continuity, and the administrative demands placed on providers. We do not recommend a particular number of plans without further analysis. Any enrollment lock-in must preserve options when access or quality fails and protect established provider relationships. People should stay with a plan because it meets their needs.

Our principal network concern under Section 3.3.1(h) is rural access. Workforce shortages, travel distances, and limited-service availability can make coordinated care difficult to obtain. DHS, MCOs, and local providers should identify those gaps together and support practical ways to maintain in-person care and home- and community-based services.

Outcomes Measures
RFI Section 3.3.2(a), (b), (d), (e), and (f)

RCPA supports a common statewide set of outcome measures, with additional measures suited to the population and initiative. Health, function, recovery, consumer experience, and the ability to remain in the community all matter. So do avoidable hospitalizations, emergency department use, and total cost of care. Community providers help produce these outcomes. They need to be included in performance arrangements and in shared-savings distributions when their services improve outcomes and reduce avoidable spending.

Evaluation should show whether community providers are participating in whole-person care and what their work contributes. MCOs and providers should agree at the outset on the population served, baseline performance, responsibilities, and how outcomes and savings will be attributed. Providers need timely data and support to do this work. The evaluation must account for the investment in community services as well as the savings that follow. Quality and access safeguards should apply, and the providers contributing to those savings should have a fair opportunity to receive a share.

Financing and Value-Based Payment RFI Section 3.3.3(a) through (d)

Whole-person care requires payment arrangements that include the providers delivering community supports. These services help people follow treatment plans, maintain stability, and remain at home. Behavioral health, substance use, disability, rehabilitation, and LTSS providers should participate in both the care model and the financial arrangements used to manage total cost of care. They should be paid for their services and coordination work and can share in savings attributable to their programs.

Before work begins, MCOs and participating providers should agree on the population served, baseline spending, quality expectations, and how savings will be attributed and distributed. Providers should be active partners in designing the arrangement and have access to the underlying performance data. When a community provider funds additional supports that reduce hospital or emergency department use, the payment model must recognize that contribution and deliver the provider's agreed share of savings.

We recommend that DHS encourage voluntary provider-led networks and accountable care organizations (ACOs) that give community providers a practical way to participate. Adequate payment for existing services, startup support, and funded coordination are necessary. Providers cannot finance this work solely on the promise of future savings. Smaller organizations need a workable entry point, and any financial risk should reflect their resources and ability to influence results. Shared savings must remain tied to quality, access, and individual choice.

Initiative Development
RFI Section 3.3.4(a) through (d)

Providers, consumers, and families should be involved before an MCO settles on an initiative or payment model. Their input should shape the care approach, measures, and shared-savings terms. Each initiative should identify whom it will serve, which organizations will participate, what resources are needed, and how progress will be assessed. The design must account for the needs of people with serious mental illness, substance use disorders, intellectual and developmental disabilities and autism, brain injury, and physical disabilities who are enrolled in Physical HealthChoices.

The scope of an initiative should reflect local needs and the capacity to meet them. Rural communities may need different workforce, transportation, and technology approaches than urban communities, with comparable expectations for access and quality. DHS should also bring MCOs together to coordinate their initiatives and reporting requirements. Providers should not face conflicting expectations for the same work. Expansion should follow a review of results and the resources needed to serve additional communities.

Partnerships
RFI Section 3.3.5(a) and (b); related Section 3.3.3(a), (c), and (d)

RCPA encourages DHS to support ACOs and similar partnerships that include community providers alongside hospitals, primary care practices, and specialists. Commercial coverage offers accountable-care and shared-savings approaches that can inform this work, with appropriate adjustments for Medicaid populations and community services. Community providers should have a meaningful role in governance, care design, and the distribution of savings. Their participation needs to extend to the decisions that affect their services and the people they support.

These partnerships should connect medical treatment with behavioral health, substance use treatment, disability services, rehabilitation, and applicable LTSS. Agreements need to spell out each partner's responsibilities, pay for coordination and information exchange, and explain how savings will be measured and distributed. Providers that help people remain stable at home, complete follow-up care, and avoid preventable hospital use should receive recognition for that contribution through the financial arrangement. Smaller organizations should be able to participate directly or through provider-led networks. Quality, choice, and continuity must remain protected.

Children with Complex Health Needs RFI Section 3.3.8(a), (c), (f), and (g)

For children with complex medical needs and children with intellectual and developmental disabilities and autism, coordination has to work across medical treatment, home nursing, therapies, behavioral and developmental services, equipment, and family supports. Families need to know who is responsible and whom to call when something breaks down. They should be partners in the care plan. MCO oversight should establish whether authorized home services are being delivered and whether equipment and specialty care are available when needed.

Before moving forward, a single specialized pediatric MCO under Section 3.3.8(a), DHS should demonstrate how the change would improve access, continuity, and the family's experience. That review must address provider capacity, consumer choice, disruption of services, and existing care relationships. RCPA recommends further stakeholder review before endorsing a mandatory statewide or regional arrangement. Children need access to specialized expertise under whichever structure the Commonwealth selects.

In 2023, the Pennsylvania Department of Human Services (DHS) launched the Children's Complex Care Blueprint Initiative goal to improve the systems which care for and support youth with an array of complex care needs and their families.

Transitions require early, practical planning. Adult providers, medications, equipment, and applicable adult services should be arranged before pediatric services end. Children need the same attention when they move between care settings. Families need clear information about benefit changes and who is responsible for the handoff. Planning should include the relevant behavioral health, developmental, LTSS, and child welfare systems. DHS must also distinguish between an unavailable benefit and an authorized service that is not being delivered, so the response addresses the actual problem.

To accomplish that goal, DHS launched The Complex Care Blueprint Initiative to better understand their needs, develop recommendations to improve the systems of care, and build capacity. The Pennsylvania Department of Human Services released their recommendations from its Blueprint Workgroup, an interdisciplinary group comprised of representation from state and local governments, health care, education, service providers, managed care, and family advocates. The work group sought to evaluate challenges that children and youth with complex, co-occurring physical and behavioral health care needs and their families experience, like accessing care and services that adapt to a youth's changing circumstances and needs, lessening the likelihood of child welfare system involvement, reducing trauma experienced by instability, prioritizing emotional wellbeing, and supporting family- and youth-driven care and choice.

Recently, the complex Blueprint Steering Committee and work group stakeholders presented to DHS secretary Dr Valerie Arkoosh and select deputy secretaries from other children serving DHS organizations, a set of actionable strategies for consideration to strengthen and support the children's complex care system and their families.

Additionally, we believe the Pennsylvania Department of Human Services' Pediatric Capacity Building Institute (PCBI) should be involved in any efforts to address children with complex medical, behavioral, and developmental challenges. PCBI is a statewide, in-depth training program designed to strengthen the administrative and clinical capacity of all systems supporting children, youth, and young adults (ages 0–21) with complex needs and their families. The initiative is a coordinated, capacity-building effort to ensure that children and youth with complex needs in Pennsylvania receive better-coordinated, evidence-based, and family-centered services through improved collaboration across systems. Both of these DHS Initiatives should be strongly considered in any efforts associated with this RFI.

Technology and Data
RFI Section 3.3.9(a), (b), and (c); related Sections 3.3.2 and 3.3.3

Whole-person care depends on information reaching the providers who need to act on it. Through the Pennsylvania Patient and Provider Network and other appropriate systems, community providers should be able to receive hospital notifications, obtain relevant care information, and contribute to shared plans. Information exchange must connect physical health, behavioral health, and LTSS providers while protecting consent and privacy.

Access must also be affordable and usable. Smaller providers cannot be expected to maintain multiple expensive interfaces or repeatedly enter the same information into different systems. Maryland's CRISP model offers a useful guide through shared information tools, training, and approved pathways for community-based organization data sharing. Pennsylvania can draw on that approach to simplify enrollment, provide a practical shared portal and technical assistance, and offer low-cost or subsidized access. Providers need this information both to coordinate care and to understand their contribution to outcomes and shared savings. Consent, privacy, and appropriate access controls remain essential.

Program Integrity
RFI Section 3.3.10(a) and (b); related Section 3.3.9(d)

Program integrity is an ongoing obligation. Maintaining highly qualified providers and operators protects the people receiving services and public confidence in Medicaid. As new partnerships and payment arrangements develop, DHS and MCOs must continue to support appropriate credentialing, workforce qualifications, organizational accountability, accurate records, and verification that authorized services are delivered. Clear guidance, provider education, and consistent, proportionate oversight will help sustain those standards.

Providers and MCOs should maintain effective compliance and quality improvement programs, including clear procedures for reviewing and promptly reporting potential fraud, waste, and abuse. Training and corrective action should address deficiencies that can be remedied. These responsibilities carry into ACOs and shared-savings arrangements. Financial incentives must be transparent and must not compromise quality or access. The objective is to maintain a qualified, accountable provider system capable of delivering dependable community services.

RCPA sees a practical path forward. Enforce the coordination obligations already in place, bring community providers into the decisions about care and payment, and make information exchange accessible. When community services improve outcomes and reduce avoidable costs, the providers doing that work should have the opportunity to share in the savings. We welcome continued work with DHS, consumers, families, MCOs, and providers to strengthen a program that supports community living and uses the Commonwealth's resources responsibly.

Contact Information

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References

Pennsylvania Department of Human Services, HealthChoices Physical Health Services, Request for Information 26-RFI-20476, October 6, 2026. Official solicitation posting: https://www.emarketplace.state.pa.us/Solicitations.aspx?SID=26-RFI-20476

Section numbering, submission address, subject line, deadline, and format requirements were checked against the reproduced RFI text available at: https://govtribe.com/file/government-file/26-rfi-20476-healthchoices-physical-health-services-dot-pdf

The official posting was unavailable during preparation. We checked submission details against the reproduced RFI text on October 29, 2026; check the official posting for amendments before submitting.

Coordination requirements: DHS HealthChoices agreements and Behavioral Health Program Standards and Requirements, available through: https://www.pa.gov/agencies/dhs/resources/medicaid/hc/hc-publications and https://www.pa.gov/agencies/dhs/resources/medicaid/bhc/bhc-publications.

Maryland CRISP tools, training, and approved data-sharing uses: https://www.crisphealth.org/ and https://www.crisphealth.org/use-cases. Simplified enrollment and subsidized access are proposed adaptations for Pennsylvania.