RCPA
REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

THE quarterly advisor

SEPTEMBER 2026

SPECIAL FEATURE

H.R. 1 Medicaid: State Begins Implementation of New Medicaid Requirements

As the clock winds down on the deadline for implementing the new Medicaid expansion population changes outlined in the H.R. 1 legislation, Pennsylvania is sprinting to the January 1, 2027 implementation finish line. What is not apparent is "The Plan." For some of this delay, many advocates and stakeholders have cited a lack of transparency; however, DHS has been hampered by the Centers for Medicare and Medicaid Services (CMS) with the promise of a final guidance, only to be told that there will be additional final guidance to the states in the future. With so much on the line for our most vulnerable in the Commonwealth, missteps on implementation could have disastrous results.

The initial timeline outlines a series of communications to Medicaid expansion recipients and those that fall into selective immigration status. This group will have their eligibility re-determined every six months instead of 12 months, and must complete 80 hours of community engagement that can include a combination of work, education, or volunteerism. For those recipients that RCPA members serve, the largest determining factor will be the exclusionary criteria for individuals who are considered "medically fragile.' Under federal law and CMS guidance, individuals deemed "medically frail"—including those who are blind or disabled, limited in activities of daily living, or living with a substance use disorder, disabling mental disorder, or serious medical condition—are officially exempt from mandatory health engagement requirements. In the recent CMS Interim Final Rule, a medical diagnosis alone is now no longer sufficient to qualify for an exemption, as enrollees must now prove their condition significantly impairs their ability to work 80 hours a month, transforming a clinical definition into a strict work-capacity test that potentially has fewer individuals expected to pass.

How the State will determine and track this critical information has yet to be made public, including what role the provider community will play in the process. RCPA has strongly advocated to multiple stakeholder policy groups, including the DHS H.R. 1 Steering Committee and Medical Assistance Advisory Committee (MAAC) that providers, as the front line connection with this population, must have access to the eligibility status data to identify individuals who fall into this category. To date, no guidance has been provided, though the State scheduled a webinar with community-based organizations for August 26.

As part of RCPA's ongoing efforts for guiding members and stakeholders through the H.R. 1 implementation process, RCPA has updated our **RCPA H.R. 1 Medicaid Resource Guide**. The guide is designed to provide education and resources for the changes that are set to occur at the state and federal levels. This edition features newly released federal and state guidance, including clarifications from the CMS Interim Final Guidance on Community Engagement Requirements (CER) and six-month renewal processes. You can also view the **CER Exemption Verification Fact Sheet** for additional information.

RCPA will continue its advocacy efforts as well as update this guide as implementation proceeds and information becomes available. These proposed standards are set to take effect January 1, 2027. ◂

About RCPA:

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.

Contact **Tieanna Lloyd**, Membership Services Manager, with inquiries or updates regarding the following:

- **Membership Benefits**
- **Your Staffing Updates** (i.e., new hires, promotions, retirements)

As a reminder, we launched a new website and EMS. If you have not already done so, you will need to create an RCPA account, which will allow you to:

- View members-only content on the new website; and
- Access your RCPA portal, which enables you to register for meetings, update your email preferences, and more.

Please note: you will need to log into your portal to register for all RCPA events.

RCPA

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September 2026

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Interested in becoming an RCPA Partner? Please contact **Tieanna Lloyd** for details.

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NEW for 2026/27 membership year:

Business Members can now choose from three different membership tiers!
Contact **Tieanna Lloyd** or view the **Business Member application** for details.

CONFERENCE

RCPA to Recognize Lifetime Achievement Award Recipients at the 2026 Conference!

Come celebrate with RCPA at our 2026 Conference in Hershey, PA, as we honor the distinguished careers of four leaders in health and human services at our Awards Luncheon. **Be sure to register today and reserve your spot at this exciting event!** RCPA is proud to announce that we will be recognizing and celebrating the lifetime achievements of:

Jim Cook, Retiring CEO, Cambria Residential Services

For more than forty years, Jim Cook has been a steady, principled, and compassionate leader in Pennsylvania's intellectual and developmental disability services community. Jim's work at Cambria Residential Services has shaped not only programs and policies but also the lives of countless people, families, and professionals who have been strengthened by his commitment to dignity, inclusion, and possibility. Jim was instrumental in opening the first group home in Pennsylvania, and his career has been defined by his unwavering commitment to the people served.

Continued on page 4

Continued from page 3

Cindy Pasquinelli, Retiring CEO, Strawberry Fields, Inc.

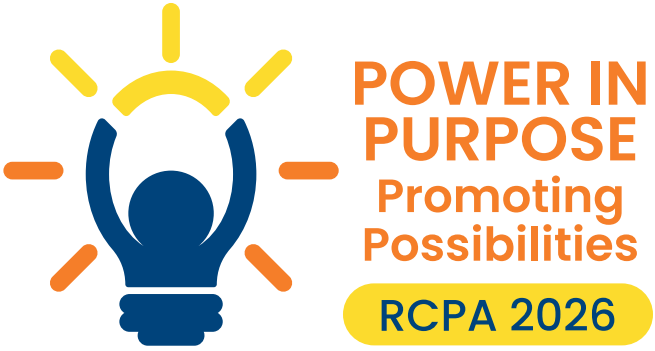
Cindy Pasquinelli is retiring after 41 years of exceptional leadership and service to Strawberry Fields. Throughout her decades-long career, Cindy has led with passion, purpose, and an unyielding commitment to providing the highest quality programs and services for individuals and families with intellectual and developmental disabilities, autism, and mental health challenges in Centre County, Pennsylvania. After her retirement, she plans to continue supporting Devereux in its efforts to forge new partnerships with organizations like Strawberry Fields that share its dedication to making a difference in the lives of individuals and families in need.

Scott Suhring, Retiring CEO, Capital Area Behavioral Health Collaborative (CABHC)

Scott Suhring has championed person centered care, data driven quality improvement, and collaborative partnerships that elevate outcomes for individuals, families, and providers across the region. As CEO of the Capital Area Behavioral Health Collaborative, Scott's leadership has shaped systems that prioritize dignity, access, and accountability. Under Scott's guidance, CABHC has become a model for how managed care oversight can be both fiscally responsible and deeply humane, ensuring that every decision reflects the needs of the people served.

Steve Suroviec, President and CEO, Achieva

Steve Suroviec is widely recognized for championing innovation and person-centered culture, strengthening Achieva's financial position, and being a stalwart supporter of Achieva's advocacy and family support mission. Under his leadership, Achieva has achieved significant milestones, including: closing Achieva's segregated sheltered workshops and day program facilities while growing community services, such as competitive-integrated employment and community-participation services for people with disabilities; creating new services prioritized to serve children with complex medical needs; offering on-demand transportation for people with disabilities; and providing supported decision-making services in lieu of guardianship.



Register today, and **view the brochure** for more details on our awards recipients, workshops, schedule, and more!

Contact Conference Coordinator **Carol Ferenz** with any questions.

MEMBER CONTRIBUTOR CORNER

Are You Paying More Simply Because You're Smaller? A Smarter Approach to Nonprofit Purchasing

By Isaac Farbowitz, Vice President, FNPAdvantage

Nonprofit leaders are no strangers to making difficult financial decisions. Every day, organizations weigh growing community needs against limited budgets, rising costs, and increasing demands on their teams. The reality is that most nonprofits have already become experts at doing more with less.

But there is one area where many organizations may be leaving money on the table: purchasing.

Whether it's food, office supplies, technology, shipping, utilities, or facility services, nonprofits rely on many of the same products and services as large corporations. The difference is that large organizations often have dedicated procurement departments and the purchasing volume needed to negotiate better pricing. Smaller nonprofits may not have the time, staff, or buying power to secure the same advantages.

That's where the conversation around Group Purchasing Organizations (GPOs) has become increasingly important.

A GPO allows organizations to benefit from collective buying power, giving nonprofits access to pricing and contracts that would otherwise be difficult to obtain on their own. However, joining a GPO is not simply about finding the biggest network or the longest list of discounts. The right partner should understand your organization's unique needs and help you identify where the greatest opportunities exist **[read full article]**. ◂

Before Pursuing a Merger: Strategic Partnership Options for Nonprofit Providers

By: Diana Ramsay, President, MPP, OT, FAOTA, The Ramsay Group

During conversations with behavioral health and human services nonprofit leaders, a consistent frustration has emerged. When their organizations bring operational, financial, or sustainability challenges to consultants and advisors, the recommendation is often the same: merge.

Many leaders feel that this recommendation arrives before the problem is fully defined or the impact is weighed.

In some cases, mergers and acquisitions can be genuinely valuable. When strategic, they can preserve critical services, strengthen financial stability, reduce duplication, and expand capacity in ways a single organization cannot achieve alone. Sometimes, a merger is the right decision.

But it's only one point on a much larger continuum of strategic partnerships. Choosing the right level of partnership depends on what the organization is trying to solve **[read full article]**. ◂

Familylinks Training Institute
The Importance of Continuing Education in Human Services

Workforce development has become one of the most pressing challenges facing behavioral health, social service, and healthcare organizations. Across Pennsylvania and beyond, providers are navigating increasing service demands, workforce shortages, evolving regulations, and rapid changes in evidence-informed practice. In such a dynamic environment, continuing education is no longer simply a professional obligation or a means of maintaining licensure. It is a strategic investment in both the workforce and the quality of care that organizations can provide.

At its core, continuing education reflects a commitment to professional excellence. The knowledge and skills required to effectively support individuals, families, and communities are not static. As research advances and service delivery

Continued on page 6

Continued from page 5

models evolve, professionals must continually refine their understanding and adapt their approaches. Ongoing learning enables practitioners to remain current, deepen their expertise, and exercise sound judgment in increasingly complex situations. It also creates opportunities for reflection, allowing professionals to critically examine their practice and integrate new ideas into their work. The value of continuing education extends beyond individual growth. Organizations that prioritize learning are often better equipped to respond to change, sustain innovation, and achieve long-term success. A culture that encourages professional development signals that employees are valued not only for the work they do today, but also for their potential to grow and contribute to the future. This investment can strengthen employee engagement, support retention efforts, and foster a sense of shared purpose across teams **[read full article]**. ◂

Clinically AI

Medicaid's Defensible Documentation Era: What Behavioral Health Leaders Need to Know

Two federal Medicaid developments are converging in ways behavioral health organizations should not treat as separate issues.

The 2025 federal reconciliation law (H.R. 1) introduces new community engagement requirements for many Medicaid expansion adults ages 19 to 64, effective no later than January 1, 2027. Qualifying activities include 80 hours per month of work, community service, or education. Exemptions exist for people who are medically frail, but CMS's 2026 rule ties frailty to functional impairment, not diagnosis alone, and leaves states to build their own determination process rather than rely on a preset list of qualifying diagnoses.

This matters for behavioral health providers. More than one in three nonelderly Medicaid adults has a mental illness, and a large share of enrollees with mental health or substance use diagnoses qualify through the expansion population most affected by these rules. Two clients with the same diagnosis can have very different functional capacity: one may sustain steady employment, another may not. That distinction lives inside the clinical record, and it may increasingly determine whether someone keeps coverage **[read full article]**. ◂

Brown & Brown

2026 OSHA Hazard Communication Changes: What Agencies Need to Know

By Gordon Smoko, CSP, CFPS, ARM, Senior Risk Manager, Certified Praesidium Guardian, Brown & Brown Insurance

OSHA revised their Hazard Communication Standard (HCS) to align with the current United Nations Globally Harmonized System, the first major revision since 2012. Changes that impact agencies focus on small container labeling and training. OSHA has set November 20, 2026 as the employer compliance date for the revised HCS standard. In this article, I highlight these changes and steps to assist with compliance.

Small Container Labeling

Under the old HCS, a "small package" container was not defined. Under the revised HCS, OSHA has defined the container sizes and labeling requirements: Containers less than or equal to 100 mL in capacity, and the other is intended for sizes less than or equal to 3 mL in capacity.

A container that is less than or equal to 100 mL must display the following information on the immediate container:

- Product identifier;
- Pictogram(s);
- Signal word;
- Chemical manufacturer's name and phone number; and
- Notice that full label information for the hazardous chemical is provided on the outer packaging.

For a container that is less than or equal to 3 mL in size, the following is required on the immediate container:

- Product identifier;
- Outer packaging must display all label information;
- Outer packaging must include a notice that the small container(s) inside must be stored in the outer packaging when not in use; and
- Labeling must be legible.

OSHA's goal was to make small packaging labels easier to read and more informative to improve hazard awareness at the point of use.

Training

Updated employee training for affected employees may be needed if changes occurred in small container labeling, or updated SDS information reveals new exposures (this HCS update also required manufacturers to update their SDSs by May 19, 2026). Agencies should consider whether revised container labeling, pictograms, hazard statements, classifications, handling precautions, or emergency measures have changed that require additional instruction.

Continued on page 7

MEMBER CONTRIBUTOR CORNER

Continued from page 6

Summary

As a best practice, maintenance of records showing what labels, procedures, SDSs, program updates, and training materials were reviewed along with what changes were made, and when those changes were implemented, is encouraged. For more information on changes to the HCS, see the link **OSHA's Final Rule to Amend the Hazard Communication Standard | Occupational Safety and Health Administration**

Thank you for your time and interest in safety! ◂

DIVERSITY, EQUITY, AND INCLUSION

Red Flag Meetings: A Trauma-Informed Approach to Organizational Problem Solving

By Larry Shallenberger, Associate Vice President of Compliance, Sarah Reed Children's Center. Larry is involved in the agency's diversity efforts.

Maslow cautioned, "When all you have is a hammer, all you see is a nail." We usually refer to Maslow's Hammer to caution ourselves not to be overly reliant on one clinical or organizational method. Caution is necessary, but we often forget the corollary: Picking the right tool changes how we view a problem and suggests a helpful solution.

At Sarah Reed Children's Center, we've found the Sanctuary™ Model's Red Flag Meeting to often be that right tool. A Red Flag Meeting is a structured, trauma-informed, problem-solving meeting that is convened in the aftermath of a critical incident, crisis, or collective disturbance occurring in the agency. The meetings are designed to prevent collective anxieties from escalating and to move the group into action, working off a co-created plan.

A Red Flag Meeting: 1) Opens with a community meeting or emotional check in; 2) Next, the group has a brief conversation to come to an agreement as to how the problem should be defined; and 3) Then, the group reviews contributing factors using the Sanctuary™ S.E.L.F. framework:

Safety: The team identifies factors that challenge a group or individual's psychological, physical, social, or moral safety.

Emotions: The team identifies the emotional state of part of the organization and how it is contributing to the problem. Then, the team discerns whether reenactments, parallel processes, or collective disturbances contributed to the problem.

Loss: The team identifies the losses that individuals of groups might be feeling because of the disturbance. Loss takes many forms; loss of power, status, connection, familiarity, etc.

Future: Lastly, the team begins to build an action plan by asking questions such as "What do we want to achieve?" "What actions will we take?" "Who is responsible?" and "How do we prevent recurrence?" After the action plan is built, the team picks a date to reconvene and measure progress.

A trauma-informed organization is distrustful of power imbalances and looks to flatten hierarchies whenever possible. One way this occurs is that anyone in the organization can call a Red Flag Meeting—a client, their family, or a new staff member who just completed orientation. This shared governance can mitigate the loss of power caused by trauma. For example, several years ago a group of staff noticed that other staff were misgendering trans and non-binary clients and refusing to use their preferred names at our organization. They called a Red Flag Meeting that was attended by staff from all departments and levels of leadership. The result was an action plan that led to an agency-wide training of our best practices for working with LGBTQIA clients, additional SOGIE (Sexual Orientation, Gender Identity, & Expression) training, and supervisory intervention for resistant staff. To prevent a recurrence of this issue, the LGBTQIA Client Treatment Policy was added to our agency orientation curriculum.

So, while Maslow's Hammer reminds us that the Red Flag Meeting isn't the solution to every problem, this trauma-informed cousin of the root cause analysis is a worthy addition to every leader's toolkit. ◂

A New Era in Mental Health Treatment Is Coming. Is Pennsylvania Prepared?

By Jack Phillips, Director of Government Affairs

Pennsylvania has been a leader in mental health care innovation for nearly three centuries. From the **founding of America's first institution treating mental illness in Philadelphia in 1751 to the breakthrough development of cognitive behavioral therapy** at the University of Pennsylvania more than 200 years later, the state has consistently stood on the front lines of medical advancement.

Today, that legacy faces its next test.

More than 2 million Pennsylvanians — **one in five** adults — live with a diagnosed mental health condition. Yet the front-line medications used to treat common conditions like post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and major depressive disorder (MDD) were developed between the **late 1980s and early 2000s**. For PTSD specifically, the Food and Drug Administration (FDA) has approved **only two drugs**; the most recent was cleared in 2001. Similarly, for GAD, the last FDA approved drug was authorized in 2007—nearly 20 years ago.

For many, available medicines fall short. Only **25.5% of patients achieved remission** on their first antidepressant, according to a 2023 analysis by University of Pennsylvania researchers. And for those with **treatment-resistant depression**, standard medicines aren't enough.

That's why, after two decades of stalled progress, researchers are turning to a new approach: psychedelic medicines.

Scheduled compounds that have existed for decades, but were historically under-researched in the United States, are now progressing through **late-stage clinical trials**, generating the rigorous scientific evidence required for FDA review. In fact, several of the medicines being researched for mental health treatment have received the **FDA's Breakthrough Therapy Designation**, a status reserved for medicines that show improvement over existing options for serious conditions.

This September, we will recognize **National Suicide Prevention Month**, reminding us that for millions of Americans, mental health care is a matter of life and death. In Pennsylvania alone, suicide was responsible for **nearly 2,000 deaths** in 2024, according to the Centers for Disease Control and Prevention. In 2023, more than **86,000 calls** were made to the state's 988 Suicide & Crisis Lifeline call centers.

Nationally, among **veterans who died by suicide with a mental health diagnosis** in 2022, 64% had been diagnosed with depression, 43% with an anxiety disorder and 40% with PTSD — the same three conditions for which front-line treatments have changed the least. In Pennsylvania, **268 veterans died by suicide** in 2023. The good news is that federal approval for psychedelic medicines to treat severe mental health conditions may be on the horizon.

Because psychedelic compounds remain Schedule I controlled substances, the FDA approval alone would not permit clinicians to prescribe it—the Drug Enforcement Administration (DEA) needs to reschedule the drug separately before it could be used in medical practice. Fortunately, the federal government has already begun to take steps to more closely align key agencies. An **April 2026 executive order**, among other things, directs increased coordination between the FDA, DEA, HHS, and the VA, to reduce barriers to research and facilitate clinical development of new mental health drugs.

At the state level, a **bipartisan co-sponsorship memo** filed in the Pennsylvania House of Representatives seeks to align state scheduling laws with FDA approvals and DEA scheduling decisions. However, further action is still needed to ensure Pennsylvania's controlled substances laws are updated promptly so that, when these medicines receive federal approval, state and federal law are aligned and patients can access treatment without unnecessary delays.

Finally, equity is another key consideration. In Pennsylvania, **more than one in four** adults with any mental illness reported an unmet need for treatment in 2022–2023, according to Mental Health America. Without deliberate access planning, these medications risk reaching only affluent patients while missing the rural communities, veterans, and underserved populations most affected by the existing treatment gap.

While researchers continue their work, it's up to Pennsylvania's legislators, policymakers, and providers to build the infrastructure and regulatory framework needed to support timely access to these medicines once they are federally approved. ◂

GOVERNMENT AFFAIRS

RCPA's Legislative Tracking Reports

RCPA is constantly tracking various policy initiatives and legislation that may have positive or negative effects on our members and those we serve. For your convenience, RCPA has created a **legislative tracking report,** containing the bills and resolutions we are currently following. You can review this tracking report to see the legislative initiatives that the PA General Assembly may undertake during the current legislative session. If you have questions on a specific bill or policy, please contact **Jack Phillips**, Director of Government Affairs. ◂

BEHAVIORAL HEALTH SUBSTANCE USE DISORDER TREATMENT SERVICES

GLP-1s Proving to Be Effective in Treating Substance Use Disorder

By Jason Snyder, Director, SUD Treatment Services

GLP-1s may be all the rage today in weight loss, but evidence is mounting that they are an effective medication at treating substance use disorder (SUD) and other addictions as well.

Glucagon-like peptide-1 (GLP-1) is a hormone naturally created by the small intestine that triggers insulin release from the pancreas, manages blood sugar levels, slows stomach emptying during digestion, increases satiety (feeling of fullness) after eating, and controls appetite.

The success of popular medications (e.g. Ozempic, Wegovy) that mimic this hormone in managing diabetes and weight loss is well-documented. Their off-label use for treating SUD may be less known, but positive early results in retrospective research and pilot programs demand a closer look.

The great potential GLP-1s hold isn't surprising, given how they work in the body, especially as it relates to their role in **influencing the release of dopamine** in the part of the brain linked to motivation, pleasure, and reward. The **physiologic explanation for opioid use disorder**, for example, centers on the large release of dopamine in response to opioid use, the brain's reduction in the natural production of dopamine over time as a result of prolonged use, and the subsequent need to continue using opioids to achieve the same effect. A medication that can reduce those cravings for opioids—or other addictive substances, including food, alcohol, or nicotine—is promising as a treatment for addiction.

In April, at this year's National Council for Mental Wellbeing Conference in Denver, **Dr. Steven Klein**, an addiction medicine physician and scientist with Caron in Pennsylvania, presented to the National Council's SUD Committee on Caron's work in treating patients with GLP-1s. At the time, Caron had treated 442 patients in its residential or partial hospitalization programs. The majority (64 percent) were treated for alcohol use disorder. Five percent had been treated for OUD, and just over 5 percent had been treated for cocaine use disorder. Those with a variety of other disorders, including stimulant and polysubstance use, made up the rest of the cohort.

Using the **WHO-5 Well-Being Index** as one measure, mean percentage scores for a subgroup of the Caron patients went from a baseline of 27 to 71 over eight months, indicating a person's subjective mental well-being and quality of life have improved. Over the same timeframe, using the **Penn Alcohol Craving Scale (PACS)**, cravings to drink alcohol decreased from 20.3 to 6.

Other outcomes measures at Caron showed retention in treatment for OUD to be 94 percent at one month for those being treated with a GLP-1 versus 69 percent for

Continued on page 10

BEHAVIORAL HEALTH
SUBSTANCE USE DISORDER TREATMENT SERVICES

Continued from page 9

those receiving traditional OUD treatment, and 84 percent at three-months versus 50 percent for those who were not receiving a GLP-1.

Multiple retrospective studies have also shown promising results, including: a **50 percent decrease in new alcohol use disorder (AUD) diagnoses and relapse; decreased alcohol-related hospitalizations; a 50 percent reduction in alcohol intoxication events; a 42 to 68 percent reduction in opioid overdose risk;** and **a 40 percent reduction in overdose events.**

In the first-ever study to directly compare **GLP-1s head-to-head against all three US Food and Drug Administration-approved AUD medications**, those using a GLP-1 had a 45 percent lower AUD relapse rate. At the same time, multiple clinical trials are under way at various phases.

The Center for Addiction Science, Policy and Research (CASPR) is central to many of the pilot programs taking place, including those at Caron. In fact, the organization is planning a major study of 1,200 individuals in Pittsburgh, in partnership with the Department of Human Services in Allegheny County. This study will measure the impact of GLP-1s on alcohol and opioid use, as well as economic and social outcomes including recidivism and employment.

Those who have publicly spoken about their SUD struggles and experience with GLP-1s cite its ability to reduce or eliminate cravings, even in the face of the strongest temptations. But for many people, the challenge in getting the medication is cost. Because the drugs are not FDA-approved to treat SUD, they are used off-label, meaning insurance does not cover them for that purpose, putting the out-of-pocket cost out of reach for the Medicaid population, for example. CASPR is working to change that. Its mission is to bring better addiction medicines to market – high impact treatments that can reduce the rates of addiction at a population scale. ◂

BEHAVIORAL HEALTH | MENTAL HEALTH

Governor Shapiro's Behavioral Health Advisory Committee Delivers a Winner

After nearly three years in the making since Governor Shapiro created the council by executive order in October 2023, the Governor has released his **Statewide Action Plan for Behavioral Health**. The plan reflects recommendations developed through a series of meetings held by the **Behavioral Health Council and its Advisory Committee;** RCPA President and CEO Richard Edley is a member of this advisory committee. The Behavioral Health Council's mission was to examine innovative care delivery models, assess workforce needs and funding sources, improve regulations and payment systems, and integrate mental health and SUD care with primary care while addressing health-related social needs.

The comprehensive plan is wide-ranging and ambitious; anchored by six overarching goals, supported by a total of more than 40 recommendations and more than 200 high-level action steps with the overall goal to overhaul care delivery, accessibility, and workforce stability. It prioritizes creating an integrated healthcare system that links mental and physical health services, reflective of federal programs like the expanding immediate crisis access, and supporting community providers to combat severe staffing shortages and pays particular attention to the intersects of behavioral health and the criminal justice system. These efforts should support the current initiative spearheaded by The Administrative Offices of the PA Courts (AOPC) and PA Supreme Court Justice the Honorable Kevin Dougherty. Additionally, the framework emphasizes boosting state transparency, delivering culturally relevant and trauma-informed equity care, and reducing administrative burden.

By implementing these strategic steps, Pennsylvania aims to eliminate long-standing barriers to critical

Continued on page 11

BEHAVIORAL HEALTH | MENTAL HEALTH

Continued from page 10

medical treatment and recovery support. The State continues to track these ongoing funding initiatives and programmatic rollouts publicly through the official Governor's Newsroom.

Several of RCPA's behavioral health provider members' longstanding priorities are featured in the Council's plan, with an explicit focus on Goal No. 3, "Strengthening the Workforce and Provider Support." This section outlines comprehensive administrative reforms to reduce provider burdens by reviewing licensing regulations across DHS, DDAP, DOH, and DOS to eliminate duplicative rules, while aiming to update statutes to streamline integrated service provider standards, establish single licenses for co-occurring disorder programs, and align agency inspection schedules. Furthermore, the plan seeks to coordinate with BH-MCOs on standardized audit protocols, evaluate "deemed status" for providers with national accreditations like CARF or the Joint Commission, and standardize core documentation requirements—such as intake and billing protocols—while prohibiting payers from unilaterally imposing new administrative demands without cost assessment.

Although the plan acknowledges funding, legislative action, and interagency coordination as three primary levers to implementation, it offers no specifics on those levers, nor does it provide a timeline or detail on how it gets accomplished. RCPA applauds the Governor and the Advisory Council for this long overdue behavioral health roadmap. We look forward to engaging in the implementation efforts, with the hope that this initiative is implemented in an efficient, timely manner.

Read the governor's full press release on the Behavioral Health Action Plan. ◂

CHILDREN'S SERVICES

CMS ABA Toolkit and Potential Implications for IBHS

In August 2026, the Centers for Medicare and Medicaid Services released an **Applied Behavior Analysis (ABA) Toolkit** to support state agencies in decisions regarding ABA service provision. ABA utilization in Medicaid and CHIP has grown significantly in recent years. Medicaid data shows a 189 percent increase in the number of children with an autism spectrum disorder (ASD) diagnosis, but a 421 percent increase in ABA spending. In accordance with a primary target of the Trump administration, CMS attributes much of the increase in expenditure to fraud, waste, and abuse in the Medicaid system. Although there are proven instances of fraud, waste, and abuse in ABA, especially within the context of private equity backed chains, this does not represent ABA services entirely.

ABA is an expensive service to deliver, and has become the most expensive service in Pennsylvania's HealthChoices program. It requires care from a highly trained and credentialed professional, and is often prescribed in an intensive manner, as data proves that early and intensive intervention is critical in achieving positive outcomes. The rapid growth in ABA utilization has, undoubtedly, put a financial strain on both federal and state Medicaid agencies, but this cannot serve as a barrier to limit access to care.

CMS is encouraging states to reevaluate their current authorization and delivery of ABA services, which can be done through a variety of measures, including limiting the number of hours that a child can receive ABA. The toolkit states that intervention intensity and frequency are not correlated with improved outcomes, despite citing multiple studies that prove the opposite, and others that show no positive association but explicitly state methodological problems that lead to inconclusive results. Other potential cost-saving measures come from tighter prior authorization requirements, increased data reporting requirements, and higher supervision standards, all to avoid authorizing too many expensive ABA hours.

Pennsylvania ABA providers are already beginning to see the impacts of this rhetoric within Pennsylvania's Intensive Behavioral Health Services (IBHS), with behavioral health managed care organizations taking measures to align their policies with those promoted by CMS. Managed care plans are able to move much more quickly than state agencies, as contract language is much easier to amend than state regulations. Although managed care organizations are reacting to a multitude of potential funding constraints with federal Medicaid changes and State changes to capitation payments, there is still concern regarding the burden this could place on providers and access to ABA care as a whole. As of now, it is unclear how Pennsylvania will respond to the cost-saving measures recommended by CMS, but RCPA will remain diligent in its efforts to ensure access to care. ◂

RCPA Launching Life Sharing Community of Practice

RCPA is establishing a Life Sharing Community of Practice for members interested in strengthening and advancing Life Sharing services within Pennsylvania's IDD system. This collaborative group will provide a forum for professionals to connect, discuss emerging issues, share experiences, exchange best practices, and learn from one another. Participants will be encouraged to actively engage in discussions and contribute case studies, successful strategies, resources, and other information that can support quality Life Sharing services across the Commonwealth.

Participation is open to all interested RCPA members. Because the value of a Community of Practice depends on member engagement, participants should be prepared to actively contribute to conversations and information-sharing opportunities. Members interested in joining should contact **Tim Sohosky** by September 11, 2026. Following the identification of participants, RCPA will schedule a kickoff meeting to discuss priorities, goals, and next steps for the group. ◄

Residential Performance-Based Contracting Standards Updated for 2027–28

The Office of Developmental Programs (ODP) has released updates to the Residential Performance-Based Contracting (PBC) standards for the 2027–28 contract year. The overall framework remains consistent with previous cycles; the new standards drive forward with ODP's shift toward measuring outcomes and implementing continuous quality improvement rather than focusing on policies and administrative documentation. The new standards seek to operationalize plans providers created in previous cycles while improving on previously identified baseline measures.

Based on feedback provided by RCPA and its members, several standards have been retired, reducing administrative burden in areas such as governance, family engagement documentation, workforce cultural competency attestations, and certain clinical resource reporting. Concurrently, ODP has introduced new metrics emphasizing measurable performance and operational results.

One material change is the increased focus on workforce credentialing. Providers will now need to demonstrate growth in Direct Support Professional (DSP) and Frontline Supervisor (FLS) credential attainment through NADSP, rather than simply attesting to participation.

Clinically Enhanced providers should pay close attention to the new staffing expectations. ODP has established separate behavioral health and medical clinical staffing ratio requirements further reinforcing the importance of clinical support resources.

Trauma-informed care, crisis prevention and de-escalation training, quality improvement initiatives, and the use of health-related outcome data continue to be woven into multiple standards and measures. Providers must go beyond simply collected data in upcoming cycle(s) and will now be expected to explicitly demonstrate how data is used to improve services, health outcomes, and organizational performance.

ODP also continues to place significant emphasis on incident management performance, timely reporting, and data-driven quality oversight. Select and Clinically Enhanced tier providers should thoroughly analyze requirements related to quality management leadership, electronic health record capabilities, and outcome reporting to ensure they are meeting the standards. Providers are encouraged to review the updated standards carefully and continue to adjust their implementation plans to ensure readiness for the 2027–28 PBC tier status review. ◄

INTELLECTUAL/DEVELOPMENTAL DISABILITIES

Legislative Update: H.B. 1939 – Index-Based Rate Adjustments

During a legislative hearing held on August 18, 2026, lawmakers and ID/A system stakeholders convened to address chronic funding challenges and the long-term sustainability of ID/A providers across the Commonwealth. H.B. 1939 seeks to establish annual indexed rate increases for ID/A providers, creating a more predictable reimbursement structure. Ultimately, this predictable funding aims to help providers recruit and retain direct support professionals by enabling more consistent budgeting.

In advance of the hearing, RCPA submitted official written testimony supporting the theory of annual indexed rate increases, while offering significant feedback to address the shortcomings of the current bill.

RCPA strongly endorses the underlying principle of automatic, predictable annual rate adjustments. Operating under reimbursement rates that fail to reflect inflation and rising wage pressures is no longer sustainable in a post-COVID environment.

RCPA's testimony highlighted key areas requiring revision. Specifically, we urged that the rate index be mandatory rather than subject to discretionary appropriations, that the specific index used be defined directly in the bill, and that the Commonwealth annually publish both actual inflation rates and cumulative funding shortfalls. Finally, we emphasized that updated rate adjustments must allow providers full discretion over internal cost deployment.

RCPA remains actively engaged with House Human Services Committee members to refine this legislation. While momentum for annual rate indexing is an encouraging step, we will continue advocating for amendments that ensure the legislation does not increase administrative burdens or otherwise negatively impact the provider community. Read RCPA's full written testimony on the RCPA website **Legislative Resources page** (must be logged into your member portal to view). ◄

BRAIN INJURY

BIAA Offers Free Webinars

The Brain Injury Association of America (BIAA) will be offering free webinars that are specific to brain injury (BI):

Atypical Concussion Presentations & Treatment Recommendations: Functional Neurological and Somatic Disorders

Led by Douglas P. Terry, PhD, ABPP-CN

This webinar provides an in-depth overview of atypical presentations following concussion, with a specific focus on somatic symptom disorder (SSD) and functional neurological symptom disorder (FND), and their role in prolonged recovery. The presentation emphasizes the importance of psychological and behavioral factors—such as fear avoidance, symptom catastrophizing, and illness perception—in driving ongoing symptoms and disability. Through clinical examples and research findings, it highlights how SSD and FND can mimic or amplify post-concussion symptoms, outlines key assessment strategies to differentiate these conditions, and presents evidence-informed, multidisciplinary treatment approaches to improve outcomes and reduce chronic impairment. This webinar is scheduled for September 15, 2026, from 3:00 pm – 4:00 pm. **Use this link** to register. ◄

Understanding Lingering Changes after Concussion

Led by Dr. Rita Lenhardt, DHSc, CCC-SLP, CBIS-AP

Many individuals who sustain a concussion appear physically recovered yet continue to experience subtle cognitive-communication and executive functioning challenges that affect daily life, work, and relationships. This live webinar will explore the often "invisible" lingering effects of mild traumatic brain injury through a functional speech-language pathology lens. Participants will learn how to recognize persistent post-concussion changes, apply evidence-informed assessment strategies, and implement practical intervention approaches aligned with current best practices and INCOG 2.0 guidelines. Case examples and clinically relevant tools will support the translation of research into real-world practice. This webinar is scheduled for October 29, 2026, from 3:00 pm – 4:00 pm. **Use this link** to register. ◄

Continued on page 14

BRAIN INJURY

Continued from page 13

BIAA Third Annual Stroke Symposium: Stroke Recovery: Body, Mind, and Relationships

Led by Clausyl Plummer II, MD, Chrystal Fullen, PsyD, and Allie Reed, MS, CCC-SLP

This half-day virtual symposium is built around conversations on stroke recovery across the body, mind, and relationships. Across three focused sessions, leading experts will share clinical insight, research, and guidance on the realities of stroke recovery. Alongside them, survivors and caregivers will share their lived experiences and perspectives from their journeys. Whether you're recovering, caring for someone who is, or providing clinical care or navigation for those who are, you'll leave with a deeper understanding of stroke recovery and the reassurance that wherever you are in your own journey, you are not alone. This webinar is scheduled for November 5, 2026, from 12:00 pm – 4:30 pm. **Use this link** to register. ◄

Brain Injury Fundamentals Virtual Training

The Brain Injury Fundamentals training course is a foundational training and certificate program designed for individuals who support people with brain injuries, including non-licensed direct care staff, facility personnel, first responders, and other community members. Brain Injury Fundamentals also provides continuing education credit options from the American Occupational Therapy Association, American Academy of Family Physicians, and Commission for Case Manager Certification.

There are sessions on November 10, 2026 and November 17, 2026, from 11:00 am – 4:30 pm. Registration for the **November** course closes **Wednesday, October 21**. **Learn more and register here**. ◄

Guidance Developed for Communicating About Brain Injury

Brain injuries are complex and can be difficult to understand for everyone. To assist with improving communication, the Brain Injury Association of America (BIAA) worked with healthcare providers, researchers, and people with brain injuries to create **guidance for communicating about brain injury**. ◄

MEDICAL REHAB

CMS Fraud Enforcement Could Lead to Unintended Consequences for Legitimate Providers

The Centers for Medicare and Medicaid Services (CMS) recently advanced a series of policy actions whose goal is to strengthen program integrity and reduce fraud, waste, and abuse across Medicare and Medicaid. Healthcare providers and industry stakeholders have concerns that these proposals could create unintended consequences for legitimate providers and patient access to care. One of these proposals would expand the CMS authority to deny or revoke Medicare enrollment for providers suspected of fraudulent activity which could lead compliant providers into lengthy administrative reviews or enrollment disputes. Critics argue that while aggressive oversight may increase scrutiny, it may do little to deter sophisticated fraud schemes while creating additional administrative burdens for providers that already face complex regulatory requirements. Healthcare groups are encouraging CMS to ensure that any new authority includes appropriate due process protections and clear enforcement standards. ◄

MEDICAL REHAB

All Medicare Facility Type Providers Encouraged to Prepare for Relaunch of PEPPER

The Centers for Medicare and Medicaid Services (CMS) is relaunching the Program for Evaluating Payment Patterns Electronic Report (PEPPER) for all Medicare facility types, including hospitals, post-acute care providers, and specialty facilities. PEPPER is a free tool that helps providers to review their Medicare billing data to identify issues before problems arise and support accurate claims. Authorized officials (AOs), access managers (AMs), and staff end users (SEUs) can access the reports through the **PEPPER Portal**.

To become an SEU:

- Sign in to the **CMS Identity & Access (I&A) System** using your existing National Plan and Provider Enumeration System (NPPES) or Provider Enrollment, Chain, and Ownership System (PECOS) credentials.
- Request the PEPPER business function for your organization. The Comparative Billing Report business function is also available and can be requested at the same time.

Additional Information:

- Review the **User Guide**
- See the I&A **Quick Reference Guide** and **FAQs**: Step-by-step instructions for AOs and AMs
- Contact the **External User Services Help Desk**

PHYSICAL DISABILITIES & AGING

Disability Consumer Market Represents a $675 Billion Opportunity

A **newly released report** from Disability:IN and the American Institutes for Research (AIR) finds that working-age adults with disabilities represent an estimated $675 billion in disposable income, including approximately $107 billion in discretionary spending power. The report challenges the longstanding perception that the disability community is a niche market and instead positions people with disabilities as a significant and growing consumer segment whose purchasing decisions influence a wide range of industries, including healthcare, technology, transportation, financial services, housing, and retail. The authors conclude that organizations that intentionally incorporate accessibility into product design, customer experience, and workforce strategies are better positioned to serve this market and capture future growth opportunities.

The report also highlights the economic realities faced by many people with disabilities. Researchers estimate that individuals with disabilities spend an average of 20 percent of household income on disability-related costs, including healthcare, assistive technology, transportation, and personal assistance services. These expenditures account for approximately $135 billion annually, reducing the resources available for savings, investment, and discretionary purchases. The findings suggest that policies and services that improve access to healthcare, community supports, employment opportunities, and assistive technologies can strengthen economic participation while enhancing independence and quality of life.

For RCPA members, the report provides another compelling reminder that disability inclusion is both a social and economic imperative. Investments in accessible technology, workforce participation, community-based services, and supports that promote independence not only improve outcomes for individuals with disabilities but also contribute to broader economic growth. As policymakers, employers, and businesses increasingly recognize the economic power of the disability community, providers will continue to play a critical role in helping individuals access the services and supports that enable full participation in community life.

About the Report: This analysis was produced by Disability:IN, the leading US nonprofit organization focused on advancing disability inclusion in business, in partnership with the American Institutes for Research (AIR), one of the nation's most respected nonpartisan research organizations. The findings are based on federal data sources, including the American Community Survey, the Bureau of Labor Statistics Consumer Expenditure Survey, the Medical Expenditure Panel Survey, and the National Health Interview Survey, providing a strong empirical foundation for understanding the economic impact and purchasing power of working-age adults with disabilities. ◂

Community HealthChoices Procurement Update

The RCPA Physical Disabilities & Aging (PD&A) Division submitted a response to the CHC RFI. The highlights of our recommendations are:

- Standardize service coordination, assessments, authorizations, and provider information sharing across CHC-MCOs;
- Strengthen provider sustainability through workforce investment, reimbursement adequacy, and payment certainty;
- Expand advanced value-based purchasing that rewards participant outcomes, continuity of Personal Assistance Services (PAS), workforce stability, and coordinated community-based care; and
- Encourage responsible use of artificial intelligence and administrative standardization to improve efficiency while preserving appropriate human oversight and participant protections.

You can read the cover letter, response, and supporting appendices via the below links:

- **Cover Letter**
- **Body of Response**

At the RCPA PD&A meeting on August 13, OLTL Deputy Secretary Juliet Marsala reported that the department received 200+ responses to the RFI, and that OLTL will summarize and distribute responses to the RFI by mid-October. This timeline implies that the RFA for the CHC procurement is not likely to come out before early November.

Some providers reported receiving credentialling packages from prospective MCOs. These should be considered as purely information gathering by these MCOs, not a commitment to contract with the recipient organization. ◂

RCPA Advocacy for Civil Rights of People with Disabilities Contributes to Governor Shapiro Issuing Letter of Support

RCPA reached out to Governor Shapiro, Secretary Arkoosh, and the leaders of both parties urging action to reinforce civil rights of people with disabilities, and to support the community options in the Olmstead decision.

Recognizing that significant steps were taken by Governor Shapiro's recent executive orders on this matter, alongside Pennsylvania's joining of the lawsuit against the recent Centers for Medicare & Medicaid Services (CMS) guidelines to de-emphasize the importance of community integration, RCPA recommends:

- Supporting Pennsylvania's continued commitment to the principles established in *Olmstead v. L.C.*;
- Opposing policies that weaken the rights of individuals with disabilities and older adults to receive services in the most integrated setting appropriate to their needs;
- Continuing to support investments that strengthen home- and community-based services and the direct care workforce; and
- Working with RCPA, providers, individuals with disabilities, and families to ensure Pennsylvania remains a national leader in community integration.

The RCPA letter outlined additional actions that the Pennsylvania legislature can take to create permanent protections for the civil rights and services built into the current Federal regulations.

You can read the RCPA letter **here** (must log in to member portal to view). ◂

PD&A Regulatory Updates

Federal Medicaid Access Rule (80/20 Rule)

Requires reporting at the individual provider level, demonstrating evidence that at least 80% of the reimbursement received is spent on labor wages and labor-related expenses. The rule also requires reporting on ownership of the individual providers. While this rule does not go into effect until January 2028, the state has to demonstrate to CMS readiness and infrastructure to gather this information. Providers should anticipate receiving directives to submit information on expenditures and ownership in the next 90 days.

Allegheny County Family Leave

This local regulation requires employers to pay their workers up to 18 weeks full pay, when the individual has to care for a spouse, partner, parent, or child. RCPA has advocated to exclude Medicaid providers from this benefit. However, the regulation has advanced to the next level of approval.

Older Adults Protections Services Act

Both the House and Senate versions of this bill were stalled during the budget process and are unlikely to advance during the fall session. These bills will have to be reintroduced when the legislature reconvenes in January 2027.

S.B. 1373

This would require certain individual direct-care workers who provide Medicaid-funded services in a home or community setting to:

- Obtain and use an individual National Provider Identifier (NPI);
- Be identified on each Medicaid claim by their NPI and Medicaid provider number; and
- Report the date of service and the service's start and end times.

RCPA, CHC-MCOs, and other provider groups have opposed this proposal. UPMC and Pennsylvania Health and Wellness have issued direction to their providers requiring the collection of birth dates and the 9 digits of social security numbers as a way to address the potential fraud.

S.B. 1371

Proposes moving CHC to an annual open enrollment period, similar to Medicare programs. It is too soon to determine whether this bill will be reintroduced in January 2027. ◂

RCPA Events Calendar

*Events subject to change; members will be notified of any developments.