RCPA
REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

THE quarterly advisor

DECEMBER 2025

SPECIAL FEATURE

Where Are We?

By Richard S. Edley, PhD, RCPA President & CEO

With the dust settling on the federal shutdown and the state budget impasse, it leads to the obvious question – so where are we within the human services system in PA?

Clearly, if nothing changes we are in for a rough ride. Federal HR 1, elimination of tax credits, provider tax elimination, work requirements, increased eligibility check requirements… certainly all of this will begin to weigh heavily. On the state side, we also continue to hear of future, projected budget shortfalls.

Recently, RCPA staff and members went to Washington, DC for a federal advocacy day. While it was a successful trip in terms of getting in front of decision makers, it also highlighted that this is not a time to give up. It is easy for all of us to begin to feel exhausted, and to wonder whether our voices will be heard.

At our recent Annual Conference, we heard from DHS Secretary Val Arkoosh and from a federal lobbyist, Al Guida of Guide Consulting Services, LLC. Secretary Arkoosh noted that there will be hard decisions ahead. What that means is that RCPA and its members need a seat at the table when reviewing these decisions. For example, does all of this have to translate into service cuts or is this an opportunity again to review the impact of administrative burden?

As I noted to Secretary Arkoosh (and subsequently to DHS deputy secretaries), looking at where cuts can occur is an important process that we need to be involved in. But it is also a bit like Sophie's Choice. All the services being provided in our system are there for a reason – they are helping individuals and families in need. I wish there was some "fluff" in the system and low-hanging fruit. There is not. Services that are less viable than others have long been eliminated. Indeed, the discussion may end up centering on the possible elimination of financially challenging services that are actually helping many. How long can providers carry such services without funding as the system is being squeezed?

As to Al Guida's update and presentation – while depressing in its own right, it ended with a slide of hope: "In the federal system, there is always another inning." And that's where we need to go; what now can we do to re-energize our efforts, get in front of leaders, and impact the implementation of so many of these policies?

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About RCPA:

With more than 400 members, the majority of who serve over one 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's, brain injury, criminal and juvenile justice, 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)

Take full advantage of your RCPA membership by signing up for **emails and meeting invitations** as well as **complete website access**.

RCPA

PAProviders.org

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December 2025

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RCPA is proud to have the following organizations as RCPA Partners:

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For example, timeframes for implementation, better definitions around exemptions for those we serve, additional availability of dollars for the implementation, and so forth.

So what does and will RCPA do? What you would expect –

- Timely position papers;
- Collection and proliferation of key data to assist the administration and legislature;
- Rallies and press conferences;
- Articles and editorial placements (print and online) to better educate the public;
- Interviews and media spots;
- Active social media presence;
- Ongoing meetings with state and federal leaders; and
- Proposing and responding to impactful legislation, ensuring that there are no unintended consequences; similarly, with policies coming from the departments.

All of the above to make sure that collectively the voice of providers (and related stakeholders and partners) is not lost.

In terms of "partners," it is also important to reposition these interactions and discussions. Often we can be on the opposite side of the table with counties, MCOs, primary contractors, and the administration. But the changes ahead are massive and we need to come together. While there is always some natural tension between payers (public and private) and providers, this is a time for all of us to come together. We are all on the same side, fighting for the system and those we serve.

Most of all this is not a time to give up. Stay involved, participate, and influence.

Finally, I used the term "depressing" above. Several RCPA members noted that the Annual Conference began with the difficult state and federal messages as noted, and then ended with a similar message from two of our national partners: ANCOR and the National Council. This was done for a reason. We cannot and should not ignore the realities. It is time to mobilize.

AI and the Future of Behavioral Health in Pennsylvania: A Path Toward Hope

QUALIFACTS™ Celebrating 25 Years

By Josh Schoeller, CEO at Qualifacts

AI is giving Pennsylvania's providers the breathing room they need — without replacing the human connection at the heart of care.

Pennsylvania's behavioral health system faces undeniable challenges — workforce shortages, rising demand, and administrative burdens that strain providers. According to the Rehabilitation and Community Providers Association (RCPA), **more than 20% of behavioral health positions remain vacant statewide**, and rural communities are disproportionately affected. These gaps mean longer wait times and fewer options for individuals seeking care.

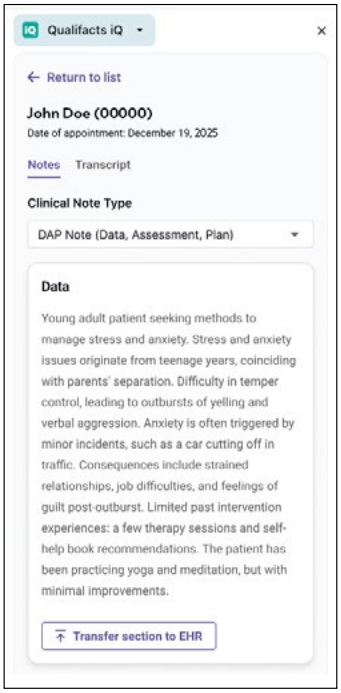
Josh Schoeller, CEO of Qualifacts

Yet, there is a reason for optimism. Artificial intelligence (AI) is emerging as a powerful ally — not to replace clinicians, but to empower them. Tools like **Qualifacts® iQ** exemplify a new generation of **compassion-led AI**, designed to strengthen the provider-client relationship rather than diminish it. By automating time-consuming tasks such as documentation, scheduling, and training, AI can give clinicians and staff back what they value most: time with the people they serve.

> **"The future of behavioral health isn't about replacing clinicians with technology — it's about using AI to remove barriers so providers can focus on what matters most: caring for people."**
>
> *– Josh Schoeller, CEO, Qualifacts*

With the help of HIPAA-compliant AI technology, clinicians can finally spend less time typing notes and more time intently listening and engaging with clients and patients. AI-driven solutions like Qualifacts iQ can reduce administrative work by up to 80%, freeing providers to focus on care and connection. In Pennsylvania, where **1.7 million residents live in mental health professional shortage areas**, these efficiencies can make a substantial difference in access and outcomes.

But AI is not a cure-all. It cannot solve systemic issues like reimbursement rates or workforce pipelines. What it can do is help organizations operate more effectively within those constraints — creating breathing room for providers and improving the experience for clients. When paired with investments in training and policy reform, AI becomes part of a holistic solution.



Qualifacts iQ Clinical Documentation DAP Note AI Generation

The future of behavioral health in Pennsylvania is not about replacing humans with machines — it's about using technology thoughtfully to support the humans who deliver care. With tools like Qualifacts iQ leading the way, the Commonwealth has an opportunity to turn a moment of crisis into a catalyst for innovation and hope. ◄

Pending Pennsylvania "Health Care Workplace Violence Prevention Act"

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

Brown & Brown

In this article, I highlight key elements of the pending Pennsylvania "Health Care Workplace Violence Prevention Act"; **House Bill 926 Health Care Workplace Violence Prevention Act**. This bill was introduced in the 2025 PA General Assembly session, passed the house May 6, 2025, and is currently in Senate committee. Many RCPA members will be impacted if this bill passes the Senate and is signed into law, and from a risk management perspective would require the following:

✔ Establishment of a Workplace Violence Prevention Committee that would be required to:

- Perform a workplace violence risk assessment evaluation. The initial risk assessment would be based on an analysis of incidents of the prior five years and then annually thereafter, as well as an evaluation of the factors that may put an employee at risk of workplace violence. The risk factors include internal and external vulnerabilities related to public or individual violent behaviors, physical layout of facilities, and training programs — and the bill contains a risk factor list in section 4. An outside consultant may be used to perform the risk assessment.
- Meet quarterly to review cases of workplace violence.
- Create, review, administer, and provide guidance on programs relating to the prevention of workplace violence at the organization's locations.
- Provide paid time off for employees serving on the Violence Prevention Committee.
- Maintain at least 50% of the members of the committee that are nonmanagement employees primarily engaged in direct patient care or clinical care services, or employees who interface with the public. Section 3 of the bill contains additional information on membership structure.

✔ Health care facilities would need to:

- Maintain a report of an incident of workplace violence, including records or documents regarding the report, for a period of no less than three years.
- Display signage indicating that assaulting a health care worker is a felony.
- Offer post-incident care including acute care and mental health services for employees.
- Provide protections against retaliation for employees filing complaints. Section 5 also has language for complaints made in bad faith to balance the protections from retaliation.

We will continue to monitor the status of this legislation and update RCPA members accordingly. Thank you for your time.◂

Save the Date

2026 RCPA Conference
Sept 29 – Oct 2
Hershey Lodge

MEMBER CONTRIBUTOR CORNER

Creative Ways Community Behavioral Health Orgs Can Strengthen Workforce Retention

Across community behavioral health, teams are doing extraordinary work under extraordinary pressure. High caseloads, administrative demands, and ongoing **workforce shortages** make it challenging to keep providers supported, engaged, and able to deliver the care their communities rely on every day.

While many external factors remain outside of your control, strengthening a few key areas can help reduce organizational risk and create more stability for staff and clients alike.

Take **recruitment, training, and retention**, for example. Turnover continues to strain community programs, often driven by burnout and overwhelming workloads. Keeping your clinicians committed to your mission not only reduces replacement costs — it preserves continuity of care and protects remaining staff from absorbing unmanageable caseloads. Focusing on supportive incentives (think shift differentials, additional compensation for direct service times, and threshold bonuses), clear growth pathways, and meaningful opportunities for connection can help teams feel grounded and valued.

Reducing **administrative burden** is another critical lever. Providers frequently describe documentation as one of the most significant contributors to burnout. Small but intentional improvements, such as streamlined processes, clearer expectations, and **AI-powered tools** that reduce repetitive tasks, can give clinicians more time for the work that matters most. When staff feel supported in completing documentation efficiently and accurately, organizations strengthen both care quality and provider well-being.

Creating space for provider well-being is equally important. Flexible scheduling where possible, thoughtful workload balancing, and regular check-ins help staff stay connected to their purpose and prevent **avoidable burnout**. Celebrating impact — whether through client success stories, team reflections, or mission-aligned recognition — reinforces why their work matters and fosters a sense of community within teams.

By focusing on these core areas and investing intentionally in the people who carry out your mission every day, community behavioral health organizations can build workplaces where providers feel seen, supported, and able to thrive — even in challenging times.

When providers are supported, clients receive more consistent care, and organizations are better positioned to **navigate uncertainty** with resilience. ◂

DIVERSITY, EQUITY, AND INCLUSION

The Case for An Integrated DEI-MEI Approach

In recent months, many organizations, universities, and corporations have begun reexamining traditional DEI (Diversity, Equity, and Inclusion) policies and frameworks. An emerging alternative, known as MEI (Merit, Excellence, and Integrity) — sometimes defined as Merit, Excellence, and *Intelligence* — emphasizes performance, accountability, and ethical standards. These two approaches are often presented as oppositional: DEI as focused on fairness and representation, and MEI as focused on merit and excellence.

However, when thoughtfully integrated, DEI and MEI can be highly complementary. In practice, the strongest organizations and service systems are built when both frameworks operate together, reinforcing and balancing one another.

A system can only reward merit if everyone has a fair chance to demonstrate it. A DEI approach strengthens the conditions necessary for excellence to emerge.

- Equity identifies and reduces structural or procedural barriers that prevent talented individuals from reaching the starting line.

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DIVERSITY, EQUITY, AND INCLUSION

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- Inclusion ensures that staff feel psychologically safe and empowered to fully contribute.
- Diversity broadens the talent pool, bringing in perspectives and skills that may otherwise be overlooked.

When efforts are made to reduce these barriers, organizations gain a clearer, more accurate view of actual performance — not just the performance of those who historically had more access or opportunity. In other words, DEI creates the environment in which MEI becomes truly possible.

Relying solely on a merit-based lens oversimplifies fairness; relying solely on a diversity lens oversimplifies skill and performance. An integrated approach avoids both limitations.

- People bring different strengths;
- Opportunities have never been evenly distributed;
- Organizations must uphold quality and competence; and
- Ethical practice requires both fairness and excellence.

Rather than choosing between fairness and performance, a balanced DEI–MEI approach recognizes that the two can strengthen each other. They support workplaces where everyone has the chance to succeed — and where excellence is defined, nurtured, and upheld for the benefit of the entire organization. ◂

Explore Deeper:

Merit thrives under evidence-based DEI practices and disparate impact protections | Industrial and Organizational Psychology | Cambridge Core

TELEHEALTH

PA Achieves Federal Telehealth "4 Walls" Compliance

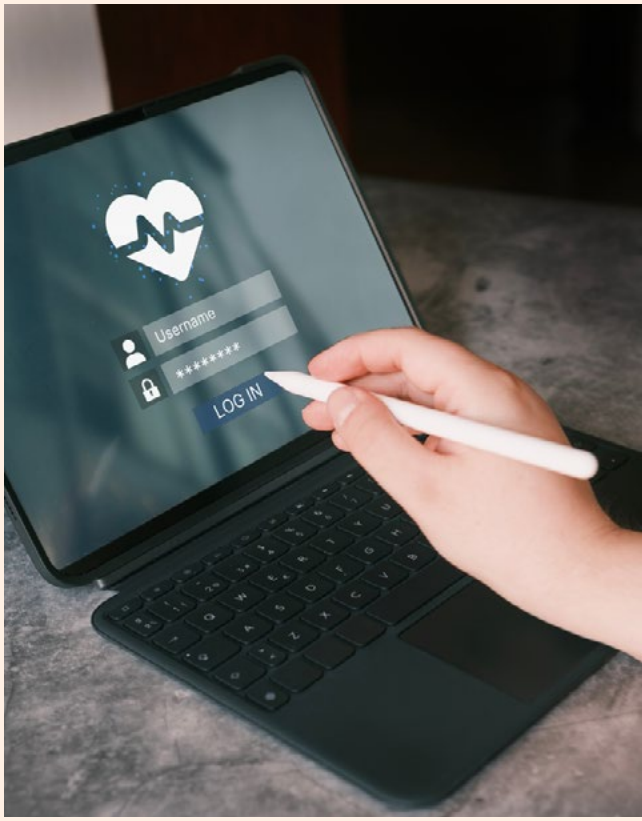
With the signing of the Human Services Code Bill by Governor Shapiro, the final hurdle in meeting the compliance requirements of the Federal "4 Walls" Telehealth Standards has been cleared.

The legislation addressed the outlying PA Medicaid payment requirements for delivering and receiving mental health or substance abuse treatment services outside the four physical walls of a clinic. The legislative pathway was paved with the passing of HB 1590 in the spring and its movement over to the Senate Health & Human Services Committee, where it eventually made its way to the Human Services Code Bill.

This summer, the Centers for Medicare and Medicaid Services (CMS) approved the Office of Mental Health and Substance Abuse Services (OMHSAS) State Plan Amendment, which addresses the operational practice considerations for the "4 Walls" requirements. The abrogation of the regulatory payment requirements for outpatient behavioral health facilities, involving the delivery of mental health and SUD services via telehealth outside the physical confines of a behavioral health clinic facility, now ensures full compliance with the federal standard.

As reported earlier by OMHSAS, the next step in the process will be the distribution of a "Telehealth 4 Walls Bulletin" that will address the specifics, though there is no current timeframe for its release. RCPA held a Telehealth Work Group meeting on Tuesday November 25, 2025, to further discuss this legislation and steps moving forward.

RCPA would like to thank OMHSAS for its partnership in this two-year process as well as our members and legislators for their advocacy and support. ◂



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

RCPA's Case Against Involuntary Commitment for SUD

Pennsylvania Sens. Dan Laughlin (R) and Anthony Williams (D) have **introduced legislation** to update the Mental Health Procedures Act (MHPA), to explicitly recognize substance use disorder (SUD) as a mental illness, thereby subjecting those with an SUD to the same procedures outlined in MHPA, including a 302 involuntary commitment to a 120-hour hold in a psychiatric hospital.

SUD, according to the senators, has been long recognized by medical professionals as a mental illness and continues to devastate families, overwhelm emergency services, and strain Pennsylvania's criminal justice system. This is the senators' attempt to take meaningful action.

Unfortunately, while well-intended, an involuntary commitment process for SUD is misguided and has proven ineffective in other states that have such a law in place.

RCPA represents nearly 400 licensed SUD treatment facilities in Pennsylvania. Our SUD treatment providers represent the entire continuum of SUD treatment, from the outpatient level of care up to hospital-based residential services that employ addiction psychiatrists who work daily with those with SUD and mental illness. Based on input from these varied levels of expertise and real-world experience, including discussion at a recent RCPA Criminal Justice Committee meeting; published research on the process; and experiences from other states with involuntary commitment laws, RCPA opposes SB 716, primarily on four points.

- Research demonstrates that involuntary commitment is not effective. Among the many examples: in Massachusetts (with a population of nearly six million fewer people than Pennsylvania), where more than 6,000 people are annually involuntarily committed for SUD, a group of physicians and clinicians followed **a group of individuals who were involuntarily committed (abstract)** from their hospital. Every patient relapsed within a year of being released from involuntary commitment and continued to have serious medical complications. Two patients died.
- Although some proponents of SB 716 cite court-mandated SUD treatment as essentially the same as an involuntary commitment to treatment, there are glaring differences between the two: those participating in a specialty court (e.g., drug-treatment court) are either accused or convicted of a crime and ultimately do have a choice, as treatment court is, in fact, voluntary. Therefore, SB 716 criminalizes people who use drugs, reinforcing existing stigma and adding traumatic experiences to many who already suffer from deep trauma.
- There has been no meaningful effort to quantify the financial cost to the system to implement involuntary commitment for SUD, although estimates in Pennsylvania have been pegged at nearly $800 million. That amount of money would be much better spent expanding intervention and treatment initiatives that are proven to be effective.
- As MHPA works today, if a petition for involuntary commitment is upheld, the person is transferred from the emergency department to an inpatient psychiatric facility where they can be held involuntarily for up to 120 hours. In an age of fentanyl, xylazine, and medetomidine, inpatient psychiatric facilities are unlikely to be prepared to manage complex SUD-specific withdrawal protocols. In fact, the entire MHPA is built around the mental health system, and there are more questions than answers as to how MHPA would be tailored to SUD.

Although well-intended, SB 716 fails to fully consider the complexities of the mental health and SUD systems, both historically and within the context of today's challenges. It also fails to consider the serious, wide-ranging consequences of this short-sighted approach. SB 716 not only risks further harming those it intends to help but will also significantly negatively affect an SUD treatment system that is already facing serious issues and threats. Therefore, RCPA opposes SB 716. ◂

BEHAVIORAL HEALTH | MENTAL HEALTH

OMHSAS Seeks Crisis Regulations Approval as Promulgation Process Begins

RCPA, in partnership with its members, has **submitted public comments** in response to the Office of Mental Health and Substance Abuse Services' (OMHSAS) proposed Licensure of Crisis Intervention Services regulations. RCPA thanks OMHSAS for their effort in creating licensing standards that align with national best practice standards for the Commonwealth's crisis intervention system and their receptivity to further recommendations from current crisis providers.

The proposed regulations have been reviewed by members of RCPA's 988/Crisis Work Group, who are some of the most experienced and knowledgeable leaders in Pennsylvania's Crisis System. With their expertise, RCPA developed comments and recommendations to guide the state towards meaningful regulations for Crisis Intervention Licensure.

The largest areas of concern in the proposed regulations are in regard to the staffing requirements and fiscal impacts, which led to the following recommendations:

- Flexibility in the staffing requirements to account for the national behavioral health workforce shortage.
- A transparent cost analysis of the true cost of implementing the regulations to ensure that the regulations do not become an unfunded mandate.
- Increased clarity on the role of community outpatient clinics that are not connected to larger hospital systems.
- The assembly of a stakeholder work group, similar to the forums that OMHSAS convened for their PRTF regulations, to ensure that provider and other stakeholder concerns are addressed before promulgation of the regulations. ◄

CHILDREN'S SERVICES

Is There an Autism Epidemic?

Over the last twenty years, there has been a profound increase in the number of children diagnosed with autism spectrum disorder (ASD), and it has captured the attention of the Trump administration as an epidemic **"running rampant."** It is true that autism prevalence in the US has increased. According to the most recent **CDC estimate**, one in 31 eight-year-old children were diagnosed with ASD in 2022, a dramatic increase from the estimated one in 150 in 2000.

Since autism was first identified in the 1940s, there have been many proposed explanations for the disorder, from unloving mothers, vaccines, and most recently, Tylenol, all of which have been disproven through scientific research. Researchers now know that autism is developed from a complex interplay of genes and other factors that can impact development in utero, and no one singular cause can be pinpointed.

If there is not one singular cause of autism, though, what is the reason for a near 300% increase in the number of children receiving the diagnosis over the past twenty years? Researchers have distinguished two main reasons for such an increase, the first being a broadened definition of autism spectrum disorder. The broader definition means more people are meeting the diagnostic criteria than previously, as diagnoses such as Asperger's syndrome and pervasive developmental disorder now fall under the autism spectrum. The second contributing factor stems from the rise in public health programs that increased screening at wellness visits. The **American Academy of Pediatrics** recommends that pediatric care providers screen all children for ASD between 18 and 24 months, and recommends additional screening if a child is at high risk or if signs and symptoms are present.

Despite the efforts of the current administration to find an arbitrary "cause" of autism, research has proven that no such epidemic exists, just better science than what existed twenty years ago. ◄

INTELLECTUAL/ DEVELOPMENTAL DISABILITIES

ODP Updates: Key Initiatives Shaping 2025–2026

The Pennsylvania Office of Developmental Programs (ODP) continues to advance several major initiatives throughout 2025, including Performance-Based Contracting (PBC), updates to the Enterprise Incident Management (EIM) system, and a review of one-person licensed residential homes.

Performance-Based Contracting

PBC for residential providers is now in its second year, with a continued emphasis on quality improvement and measurable outcomes. After collecting baseline data and developing improvement plans during the first phase, providers are now implementing those plans and tracking progress against established benchmarks. Over the next year, providers will again submit data to maintain or adjust their tier status. Supports Coordination Organizations (SCOs) are also entering their initial data-submission phase, with the next phase beginning in January 2026.

Enterprise Incident Management Review

ODP is evaluating current EIM processes through its ongoing Rebalancing Effort. This work aims to streamline incident management requirements and reduce provider burden. Updated definitions, processes, and training are being rolled out, along with targeted technical assistance. These efforts will continue as ODP works to strengthen service quality and system efficiency.

One-Person Licensed Residential Homes

Beginning in late 2025 and continuing into early 2026, ODP will convene stakeholder groups to evaluate the use of one-person licensed residential settings. While recognizing that these homes are sometimes necessary, ODP aims to reduce their use when appropriate, ensuring individuals are not isolated due to their living arrangements. Early data indicates many people supported in one-person homes can be successful living with roommates when proper supports are in place. RCPA is actively represented in these discussions and will continue to advocate for solutions that benefit individuals, families, and providers. ◂

BRAIN INJURY

RCPA BI Regulatory Oversight Work Group Submits Letter to OLTL on Cost Savings Recommendations

The RCPA Brain Injury Committee formed a small regulatory oversight work group to review the many regulatory oversight agencies and groups that brain injury providers are subject to. The group developed a number of recommendations on how changes to the overregulation process could provide a cost savings to the state. A letter containing recommendations has been sent to the deputy secretary of the Office of Long-Term Living (OLTL). This initiative stemmed from a request for cost savings efforts from OLTL. ◂

BI Organizations Collaborate and Release Joint Statement on Improving Communication About Brain Injury

The Brain Injury Association of America (BIAA), along with a group of brain injury organizations and advocates, collaborated to release a **joint statement** that was developed to improve how brain injuries are discussed and understood. The statement provides a definition of brain injury and its causes, that it can develop into a long-term chronic health condition, and that it can sometimes lead to disability. The statement also includes 12 things to consider when talking about brain injury. ◂

BRAIN INJURY

BIAA Announces Trainings Available in Early 2026

The Brain Injury Association of America (BIAA) has announced brain injury trainings scheduled for early 2026:

Certified Brain Injury Specialist (CBIS) Certification Prep Bundle: January 14, 21, and 28, 2026
11:00 am – 4:30 pm
Registration closes December 17

This three-day training program is designed to equip participants with the knowledge to enhance the quality of care for individuals with brain injury. The curriculum addresses the unique challenges of brain injury treatment, rehabilitation, and long-term support, incorporating evidence-based practices and current research. Ideal for professionals in acute care, post-acute rehabilitation, behavioral health, social work, vocational rehabilitation, and education, this bundle includes a virtual live training led by certified brain injury specialist trainers, the certified brain injury specialist application fee, a hardcover copy of The Essential Brain Injury Guide 6.0 and study companion workbook, and a one-year subscription to the Journal of Head Trauma Rehabilitation.

Brain Injury Fundamentals Training: February 18 and 25, 2026
11:00 am – 4:30 pm
Registration closes February 4

Brain Injury Fundamentals is a foundational training and certificate program developed by experienced clinicians and rehabilitation professionals. It is designed for individuals who support people with brain injuries, including non-licensed direct care staff, facility personnel, family members, first responders, and other community members – no prerequisites required. Brain Injury Fundamentals also provides continuing education credit options from the American Academy of Family Physicians, Commission for Case Manager Certification, and the National Board of Certified Counselors. ◄

MEDICAL REHAB

Webcast to Focus on Clarifying Medicare's Most Misunderstood Rules

A new live webcast will be held on December 4, 2025, from 12:30 pm – 1:30 pm that will focus on Medicare regulations. The webcast, "Ask Dr. Hirsch: Clarifying Medicare's Most Misunderstood Rules," will focus on some of the toughest and most frequently misinterpreted issues, from observation after surgery and the Two-Midnight Rule to inpatient order timing, cancelled surgeries, and the use of Advanced Beneficiary Notices (ABNs) for social admissions. Dr. Hirsch will provide actionable, referenced guidance you can rely on, and answer real-world questions submitted by peers from across the country. Register **here**. ◄

Valuable Payment Basics Overview Now Available

The Payment Basics Overview for **Inpatient Rehabilitation Facilities Payment System** has been revised and is now available. Payment Basics is a series of brief overviews of how Medicare's payment systems function, and is a resource for policymakers and others to better understand how Medicare pays for health care services. ◄

Movement Towards More Integrated Care

The Center for Medicare and Medicaid Services (CMS) has provided guidance that Long-Term Services and Supports are required to be integrated with physical health services when delivered through a managed care scheme. This guidance implies that by 2030, consumers in Pennsylvania would have to choose a single MCO to deliver their MLTSS CHC and physical health services.

A **white paper** published by the National MLTSS Health Plan Association identified Dual Special Needs Plans (D-SNPs) as the most effective way to deliver such integration.

The primary conclusion in the study is:

"The integrated care landscape is as varied as the dually eligible population, and multiple coverage options ensure robust opportunities for member choice and competition. Ultimately, we believe that D-SNPs are the only truly integrated and scalable model available for dually eligible individuals. The D-SNP platform is robust and is supported by managed care networks that span the entire nation. We believe that the expertise, experience, and expansive reach of the D-SNP model can support its continued growth and evolution as the primary pathway for integrated care for dually eligible individuals."

If this conclusion is correct, providers in Pennsylvania need to better understand the landscape we serve. DHS publishes monthly data, updating enrollment figures across various plans. The dashboard offers data on different program aspects, but this analysis will focus on dually eligible consumers and the development of D-SNPs in Pennsylvania, and Office of Long-Term Living Data Dashboard.

- Over 90% of CHC enrollees are dually eligible;
- Only 11% of the CHC enrollees are currently enrolled in an aligned Medicare plan;
- Over 240,000 Pennsylvania adults are enrolled in a D-SNP;
- A significant majority of D-SNP enrollees are currently with plans that do not have CHC contracts today; and
- The leaders in the D-SNP space are Aetna, Highmark, and United Healthcare.

Action Needed by Providers

- Gather information about your consumers' physical health, HealthChoices MCO, and D-SNP provider;
- Monitor waiver amendments and changes in state policy to address the CMS guidance;
- Increase your awareness of the motivations and incentives that will be available when integration is mandated; and
- Consider activities that you can provide to manage the total cost of care. ◄

Disability Community Collaboration to Protect Disability Rights in Pennsylvania

RCPA is working closely with the Coalition for Choice to address recent federal regulatory changes and their implications for disability rights in Pennsylvania.

Recent federal actions have:

- Narrowed "program access" standards, reducing obligations to modify older facilities and programs.
- Relaxed digital accessibility requirements, delaying or weakening WCAG 2.1 adoption.
- Limited "reasonable modifications" obligations, particularly in health and education.
- Reduced grievance and procedural safeguards, including removal of coordinator and timeline requirements.
- Rolled back gender identity protections under § 504/ Title IX in some contexts.
- Reduced federal oversight, weakening systemic enforcement.

The current strategy is to seek legislative and administrative action to protect against these changes.

A. Legislative Amendments to Pennsylvania Human Relations Act (PHRA)
   1. Add Program Access Standards
      - Codify "meaningful access" requirements for state/local programs and publicly funded services, modeled on pre-rollback § 504 regulations.
      - Include both physical accessibility (facility/program modifications) and programmatic accessibility for people with IDD.
   2. Incorporate Digital Accessibility Requirements
      - Require WCAG 2.1 or equivalent standards for covered entities' websites, portals, and digital communications.
   3. Define Reasonable Modifications and Effective Communication
      - Align with pre-rollback ADA/504 standards, including physical accommodations, auxiliary aids, behavioral supports, and communication assistance.
   4. Require Grievance Procedures
      - Mandate § 504-style grievance officers and procedures for schools, public programs, and large employers.
   5. Explicitly Include Gender Identity and Sexual Orientation
      - Ensure statewide protection consistent with Bostock v. Clayton County and previous federal interpretations.
   6. Expand Pennsylvania Human Relations Commission (PHRC) Systemic Enforcement Powers
      - Enable PHRC to conduct compliance reviews and issue accessibility regulations, beyond individual complaints.

B. Administrative & Provider Actions
   1. Providers: Continue applying pre-rollback § 504/ADA standards internally for facilities, digital systems, and modifications.
   2. School Districts: Maintain current grievance and accommodation systems to avoid regression.
   3. State Agencies: Issue administrative guidance mirroring pre-rollback standards pending legislative change.
   4. Advocacy Organizations: Educate individuals and families on filing complaints under PHRA and local ordinances. ◂

RCPA Events Calendar

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

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