REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

November 16, 2026

Re: Final-Form § 5330 Psychiatric Residential Treatment Facility (PRTF) Regulations as Developed by the Office of Mental Health & Substance Abuse Services (OMHSAS)

Dear Commission,

The Rehabilitation and Community Providers Association (RCPA) is a statewide association representing more than 400 providers of health and human services across the Commonwealth, with our member organizations serving over two million Pennsylvanians annually. RCPA is among the largest and most diverse state health and human services trade associations in the nation, with members providing 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.

On behalf of RCPA and our members, please accept these comments on the final-form regulation #14-555: Psychiatric Residential Treatment Facilities Chapters § 1330 and § 5330 regarding the payment and minimum licensing standards for psychiatric residential treatment facilities.

RCPA thanks the Office of Mental Health and Substance Abuse Services (OMHSAS) for its dedication to ensuring Pennsylvania's children, youth, and young adults receive the highest quality residential treatment under the care of educated staff. While RCPA and our children's residential provider members fully share this dedication to high-quality care, we believe this regulatory package risks undermining the communities it is meant to serve rather than establishing a supportive framework.

We appreciate the Department's efforts to engage stakeholders in the development of these regulations. While the stakeholder engagement that occurred was helpful in developing some changes to the proposed regulations, we do not believe it has been sufficient. The most recent significant provider dialogue on the development of these regulations occurred in May 2025. During the 18 months that followed, communication was limited to brief updates, without any true discussion on the regulations themselves. We feel the shortcomings in these final form regulations reflect deficiencies in the stakeholder engagement process.

We feel it incumbent on the Department to address the questions that satisfy the IRRC decision-making matrix in determining that promulgating these regulations are in the best interest of the Commonwealth, including the children and youth with the most complex behavioral health needs and those responsible for their safety and care.

To that end, RCPA offers the following responses and recommendations regarding:

- Staffing requirements and supervision;
- Treatment services;
- Restrictive procedures; and
- Implementation costs.

§ 5330.41 Supervision of Staff

We appreciate the Department's commitment to ensuring that PRTF staff are appropriately educated; however, the staff supervision requirements are demanding and have the potential to detract them from other responsibilities. Not only will staff be required to receive two hours of supervision each month, with at least

half of that time being in person, but they must also receive one hour of observation every six months. The Department has not provided any evidence-based justification for such high levels of supervision.

Pennsylvania's Intensive Behavioral Health Services (IBHS) regulations also have incredibly demanding supervision requirements, and this supervision has become a costly administrative burden on this program. No data has been released demonstrating that this level of supervision improves outcomes, and we are concerned that such excessive supervision could have a similar impact on PRTF programs, with the potential to be both costly and burdensome.

§ 5330.42 Staff Requirements

In regard to § 5330.42(a) and (b), RCPA appreciates the Department's willingness to lower the minimum age for PRTF staff from 21 to 18. However, the practical impact of this change is limited because staff under 21 still cannot be counted toward required supervision ratios. During the public comment period, commentors expressed that, by increasing the age requirement to 21, it would be more difficult to find enough staff to fulfill the newly-required ratios. While the Department did lower the minimum age, this change will not aid providers in being able to find sufficient staff, due to their exclusion from the ratios.

In addition, we have concerns regarding the requirement of § 5330.42(d)(3) that a mental health professional or clinical director be present during all waking hours. We appreciate the Department's intent to ensure that children, youth, and young adults have access to clinical care in a timely manner; however, a large number of public commentors expressed deep concern with the ability to find clinical staff to comply with this requirement. Although a 24-month implementation period gives facilities more time to comply, it does not guarantee that enough clinical staff will become available over those two years to fill these positions. An extended timeframe does not resolve the workforce shortage; it simply delays the problem.

We ask the Department to clarify how it concluded that requiring a mental health professional or clinical director onsite during all waking hours is reasonable, given direct feedback from commenters opposing this mandate. What evidence can the Department provide to substantiate that having a particular health professional or clinical director onsite during all waking hours will improve PRTF outcomes, especially when compared to on-call availability?

§ 5330.144 Treatment Services

During the original public comment period, RCPA expressed concerns with the prescriptive nature of treatment services in the regulations. We appreciate the Department's comparison in minimum treatment service scheduling with those of surrounding states, though we do not believe the Department has provided adequate clinical justification for these requirements. These seemingly arbitrary requirements do not account for factors such as the child's age, diagnoses, cognitive levels, or family system, and this lack of individualization creates an emphasis on compliance rather than on well-established clinical and ethical standards of care.

Like many other commentors, RCPA is also concerned with the stipulation in § 5330.144(d)(1), which requires at least one hour of time with a treatment team leader per month without any evidence-based justification. Once again, this regulation does not account for individual treatment need and has the potential to detract psychiatric availability away from youth who genuinely need the time. The amount of psychiatric time needed should be determined by the medical professionals who are trained in delivering this level of care.

We believe that the Department is seeking to ensure that adequate treatment is given to all children, youth, and young adults who enter a PRTF, but in their efforts to do so, they have overlooked the professional and

clinical judgement of the certified professionals in determining a youth's individual treatment needs. PRTFs, as well as other OMHSAS-licensed programs, require clinical staff to have high levels of education, experience, training, and supervision to ensure quality behavioral health treatment. It is crucial to trust these professionals and their clinical judgement in delivering treatment services rather than replacing this individualized expertise with a "one size fits all" blueprint.

§ 5330.182. Ordering a Manual Restraint

The Department has proposed restrictive procedure requirements that are significantly more stringent than the federal requirements defined in 42 CFR § 483.358, but they have not adequately demonstrated how these changes are in the best interest of the regulated community—specifically, the proposed provision § 5330.182(i), in which the order for a manual restraint and application of a manual restraint may not exceed 30 minutes. Although we understand the Department's intent to limit trauma during the use of a restrictive procedure, there has been no clinical evidence that supports these changes. This regulation does not take into account the complex nature of the crises that lead to the use of a restraint.

The nature of safe crisis management interventions does not fit into predetermined time blocks, and the proposed process of release and reordering of the restraint can create additional and unnecessary trauma for the youth as well as jeopardize the safety for all individuals involved. We appreciate the Department's efforts to avoid re-traumatization in regard to manual restraints; however, we are concerned about the lack of clinical evidence that demonstrates why the proposed requirement would be beneficial.

Lastly, the administrative requirements for the use of restrictive procedures have become a complex web of documentation and process redundancies that reflects the tenets of a legal agreement rather than clinical operating protocol. The current practices related to the use of restrictive procedures have been developed over decades of trauma-informed recognition and professional expertise, already keeping the safety and well-being of the child paramount.

Costs

We would like to thank the Department for re-evaluating their initial cost analysis for the projected implementation of this regulatory package. These costs in the final-form regulation closely match the analysis provided by children's residential provider members of RCPA. The Department has stated that they learned through a current cost analysis that many RTFs contracted with BH-MCOs already receive a per diem rate that meets or exceeds the projected per diem rates to implement all the requirements under the final-form rulemaking. However, no RCPA provider has reported receiving sufficient rates to cover current requirements, let alone adequate rates to cover projected costs.

Providers report requesting rate increases with minimal success, with BH-MCOs citing shortfalls in capitation payments as the limiting factor. It seems likely that the RTFs receiving rates higher than the projected per diem rates for implementation are single-case agreements rather than broadly applicable sources.

Additionally, while we appreciate the steps the Department will be taking to ensure adequate funding for PRTF programs, we are concerned that shortfalls in behavioral health capitation, as decided by the General Assembly, will limit the ability of the BH-MCOs to provide appropriate rates. The Department states that, by the end of the 24-month implementation period, they intend to have both the fee-for-service rates and capitation rates adjusted to account for increased costs, but how can the Department ensure actuarially sound rates when they have no control over the dollar amount assigned to behavioral health capitation? As a follow-up, we ask how providers will be reimbursed over the two-year implementation period as they operationalize compliance.

We are grateful that the Department has reviewed their preliminary cost estimates and will be taking steps to ensure PRTF programs will receive adequate rates, but we remain concerned that some of the foundational premises used as justification may not be an accurate reflection of the current system.

Conclusion

We once again wish to thank OMHSAS for their nearly decade-long effort to codify the PRTF regulations. We agree that the strategy OMHSAS has recently employed to enhance stakeholder engagement has improved, but unfortunately the current approach has not been sufficient.

When the state's ability to adequately fund service delivery depends on the budget process and the General Assembly, this approach creates a serious risk of establishing a regulated service as an unfunded mandate. This process offers no financial reassurance to the regulated community, as the ultimate funding is not in the hands of the Department. This must be considered as a potential barrier in the final-form rulemaking.

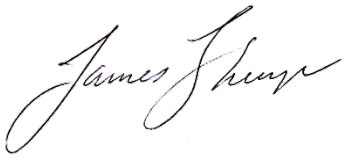
While these regulations are undoubtedly well-intended for the safety and well-being of the Commonwealth's most vulnerable children, youth, and young adults, they fail to acknowledge the current staffing, clinical, and financial landscape in which providers operate. Additionally, our members and the greater provider community do not feel the State has sufficiently addressed the public feedback from the proposed PRTF regulations generated by the IRRC, legislators, providers, and stakeholders—especially those tied to staffing and funding as clinical and operational rationales.

In closing, framing these final-form regulations around an agenda of legal protection in lieu of standards that reflect the mission of delivering safety and high-quality services may profoundly impact the outcomes for our most complex youth for decades. RCPA feels that, with deeper stakeholder engagement, these regulations can be re-envisioned in a two-year promulgation window. We feel this would not only achieve the best outcomes for the children, youth, and impacted families of Pennsylvania, but also address the ultimate question of the IRRC on standards that work in the best interest of the Commonwealth and those it serves.

With so much at stake, RCPA is unable to support these regulations; this is a risk our association and our members simply cannot take.

We thank our members for their guidance and support as well as OMHSAS for their partnership and the opportunity to present before the IRRC.

Respectfully,



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