Regulatory Analysis Form (Completed by Promulgating Agency) **(All Comments submitted on this regulation will appear on IRRC's website)**	***INDEPENDENT REGULATORY REVIEW COMMISSION*** RECEIVED Independent Regulatory Review Commission October 16, 2026 IRRC Number**: 3417**
(1) Agency: Department of Human Services	
(2) Agency Number: 14 Identification Number: 555	

(3) PA Code Cite: 55 Pa. Code Chapters 1330, 5330 and 3800

(4) Short Title: Psychiatric Residential Treatment Facilities

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(6) Type of Rulemaking (check applicable box):

- ☐ Proposed Regulation
- ☒ Final Regulation
- ☐ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
- ☐ Certification by the Governor
- ☐ Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The final-form rulemaking codifies the minimum licensing standards and Medical Assistance (MA) participation requirements and payment conditions for psychiatric residential treatment facilities (PRTFs) that provide medically necessary behavioral health treatment to children, youth or young adults under 21 years of age with a behavioral health diagnosis who cannot be effectively treated in their home and community.

(8) State the statutory authority for the regulation. Include specific statutory citation.

The Department of Human Services' (department) statutory authority is under sections 201(2), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 911 and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)).

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as any deadlines for action.

The final-form rulemaking is not mandated by any Federal or State law, court order, or federal regulation. There are no relevant Federal or State court decisions. However, the department is promulgating this rulemaking to establish comprehensive state licensing standards and Medical Assistance participation requirements for PRTFs, while aligning Pennsylvania's regulatory framework with the Federal requirements applicable to PRTFs participating in the Medicaid program. Those Federal Medicaid participation requirements include 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individuals under 21 years of age in psychiatric facilities or programs) and 42 CFR Part 483, Subpart G (relating to conditions of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21).

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The department currently licenses residential treatment facilities (RTFs) that serve children, youth or young adults. A subset of these RTFs, which provide medically necessary psychiatric treatment in a residential setting for children, youth or young adults under 21 with a behavioral health diagnosis, are also certified by the department. In the final-form rulemaking, these RTFs are referred to as PRTFs.

PRTFs are the most intensive residential level of care for children, youth and young adults with severe behavioral health diagnoses. PRTFs offer a safe and structured environment to effectively deliver medically necessary intensive psychiatric treatment under the direction of a physician, which cannot be provided in less-restrictive settings, such as a home or outpatient setting. PRTFs provide children, youth and young adults with the necessary treatment to improve their behavioral health and prevent further regression. PRTFs play a crucial role by providing stable, medically necessary treatment when less-restrictive approaches have proven ineffective in meeting the needs of children, youth or young adults.

The primary purpose of the final-form rulemaking is to ensure that all RTFs certified by the department and behavioral health residential treatment facilities planning to become PRTFs meet minimum Federal requirements and Commonwealth standards while promoting a trauma-informed therapeutic environment. Additionally, the final-form rulemaking reflects the need to ensure the health and safety of children, youth or young adults receiving treatment in a PRTF. PRTFs provide short-term medically necessary behavioral health treatment in residential settings with the goal of children, youth and young adults returning to the community as quickly as possible. The final-form rulemaking will codify the minimum licensing requirements for all PRTFs across the Commonwealth. This final-form rulemaking will simplify the department's licensing process and distinguish PRTFs that provide medically necessary behavioral health programs for children, youth and young adults from RTFs licensed under Chapter 3800. RTFs licensed under Chapter 3800 generally provide a less restrictive environment without offering behavioral health treatment under a physician’s supervision. Another objective of the final-form rulemaking is to reduce the length of stay for children, youth or young adults. The average stay in an RTF licensed and certified by the department is currently approximately 1 year.

The final-form rulemaking is needed to establish the minimum licensing standards, MA participation

requirements, and payment conditions for RTFs that are certified by the department to provide behavioral health treatment. As of January 1, 2026, there are 20 providers with 77 licensed programs accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA). Additionally, six providers operate 32 licensed programs that are not accredited. During 2024, approximately 1,600 children, youth and young adults received MA-funded behavioral health treatment in a department-licensed and certified RTF. To provide a snapshot, on December 31, 2024, 804 children, youth and young adults received treatment in a department-licensed and certified RTF. Of these, 105 received treatment in a non-accredited RTF.

The final-form rulemaking is needed to establish minimum and consistent requirements for treatment services, including the required frequency of individual, group and family therapy. The final-form rulemaking also makes changes to staff qualifications, roles, responsibilities and training to ensure behavioral health treatment is provided by qualified staff. Children, youth or young adults will benefit from these changes because they will receive services that meet their clinical needs in a consistent and therapeutic manner. Additionally, children, youth or young adults will benefit from enhanced staff ratio requirements and the requirement that a clinical director or a mental health professional be present at the PRTF during all awake hours, increasing clinicians' availability to respond to immediate treatment needs.

In addition, the final-form rulemaking will reduce the length of time a manual restraint may be applied to a child, youth or young adult. This change will benefit children, youth and young adults by leading to better treatment of their behavioral health needs and by providing a more trauma-informed approach to care.

The final-form rulemaking will also benefit children, youth and young adults who receive services in a PRTF because the final-form rulemaking requires planning for discharge upon admission.

Furthermore, by setting minimum training standards and requiring staff training in trauma-informed care, child development and cultural competency, the final-form rulemaking will ensure that staff are appropriately trained.

The final-form rulemaking will also benefit children, youth, young adults, and their parents, legal guardians or caregivers by clarifying the requirements for admission to a secure PRTF. Secure PRTFs are facilities where egress is restricted through internal locks, exterior locks or secure fencing around the perimeter. Under the final-form rulemaking, admission of a child, youth or young adult whose treatment is funded by MA to a secure PRTF will be based on the individual's medically recommended treatment needs rather than their delinquency status. Additionally, the department must approve the admission of each child, youth or young adult to a secure PRTF. The rulemaking also introduces more stringent staff-to-resident ratios for secure PRTFs, enhancing the safety of all children, youth and young adults receiving services there.

The final-form rulemaking will also benefit parents, legal guardians or caregivers of children, youth or young adults who receive treatment in a PRTF by setting a minimum requirement of 4 hours of family therapy each month, and promoting the participation of parents, legal guardians or caregivers in treatment and discharge planning.

(11) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

The provisions in the final-form rulemaking that address the use of restrictive procedures are different than Federal regulations, and what is currently permitted. Current Federal regulations permit the use of seclusion, chemical restraints and physical restraints (see 42 CFR §§ 483.352, 483.358 (relating to definitions; orders for the use of restraint or seclusion)). Federal regulations do not specifically prohibit physical restraints that place a child, youth or young adult in a prone position (face down, stomach to floor). Also, Federal regulations permit physical restraints to occur for no longer than 4 hours for young adults ages 18 to 21 years of age, 2 hours for youth ages 9 to 17 years of age and 1 hour for children under 9 years of age (see 42 CFR § 483.358(e)(2)). The final-form rulemaking, however, prohibits prone restraints, exclusion, seclusion, chemical restraints and mechanical restraints due to the significant risk of injury and trauma that they place on children, youth or young adults. The final-form rulemaking also prohibits physical restraints that exceed 30 minutes to limit the risk of injury and trauma for children, youth or young adults.

Additionally, the provisions in the final-form rulemaking that address reportable incidents are broader than the Federal regulations and current standards. Current Federal regulations mandate that a child's, youth's or young adult's death, serious injury or suicide attempt be reported no later than the close of business on the next business day (see 42 CFR § 483.374(b)(1) (relating to facility reporting)). They also require that parents, legal guardians or caregivers be informed of such incidents within 24 hours of the occurrence (see 42 CFR § 483.374(b)(2)). The final-form rulemaking enhances these Federal requirements by requiring the reporting of incidents that results in children, youth or young adults sheltering in place or relocating, a child's, youth's or young adult's elopement from a PRTF as well as disruptions to water, heat, cooling or power, to the department. Moreover, it mandates that the department and parents, legal guardians, or caregivers be notified within 12 hours of the department learning of any such incident.

The final-form rulemaking also expands the list of serious incidents that must be reported to the department and requires notification of the child's, youth's or young adult's parents, legal guardians or caregivers. Additional incidents that need to be reported to the department and require parental notification include suspected abuse or actual abuse of a child, youth, or young adult; activation of the PRTF's emergency preparedness plan and any medication error. These changes are intended to ensure that the child's, youth's or young adult's parents, legal guardians or caregivers and the department are better informed about serious incidents occurring at a PRTF.

Additionally, Federal regulations do not address how often children, youth or young adults should individually meet with their assigned mental health professional, attend group therapy or attend family therapy. The final-form rulemaking includes the following minimum treatment requirements: individual therapy with the child's, youth's or young adult's mental health professional must be provided for at least 6 hours each month; group therapy must be provided for at least 12 hours each month; family therapy must be provided for at least 4 hours each month and psychoeducation group must be provided as directed by the treatment team. These minimum standards are included in the final-form rulemaking as a result of discussions with a stakeholder workgroup, as discussed below. The minimum requirements will support the continuity of care needed for children, youth or young adults to transition to their home or community in the shortest time.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

Pennsylvania does not compete with other states to provide PRTF services to children, youth or young adults enrolled in the MA program in Pennsylvania. The final-form rulemaking will allow Pennsylvania to better serve children, youth or young adults with mental, emotional or behavioral health needs.

As an integral part of comparing the final-form rulemaking with other states, the department reviewed the licensure and payment conditions regulations for PRTFs in Pennsylvania's bordering states along with other states. Specifically, the department examined current PRTF requirements for the neighboring states of Maryland, Ohio, New Jersey, New York, Virginia and West Virginia, as well as Florida, Maine, Arkansas and Minnesota (links provided in response to Question 28 below). The department did not review Delaware's requirements because it does not have in-state PRTFs and utilizes other states for this service. The department included a myriad of similar minimum standards from bordering states' regulations in the final-form rulemaking. For example, the department, consistent with requirements imposed by neighboring states, allows a PRTF to choose which accreditation body it will use to accredit it. Only Maryland requires that PRTFs be accredited by a specific accreditation body. The department also observed that similar to other states a detailed service description for each program is required.

When it reviewed the requirements of bordering states, the department examined the following areas: quality assurance processes; staff ratios; mental health professional qualifications; minimum standards for individual, group, and family therapy sessions; restrictive procedures; and trauma-informed care approaches. For example, the final-form rulemaking requires a PRTF to have a quality assurance process. Similarly, New York, Ohio and West Virginia also require a quality assurance process.

The final-form rulemaking sets a minimum staff ratio of one staff member for every six children, youth or young adults during awake hours and one staff member for every 12 children, youth or young adults during sleeping hours. The minimum staff ratio is more stringent than what is currently required under Chapter 3800. Nevertheless, this ratio was established based on input from the stakeholder workgroup, the served population and comparisons to neighboring states. The department recognizes that many of the RTFs subject to the final-form rulemaking currently surpass these existing staffing requirements. West Virginia has stricter staffing ratios than those in the final-form rulemaking, requiring one staff member for every three children, youth or young adults during awake hours and one for every six children, youth or young adults during sleeping hours. Additionally, New York has a more rigorous staffing ratio requirement during awake hours, with one staff member required per every five children, youth or young adults, and a less strict standard during sleeping hours, requiring one staff member per every 14 children, youth or young adults. Ohio's requirements are also stricter than those in the final-form rulemaking in that Ohio requires a staff ratio of one staff member for every three children, youth or young adults during awake hours. The ratio is even stricter if the Ohio PRTF serves children, youth or young adults with intellectual disability, as that ratio is one staff member for every two children, youth or young adults during awake hours. Ohio does not have staff-ratio requirements during sleeping hours. Maryland, New Jersey and Virginia do not specify minimum staffing ratios during awake and sleeping hours.

In addition, the final-form rulemaking does not require a mental health professional to be licensed to work in a PRTF. This is similar to New Jersey's, New York's, and West Virginia's requirements for PRTFs. Virginia and Ohio require mental health professionals to be licensed to work in a PRTF.
The department also compared the hourly minimum standard for the frequency of individual, group and family therapy sessions. The final-form rulemaking requires that individual therapy be provided at least 6 hours each month with a mental health professional. Group therapy must be provided at least 12 hours each month, and family therapy at least 4 hours each month. West Virginia requires individual therapy for at least 1 hour each week, group therapy for at least 3 hours each week and family therapy for at least 2 hours each month. Virginia, however, requires that individual therapy be provided 3 times each week but does not specify the duration of each session. Additionally, Virginia mandates that group and family therapy be provided when indicated. Ohio requires individual counseling, not less than twice a week, for a total of at least 90 minutes each week and that group therapy occur for at least 5 hours each week (20 hours each month). Maine requires that individual therapy occurs for at least 2 hours each week (8 hours each month), group therapy occurs once per day (30 hours each month), and family therapy occurs at 2 hours each week (8 hours each month). Similarly, Minnesota's treatment requires that individual therapy be provided a minimum of twice per week with active treatment seven days per week that may include individual, family, or group therapy as determined by the individual care plan. West Virginia requires individual therapy for at least 1 hour each week, group therapy for at least 3 hours each week and family therapy for at least 2 hours each month. Arkansas requires a total of 40 hours per week of documented treatment services, which equates to 160 hours of treatment services each month. Maryland, New Jersey and New York do not have requirements regarding minimum standard for the frequency of individual, group and family therapy sessions. The minimum standards for therapy in the final-form rulemaking support the physical and psychological well-being of children, youths or young adults, and encourages active involvement from their parents, legal guardians or caregivers.

The qualifications that the treatment team leader must be met by a psychiatrist are in line with clincial guidance and is similar with Ohio, West Virginia, Florida and Arkansas.

Ohio specifies that "If the medical director is not a board certified or board eligible psychiatrist, the PRTF will also employ or contract with a psychiatrist who meets this qualification," which is specified in the Ohio Administrative Code, Rule 5122-41-06(a) (relating to staffing, staffing qualifications, and staff ratios). Several of Ohio's PRTFs are currently enrolled in the Commonwealth's MA program and serve many children, youth or young adults from the Commonwealth.

The department also reviewed the requirements in West Virginia, which specifies that "The facility must appoint a medical director to be responsible for coordinating medical services and directing member treatment. The medical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry." Of note, the final-form rulemaking is less restrictive than West Virginia's requirements as it does not require the psychiatrist to have specific experience in child/adolescent psychiatry.

Similarly, Florida also requires that residential treatment center providers have on staff or under contract a psychiatrist who is board certified or board eligible in child and adolescent psychiatry to serve as medical director for the program and such position shall oversee the development and revision of the treatment plan and the provision of mental health services provided to children.

Arkansas also requires that PRTF services "be under the direction of a psychiatrist or physician with

oversight by a psychiatrist (contracted physicians are acceptable)."

The department is aware of the widespread impact of trauma and understands the importance of integrating trauma-informed care into policies, procedures and practices. For this reason, trauma-informed care approaches were embedded into the final-form rulemaking. With the exception of Ohio, no neighboring states included requirements specific to trauma-informed approaches in their regulations. The final-form rulemaking provides a strengths-based approach to service delivery that requires the incorporation of trauma-informed care. Specifically, PRTFs will need to describe how trauma-informed practices, trauma assessments and staff training on trauma-informed care will be implemented and utilized.

The department's review of restrictive procedures revealed differences among the bordering states. The final-form rulemaking prohibits the use of seclusion, mechanical restraints, chemical restraints and limits the length of time a manual restraint may be continuously applied to 30 minutes, regardless of the child's, youth's or young adult's age. These maximum limits are different and more restrictive than the Federal and bordering states' requirements, as the department sought to utilize a trauma-informed approach to restrictive procedures if they are deemed necessary. Maryland, New York and New Jersey follow the Federal allowances for seclusion and mechanical and chemical restraints and extended time for a physical restraint based on the child's, youth's or young adult's age. Ohio permits the use of seclusion for all children, youth or young adults and mechanical restraints for individuals who are at least 18 years of age. Furthermore, Ohio's requirements are silent regarding the maximum length of time a manual restraint may be applied to a child, youth or young adult.

(13) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No, the final-form rulemaking will not impact other regulations.

RTFs currently licensed and certified by the department to provide behavioral health treatment to children, youth and young adults will need to be regulated under the new licensing and payment chapters as PRTFs within 24 months of the publication of the final-form rulemaking.

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

Throughout the drafting of the proposed and final-form rulemaking, the department updated the Mental Health Planning Council Children's Committee. The Committee advises the department on issues related to mental health, substance abuse, behavioral health disorders and cross-system disability. The department also collaborated with a stakeholder workgroup to develop the proposed rulemaking. This workgroup included family members of children, youth or young adults who received RTF services; and family advocates and representatives from the following: RTF providers currently certified and licensed by the department; the Mental Health Association of Pennsylvania; Rehabilitation and Community Providers Association (RCPA); Pennsylvania Council of Children, Youth & Family Services (PCCYFS); Disability Rights Pennsylvania; National Partnership for Juvenile Services; behavioral health managed care organizations (BH-MCO) and county mental health departments.

The stakeholder workgroup held an initial in-person meeting on February 11, 2020. After the start of the COVID-19 pandemic, the workgroup met virtually on June 11, 2020, June 17, 2020, and July 31, 2020. The group discussed staff qualifications and training, treatment planning, administering medication, ensuring health and safety and the use of restrictive procedures. A summary of each meeting was provided for workgroup members. Members were encouraged to ask questions, make suggestions or share concerns via email.

The department also held individual consultations with family advocates; family members of children, youth or young adults who received RTF services; medical directors of BH-MCOs; psychiatrists; and other offices within the department regarding whether there is a clinical need for secure treatment settings. It was determined that, in certain circumstances, children, youth or young adults do require medically necessary behavioral health treatment in a secure PRTF. To ensure active participation from family members of children, youth or young adults currently receiving treatment in an RTF, the department met with them on March 19, 2021, June 25, 2021, September 1, 2021, and September 10, 2021, to discuss their thoughts on the proposed regulations.

The department held informational webinars before the public comment period for the proposed rulemaking. The purpose of the webinars was to inform stakeholders about the sections of the proposed rulemaking the department expected would receive the most feedback. The department conducted a webinar with stakeholders on July 23, 2024, and with BH-MCOs, primary contractors and county mental health representatives on July 25, 2024.

When the proposed rulemaking was published, the department shared a copy with stakeholders, including youth and young adults and their family members, advocates and the Mental Health Planning Council Children's Committee. Family members and family advocates orally supported the proposed rulemaking.

While drafting the final-form rulemaking, the department met with a transition-age youth and young adult subcommittee of the Mental Health Planning Council on April 8, 2025, and April 22, 2025. The subcommittee members supported the changes the department was considering in the final-form rulemaking related to restrictive procedures and treatment requirements. The department also collaborated with PCCYFS and RCPA for an informational meeting on May 21, 2025. The meeting highlighted sections of the proposed rulemaking that received the highest number of comments during the public comment period. Furthermore, RCPA was updated on the final-form rulemaking on June 5, 2025, July 9, 2025, and July 16, 2025. PCCYFS was updated on June 24, 2025, July 15, 2025, and August 29, 2025.

Approximately 216 stakeholders attended the informational meeting either in person or virtually on May 21, 2025. The department appreciated the opportunity to further engage with stakeholders to gather additional feedback and recommendations for the final-form rulemaking. The stakeholders included representatives from the following: RTF providers currently certified and licensed by the department, provider organizations, the Pennsylvania Senate Health and Human Services Committee, the Pennsylvania House Republican Children and Youth Committee, the Pennsylvania Psychiatric Society, BH-MCOs, primary contractors, county mental health representatives and other behavioral health providers.

The department kept interested parties and organizations informed throughout the drafting of this final-form rulemaking to ensure a transparent process. The Juvenile Court Judges Commission received an update on the final-form rulemaking on July 9, 2025. The County Commissioners Association of

Pennsylvania was updated on January 15, 2025, July 16, 2025, and August 8, 2025. The Mental Health Subcommittee of the Judges State Round Table was updated on January 14, 2025, February 13, 2025, March 21, 2025, April 17, 2025, May 15, 2025, and August 18, 2025. The Montgomery County Association for Excellence was updated on January 30, 2025. The department also provided updates during a standing public quarterly stakeholder call held by the Office of Mental Health and Substance Abuse Services on five occasions between January 2025 and August 2026. These stakeholder calls are open to any member of the public and attendees include county mental health administrators, HealthChoices primary contractors, BH-MCOs, behavioral health care providers, and individuals and families of those receiving behavioral health services. The department also informed the Centers for Medicare & Medicaid Services (CMS) on April 9, 2025, that the primary purpose of the final-form rulemaking was to align the Commonwealth's requirements with Federal requirements. CMS provided positive feedback to the department.

Comments and feedback from interested parties and organizations were considered during the drafting process.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

All RTFs currently licensed and certified by the department that seek to become a PRTF must comply with the final-form rulemaking. As of January 1, 2026, 20 providers with 77 licensed programs are accredited by TJC, CARF or COA. Additionally, as of January 1, 2026, there are six providers with 32 licensed programs that are not accredited.

The impact of the final-form rulemaking on each RTF will depend on its staff's current qualifications and training requirements, as well as its organizational structure. Additionally, all current RTFs seeking licensure as a PRTF will need to meet the new requirements outlined in the final-form rulemaking within 24 months of publication of the final-form rulemaking. RTFs that are not accredited will also have 24 months to complete the necessary steps to become accredited to comply with the final-form rulemaking.

In addition, new facilities seeking to become a PRTF will need to immediately comply with the requirements in the final-form rulemaking.

Section 3 of the Regulatory Review Act (71 P.S. § 745.3) includes the following definition of "small business:" "As defined in accordance with the size standards described by the United States Small Business Administration's Small Business Size Regulation under 13 CFR Ch. 1 Part 121 (relating to Small Business Size Regulation) or its successor regulation." The Federal regulations reference the North American Industry Classification System (NAICS) standards. The NAICS small business standard for psychiatric and substance abuse hospitals is $41,500,000 in annual revenue.

As of January 1, 2026, eight of the 26 providers enrolled in the MA program, whether accredited or not, are for-profit businesses. The remaining 18 providers are non-profit organizations. Based on a review of the department's paid claims data for calendar years 2023 and 2024, each of the eight for-profit and the 18 non-profit providers delivering RTF level of care received less than $41,500,000 in department funds during that year. The department does not have access to information on the total revenue each provider reports on IRS tax forms, as these providers contract with private insurance

companies and other entities to provide treatment, which results in additional revenue. Therefore, using only the department's paid claims data, all 26 providers will be considered small businesses.

The final-form rulemaking does not have any exemptions for small businesses due to minimum health, safety and payment requirements and will equally affect all RTFs under the scope of the final-form rulemaking.

Staff employed by an RTF that seek licensure as a PRTF may be affected by the final-form rulemaking because the minimum qualifications and responsibilities of positions have changed to meet the behavioral health needs of children, youth or young adults in PRTFs. Staff may also need to obtain additional education or training.

All children, youth or young adults receiving treatment in an RTF licensed and certified by the department will be impacted by the final-form rulemaking. In 2024, approximately 1,600 children, youth or young adults received MA-funded behavioral health treatment in an RTF certified by the department. To provide a point-in-time perspective, on December 31, 2024, there were 804 children, youth or young adults receiving treatment in an RTF licensed and certified by the department.

The final-form rulemaking will affect children, youth or young adults who receive treatment in a PRTF because it increases staff ratio requirements. The increased staff ratio requirements will increase supervision of children, youth or young adults and provide additional access to clinicians during awake hours. In addition, there will be more clinical staff onsite to provide support and guidance to direct care staff.

Children, youth or young adults will also be affected by the final-form rulemaking because it establishes minimum standards for the frequency and duration of individual, group and family therapy. This will help children, youth and young adults receive services that meet their clinical needs in a consistent and therapeutic manner. Additionally, by setting minimum training standards and requiring staff training in trauma-informed care, child development, cultural competency, diversity, equity and inclusion, the final-form rulemaking will ensure that staff are adequately trained. The increased staff qualifications included in the final-form rulemaking will also help ensure that services are delivered by qualified staff, resulting in services that meet the clinical needs of children, youth or young adults in a consistent and therapeutic manner.

The final-form rulemaking also impacts children, youth or young adults by including requirements for secure PRTFs. A child, youth or young adult whose treatment is funded by MA can now receive medically necessary treatment in a secure PRTF without being an alleged delinquent or adjudicated delinquent, which is currently required. It also affects children, youth or young adults by adding safety requirements, including expanding the list of incidents that must be reported and significantly reducing the duration a manual restraint may be used on a child, youth or young adult compared to what is currently permitted. Additionally, the final-form rulemaking will help protect the health and safety of children, youth or young adults receiving services in a PRTF by prohibiting the use of seclusion, exclusion, and prone, chemical and mechanical restraints.

The final-form rulemaking will affect parents, legal guardians and caregivers of children, youth or young adults who receive treatment in a PRTF because it sets a standard for family therapy and promotes the participation of parents, legal guardians and caregivers in treatment and discharge planning.

The final-form rulemaking will affect local governments. Currently, local governments may pay for room and board for children, youth or young adults in a non-accredited RTF. Should the final-form rulemaking go into effect, local governments may experience cost savings, as MA would cover room and board costs.

(16) List the persons, groups or entities, including small businesses, that will be required to comply with the regulation. Approximate the number that will be required to comply.

All RTFs that currently provide medically necessary behavioral health treatment in a residential setting to children, youth, or young adults including those that qualify as small businesses (see #15 for additional information), will be required to comply with the final-form rulemaking if they want to continue to provide services.

All future providers seeking to provide medically necessary behavioral health treatment in a residential setting to children, youth and young adults will need to comply with the final-form rulemaking.

Although the final-form rulemaking includes requirements for children, youth or young adults to receive treatment in a PRTF, children, youth or young adults do not need to comply with it. Rather, facilities must comply with the final-form rulemaking to be licensed and receive MA payment.

(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

The financial impact of the final-form rulemaking on RTFs that are currently licensed and certified by the department and future providers that seek to provide PRTF services is the same regardless of whether the RTF is a small business.

Existing providers who operate unaccredited RTFs will need to incur the cost to become accredited. The cost to become accredited depends upon the accreditation body selected by the provider as well as the size of the provider. Annual costs for accreditation are an allowable cost for payment through the cost reporting process. It is anticipated that providers will seek higher payment rates through the submission of cost reports for expenses related to becoming accredited and maintaining accreditation.

Currently, if a child, youth or young adult who is eligible for MA receives medically necessary behavioral health treatment in an accredited RTF that is certified by the department, the MA program will pay for the child's, youth's or young adult's behavioral health treatment and for room and board. However, if the child, youth or young adult is receiving medically necessary behavioral health treatment in a non-accredited RTF certified by the department, the MA program will only pay for the child's, youth's or young adult's behavioral health treatment. Another funding source, such as local governments, cover the cost for the room and board.

The department will require both accredited and non-accredited RTFs certified by the department to comply with the final-form rulemaking 24 months after promulgation.

RTFs may also incur additional costs because of increased staff training requirements, an increase in supervisory staff and changes to staff responsibilities and supervisory ratios. Costs will vary among

providers because they are dependent on the provider's current organizational structure.

The final-form rulemaking includes minimum treatment standards for individual therapy, group therapy and family therapy. The financial impact of these minimum standards will vary and depend on the RTF's current organizational structure.

The final-form rulemaking will not have a financial or economic impact on labor communities or other public and private organizations.

The final-form rulemaking does not have a social impact on small businesses, businesses, labor communities and other public or private organizations.

The final-form rulemaking will benefit the 26 accredited and non-accredited providers who offer behavioral health treatment to children, youth or young adults in a residential setting by creating a streamlined licensing process that eliminates the need for an additional certification from the department.

The final-form rulemaking will clearly distinguish between PRTFs and RTFs. This distinction will help all children, youth and young adults in care, along with their families and providers, to make informed choices about care coordination.

It is anticipated that RTFs participating in the MA program will seek higher payment rates through a review of cost reports, which will include costs related to complying with the new requirements in the final-form rulemaking. The department recognizes the costs associated with new requirements and is taking steps to ensure that fee-for-service rates appropriately reflect these requirements. Specifically, RTFs who elect to transition to a PRTF will submit a projected cost report that will contain an additional column for new, anticipated costs, prior to the provider actually incurring the costs of compliance with the final-form rulemaking. After the department reviews the projected cost report, which includes the new costs, the RTF will be sent a proposed adjusted rate to review. Once the adjusted rate is finalized, a new rate letter will be sent to the RTF. By the end of the 24-month implementation period, the department intends to have both the fee-for-service rates and capitation rates adjusted to account for the increased costs of RTF providers that elect to transition and are licensed as a PRTF. Throughout this process, the department will ensure that all capitation rate adjustments are actuarially sound as required by Federal requirements.

Implementation of the requirements of the final-form rulemaking will result in an estimated annual cost to the MA program of approximately $24,464,000 ($10,420,000 in State funds), which reflects the estimated aggregate costs for facilities to implement the final-form rulemaking (Room and Board Expenses - $7,464,000 (state funds $3,179,000); Staffing Requirements – $15,000,000 (state funds $6,389,000); Secure PRTF - $1,000,000 (state funds $426,000); and Transportation and Living Costs - $1,000,000 (state funds $426,000)). Based on the expected timeline for implementing the final-form rulemaking, the cost for the first fiscal year will be three-quarters of the total annual cost incurred in subsequent years after the rulemaking is promulgated. The first-year costs are approximately $18,348,000 ($7,816,000 in State funds). These costs include MA payments for room and board for children, youth or young adults in previously non-accredited RTFs; payments for costs PRTFs incur to comply with new requirements in the final-form rulemaking; costs for increased staffing in secure PRTFs; transportation and living expenses for parents, legal guardians or caregivers when they visit the PRTF and the cost to the department to hire additional staff to oversee PRTF licensing.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

The primary benefit of the final-form rulemaking, which outweighs any cost and adverse effects, is ensuring that all RTFs certified by the department and behavioral health residential treatment facilities seeking to become PRTFs participating in the Medical Assistance program meet Federal Medicaid participation requirements.

This final-form rulemaking benefits children, youth or young adults receiving medically necessary services in a PRTF by implementing changes aimed at effectively delivering medically necessary intensive psychiatric treatment under the direction of a physician, which cannot be provided in less-restrictive settings, such as a home or outpatient setting. PRTFs provide children, youth or young adults with the necessary treatment to improve their behavioral health and prevent further regression. The final-form rulemaking promotes a strong commitment to trauma-informed principles; highlights active engagement of children, youth or young adults in their treatment and encourages planning for discharge to begin upon admission.

Additional benefits of the final-form rulemaking for children, youth or young adults as well as RTFs and facilities aspiring to become PRTFs participating in the Medical Assistance program include a pathway for the Commonwealth to ensure that PRTFs are complying with Federal Medicaid participation requirements; direct support for the behavioral health needs of the children, youth and young adults being served; ensuring the delivered services are provided by trained professionals who have the knowledge, skills and abilities to meet the behavioral health needs of children, youth and young adults; enable coordination of care upon discharge from the PRTF and promotion of trauma-informed approaches.

The benefit of the final-form rulemaking also outweighs any costs or adverse effects to providers of RTF services because the final-form rulemaking establishes minimum standards for staff qualifications, staff responsibilities, staff ratios, staff training and treatment requirements for all PRTFs. These standards will increase safety and enhance the behavioral health treatment of the children, youth and young adults receiving treatment in a PRTF, which may result in reduced lengths of stay.

Having consistent staff training will also benefit current RTFs and future providers seeking to offer PRTF services because a staff member will not need to be retrained if they transfer from one PRTF to another, and the provider will avoid additional costs for training when hiring new staff. Additionally, children, youth and young adults will benefit from the requirement that staff hold higher qualifications and receive additional training, as this will help ensure their clinical needs are met consistently and therapeutically.

The final-form rulemaking increases the staff ratio requirements. The new staff ratio requirements will enable better supervision of children, youth and young adults, and provide additional support from direct care staff in case of an emergency at a PRTF. Additionally, the staff ratio requirement is increased for a secure PRTF, which will improve the safety of the children, youth and young adults served and help the PRTF better address severe behavioral health needs.

The final-form rulemaking also requires that a mental health professional or a clinical director be available at the PRTF during awake hours each day. Awake hours will be determined by the PRTF but

can range from 7:00 am to 9:00 pm, depending on the PRTF's structure. Having a mental health professional or a clinical director available throughout the day and evening hours will ensure that a clinician is immediately accessible to respond to treatment needs. Furthermore, evening hours are a time when many children, youth or young adults face conflicts or emotional challenges.
The final-form rulemaking will also improve clarity and consistency and will simplify the licensing and payment processes.

The benefits of the final-form rulemaking outweigh any increased costs and adverse effects because it makes secure PRTF settings available to children, youth, and young adults based on their behavioral health treatment needs, not their delinquency status.

The benefits of the final-form rulemaking also outweigh any cost or adverse effects because it sets a standard for family therapy and promotes the participation of parents, legal guardians and caregivers in treatment and discharge planning.

(19) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

To be licensed as a PRTF under the final-form rulemaking, accreditation is required. Non-accredited RTFs certified by the department that seek to become PRTFs will incur the cost of becoming accredited. The cost to become accredited and maintain accreditation depends upon the accreditation body selected by the non-accredited RTF, as well as the size of the provider. The initial cost for accreditation, as well as the cost to maintain accreditation, can be up to $10,000. This cost is an estimate and includes annual upkeep costs and fees to be accredited and maintain accreditation. For example, the department estimated that it would cost $3,000 a year for a 3-year accreditation and an additional $1,000 for the on-site review. However, the cost can vary based on the accreditation agency chosen by the PRTF. It is anticipated that providers will seek higher payment rates through a review of cost reports for costs related to becoming accredited and maintaining accreditation.

As further discussed below, RTFs that seek to be licensed as PRTFs may also incur costs related to changes in staff qualifications, staff responsibilities, staff ratios and staff training requirements. The exact cost for each RTF depends on the RTF's current treatment modalities, organizational structure, staff qualifications and supervision and training needs. It is anticipated that RTFs that currently participate in the MA program and who intend to seek licensure as a PRTF will seek higher payment rates through the submission of cost reports including costs for changes to staff qualifications, responsibilities, ratios and training in the final-form rulemaking. The final-form rulemaking makes changes to the existing staff requirements to allow PRTFs to better meet the medically necessary behavioral health needs of the children, youth or young adults served. While the final-form rulemaking maintains the structure of a director, child care worker and child care worker supervisor, the requirements for these positions are changed in the final-form rulemaking.

The requirements for the program director position are less stringent than the current requirements under Chapter 3800. Specifically, the final-form rulemaking allows a program director with a master's degree to have 1 year less work experience and a program director with a bachelor's degree to have 2 years less work experience. The final-form rulemaking also allows an individual with an associate's degree and 3 years of work experience or an individual with a high school diploma or equivalent and 5 years of work experience to become a program director.

The qualifications for a mental health worker are revised from the proposed rulemaking. The final-form rulemaking requires a mental health worker to have at least 12 credits in a behavioral health field or have a high school diploma (or equivalent) and at least 6 months of experience in a behavioral health or related field. The final-form rulemaking also permits a PRTF to provide this 6-month required experience for mental health workers.

The education and experience requirements for a mental health worker supervisor are less stringent than current standards. Specifically, the final-form rulemaking allows individuals with a bachelor's degree to have 6 months less work experience. Additionally, individuals with an associate's degree need 2 years less experience. The final-form rulemaking also permits individuals with a high school diploma (or the equivalent) and 2 years of work experience to become mental health worker supervisors. It is important to note that under the final-form rulemaking, PRTFs are not required to employ a mental health worker supervisor.

Consistent with Federal Medicaid requirements, the final-form rulemaking also requires additional positions. These positions were added to better support children, youth or young adults with behavioral health needs receiving medically necessary treatment in a PRTF. The new positions include a medical director, treatment team leader, clinical director, mental health professional and a registered nurse. A medical director may also serve as the treatment team leader and clinical director, so long as the requirements for each position are met.

It is anticipated that RTFs participating in the MA program will seek higher payment rates through a review of cost reports, which include costs related to complying with the staff requirements in the final-form rulemaking.

If an RTF needs to hire a medical director, treatment team leader, clinical director, mental health professional or registered nurse to meet the requirements of the final-form rulemaking, the approximate annual cost, including benefits, for each position is as follows: $468,154 for a medical director or a treatment team leader; $189,814 for a clinical director, unless a physician assumes the role (which would increase the salary); $117,504 for a mental health professional, unless the individual is a licensed practitioner (which would increase the salary); and $154,988 for a registered nurse.

The final-form rulemaking permits a PRTF to employ a licensed practical nurse or an advanced practice professional. If an RTF chooses to use a licensed practical nurse, the average annual salary, including benefits, is approximately $106,471. An advanced practice professional may be licensed as a physician assistant or a certified registered nurse practitioner. Should an RTF opt to employ an advanced practice professional, the average annual salary including benefits is approximately $205,499.
During the stakeholder workgroup meetings, many RTF providers stated that their staff ratios exceed existing requirements and already meet the staff ratio requirements in the final-form rulemaking. RTF providers that are not currently exceeding the minimum staff ratio requirements will incur costs under the final-form rulemaking.

Under the final-form rulemaking, § 5330.42 (relating to staff requirements), requires at least one PRTF staff person for every six children, youth or young adults during awake hours, and at least one PRTF staff person for every 12 children, youth or young adults during sleeping hours. As noted above, these ratios are similar to surrounding states. Although the department is maintaining the staff ratio requirements from the proposed rulemaking, the department has extended the time period for compliance for those existing facilities seeking licensure as a PRTF until 24 months after publication

of the final-form rulemaking. As noted above, the department has also revised the qualifications for mental health workers under the final-form rulemaking in order to assist facilities in meeting these new ratios.

Using a 16-bed provider as an example, a PRTF that is not currently exceeding the minimum staffing requirements will need to hire two additional mental health workers at an average salary, including benefits, of approximately $89,391. The total additional cost to the provider would be $178,782. It is anticipated that RTFs that currently participate in the MA program and who intend to seek to be licensed as a PRTF participating in the MA program will seek higher payment rates through the submission of cost reports for any costs incurred to meet the staff-ratio requirements.

While the number of hours of annual training staff who directly work with children, youth or young adults must complete before working with children, youth or young adults remains unchanged from what is currently required under Chapter 3800, the final-form rulemaking adds new training topics. These new training topics include cultural competency, child development, diagnosis and treatment and trauma–informed care principles. These additions were informed by feedback from workgroup members and aim to support the Commonwealth's goal of becoming a trauma-informed and healing-centered state. If an RTF does not provide training on additional topics and lacks the resources to provide additional training, the estimated cost for training each PRTF staff member would be approximately $1,857 a year. This estimate accounts for the cost of training staff on the new topics and assumes a 35% staff turnover rate.

The final-form rulemaking also establishes requirements for secure PRTFs. Currently, there are no secure PRTFs in the Commonwealth. An MA-enrolled provider choosing to become a secure PRTF will bear the costs of meeting the heightened staff requirements. The staff ratio requirements for secure PRTFs are more stringent than those for non-secure PRTFs. The final-form rulemaking mandates that secure PRTFs have one mental health worker for every four children, youth or young adults during awake hours and one mental health worker for every eight children, youth or young adult during sleeping hours.

If an RTF under the scope of the final-form rulemaking that does not exceed the minimum staff requirements chooses to transition to a secure PRTF, the RTF would need to hire additional mental health workers at an average salary, including benefits, of approximately $89,391. Using a 16-bed provider as an example, an RTF will need to hire three additional mental health workers. The total additional cost to the provider would be $268,173. It is anticipated that RTFs participating in the MA program will seek higher payment rates through a review of cost reports, which include costs related to complying with the staff requirements for secure PRTFs in the final-form rulemaking.

The final-form rulemaking imposes additional paperwork requirements (see #22 for additional information). Should an RTF not already meet the requirements of the final-form rulemaking, the one-time cost for the RTF to develop the documents will be approximately $5,760. The cost is based on an average hourly rate of $72.00 for a program director, who is estimated to require 80 hours to develop the documents.

PRTFs may incur the costs for installing an automated external defibrillator (AED) on grounds. Should a PRTF not currently have an AED on its grounds, the cost to purchase one can range from $1,500 to $2,500 depending on the type of AED purchased. The department anticipates that most RTFs seeking to be licensed as PRTFs already have an AED on their grounds.

Regarding quality assurance plans, RTFs accredited by organizations such as TJC, CARF or COA are currently required by these organizations to complete quality improvement plans. Given the common practice of utilizing quality assurance activities, increased costs to implement this requirement are expected to be minimal.

As noted above, it is anticipated that RTFs participating in the MA program will seek higher payment rates through a review of cost reports, which include costs related to complying with the new requirements in the final-form rulemaking. The department recognizes the costs associated with new requirements and is taking steps to ensure that fee-for-service rates appropriately reflect these requirements. Specifically, RTFs who elect to transition to a PRTF will submit a projected cost report that will contain an additional column for new, anticipated costs, prior to the provider actually incurring the costs of compliance with the final-form rulemaking. After the department reviews the projected cost report, which includes the new costs, the RTF will be sent a proposed adjusted rate to review. Once the adjusted rate is finalized, a new rate letter will be sent to the RTF. By the end of the 24-month implementation period, the department intends to have both the fee-for-service rates and capitation rates adjusted to account for the increased costs of RTF providers that elect to transition and are licensed as a PRTF participating in the MA program. Throughout this process, the department will ensure that all capitation rate adjustments are actuarially sound as required by Federal requirements.

No new legal, accounting, or consulting procedures will be required as a result of the final-form rulemaking.

The department cannot determine whether PRTFs will incur costs or have cost savings as a result of private insurance payments because it does not have access to private insurance payment information.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

Local governments may potentially experience cost savings of approximately $7,464,000 in the first full year of implementing the final-form rulemaking. Based on the expected timeline for implementing the final-form rulemaking, the savings for the first fiscal year will be three-quarters of the total annual savings in subsequent years after the rulemaking is promulgated. The department anticipates savings to local governments for the partial first year of implementation to be $5,598,000. Currently, local governments may pay for room and board for children, youth or young adults receiving treatment in a non-accredited RTF. Once all PRTFs are accredited, local governments will no longer be responsible for paying for room and board as MA will cover the child's, youth's or young adult's room and board.

These potential savings were determined by breaking out the room and board component and averaging it to $122.90 per day. The room and board component was then multiplied by the number of billed bed days for current non-accredited RTFs certified by the department, which was 60,730 billed bed days annually.

No new legal, accounting or consulting procedures are required for local governments.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

Implementation of the requirements of the final-form rulemaking will result in an estimated annual cost to the MA program of approximately $24,464,000 ($10,420,000 in State funds), which reflects the estimated aggregate costs for facilities to implement the final-form rulemaking (Room and Board Expenses - $7,464,000 (state funds $3,179,000); Staffing Requirements – $15,000,000 (state funds $6,389,000); Secure PRTF - $1,000,000 (state funds $426,000); and Transportation and Living Costs - $1,000,000 (state funds $426,000)). Based on the expected timeline for implementing the final-form rulemaking, the cost for the first fiscal year will be three-quarters of the total annual cost incurred in subsequent years after the rulemaking is promulgated. The first-year costs are $18,348,000 ($7,816,000 in State funds). These costs include MA payments for room and board for children, youth or young adults in previously non-accredited RTFs; payments for costs PRTFs incur to comply with new requirements in the final-form rulemaking; costs for increased staffing in secure PRTFs incurred as a result of this rulemaking; transportation and living expenses for parents, legal guardians or caregivers when they visit the PRTF and the cost to the department to hire additional staff to oversee PRTF licensing.

It is anticipated that MA payment for room and board expenses for the non-accredited RTFs certified by the department that are expected to convert to PRTFs will result in an annual cost of approximately $7,464,000 ($3,179,000 from state funds). The annual cost was determined by isolating the room and board component and averaging it at $122.90 per day. This room and board cost was then multiplied by the number of billed bed days for the current non-accredited RTFs certified by the department, totaling 60,730. Annual costs for accreditation are an allowable cost for payment through the cost reporting process.

As noted previously, it is anticipated that RTFs participating in the MA program will seek higher payment rates through a review of cost reports, which include costs related to complying with the staff requirements in the final-form rulemaking, which will result in an annual cost to the MA program of approximately $15,000,000 ($6,389,000 in State funds). In addition, it is anticipated that MA payment for the more stringent staff ratio requirements for four facilities that are not currently providing an RTF level of care but are expected to develop a secure PRTF will result in an annual cost to the MA program of approximately $1,000,000 ($426,000 in State funds).

The department made changes to non-allowable costs in the final-form rulemaking. Transportation and living costs related to on-site visits by parents, legal guardians or caregivers are now considered allowable expenses for PRTFs and providers can seek payment for these costs. This will result in an annual cost to the MA program of approximately $1,000,000 ($426,000 in State funds).

Implementing the requirements in the final-form rulemaking may lead to better outcomes, shorter stays at PRTFs and reduced use of higher-cost care options like hospitalizations. However, the department cannot estimate the potential savings from improved outcomes because it cannot determine how much utilization of higher levels of care or length of stay might decrease because of the final-form rulemaking requirements.

No new legal, accounting or consulting procedures will be required as a result of the final-form

rulemaking.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

While the final-form rulemaking maintains most of the current paperwork required for RTFs licensed and certified by the department, it also includes some new documentation requirements. The final-form rulemaking will require PRTFs to develop written policies and procedures on the following:

- Identification and reporting of abuse and plan of supervision for any staff implicated in abuse.
- Reporting, investigating and management of reportable incidents.
- Reporting, investigating and management of recordable incidents.
- Management and disbursement of a child's, youth's or young adult's funds.
- Protecting the confidentiality and privacy of children's, youth's or young adults' information.
- Therapeutic leave with legal guardians, parents or caregivers.
- Rights of children, youth or young adults and their parents, legal guardians or caregivers.
- Grievances
- Searches of a child, youth or young adult or the child's, youth's or young adult's personal property.
- Supervision of PRTF staff.
- Monitoring of initial and annual staff training.
- Ensuring that PRTF staff that have contact with children, youth or young adults comply with mandated reporting and training requirements
- Use of hazardous equipment.
- Fire safety monitoring if a smoke detector, fire alarm or carbon monoxide detector becomes inoperative.
- Use of drugs, alcohol, tobacco, and e-cigarettes.
- Use of a level system.
- Handling of discontinued and expired medications.
- Use of manual restraints.
- Debriefing after a manual restraint.

The final-form rulemaking will also require PRTFs to enter into written agreements describing the accessibility to and availability of providers and programs and to develop a written quality assurance plan.

The final-form rulemaking will not require children, youth or young adults who receive treatment in a PRTF or their parents, legal guardians or caregivers to complete additional reporting, recordkeeping or other paperwork requirements.

Further, the payment provisions under Chapter 1330 (relating to psychiatric residential treatment facility) do not require additional paperwork.

The final-form rulemaking does not require any legal, accounting or consulting procedures.

(22a) Are forms required for implementation of the regulation?

All facilities seeking to become a PRTF and receive MA payment must complete the PROMISe enrollment application. The link to the department's website for provider enrollment in PROMISe is provided below.

All facilities seeking to be licensed as a PRTF must complete a licensing application, which can be accessed at the following address:
Application for Certificate of Compliance (HS 633)

(22b) If forms are required for implementation of the regulation, **attach copies of the forms here.** If your agency uses electronic forms, provide links to each form or a detailed description of the information required to be reported. **Failure to attach forms, provide links, or provide a detailed description of the information to be reported will constitute a faulty delivery of the regulation.**

The electronic forms for licensure and MA enrollment, including instructions, are available at the following address:
PROMISe™ Internet Portal > Home

Application for Certificate of Compliance (HS 633)

Gloria K. Gilligan 08/17/2026

(23) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	26-27 Current FY Year	27-28 FY +1 Year	28-29 FY +2 Year	29-30 FY +3 Year	30-31 FY +4 Year	31-32 FY +5 Year
SAVINGS:	**$**	**$**	**$**	**$**	**$**	**$**
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$5,598,000	$ 7,464,000	$ 7,464,000	$ 7,464,000
State Government	$0	$0	$0	$0	$0	$0
Total Savings	$0	$0	$5,598,000	$ 7,464,000	$ 7,464,000	$ 7,464,000
COSTS:						
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$0	$0	$0	$0
State Government[1]	$0	$0	$ 7,816,000	$10,420,000	$10,420,000	$10,420,000
Total Costs	$0	$0	$ 7,816,000	$10,420,000	$10,420,000	$10,420,000
REVENUE LOSSES:						
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$0	$0	$0	$0
State Government	$0	$0	$0	$0	$0	$0
Total Revenue Losses	$0	$0	$0	$0	$0	$0

(23a) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY –2023-2024	FY -2024-2025	FY -2025-2026	Current FY-2026-2027
Medical Assistance - Fee-for-Service	$697,354,000	$691,787,000	$711,984,000	$790,219,000
Medical Assistance – Capitation	$3,594,065,000	$3,557,219,000	$3,017,959,000	$3,502,653,000

[1] The department recognizes the costs associated with new requirements and is taking steps to ensure that fee-for-service rates appropriately reflect these requirements. In addition, Medicaid capitation rates are required to be actuarially sound, ensuring that managed care plans are positioned to cover all appropriate costs.

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

(a) An identification and estimate of the number of small businesses subject to the regulation.
(b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.
(c) A statement of probable effect on impacted small businesses.
(d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Responses:

(a) Of the 26 accredited and nonaccredited providers enrolled in the MA program as of January 1, 2026, that will need to be licensed as PRTFs, eight are for-profit providers, while the remaining are non-profit providers. These providers may also contract with private insurance companies, which generates additional revenue for the provider. Based upon a review of the department's paid claims data for calendar years 2023 and 2024 all of the providers received less than $41,500,000 in department funds, which would meet the small business definition in section 3 of the Regulatory Review Act (71 P.S. § 745.3). The department does not have access to information on all revenue generated by each provider and can only base its estimate of the number of small businesses on the department's paid claims data.

(b) The final-form rulemaking includes new documentation requirements, including the requirement for PRTFs to develop several new written policies and procedures, enter into written agreements to coordinate services with other service providers, develop a written quality assurance plan and generate annual quality assurance reports (see #22 for more information). In addition, all facilities seeking to provide PRTF level of care will need to complete the PROMISe enrollment application.

(c) The final-form rulemaking will affect all PRTFs equally since the department considers all currently licensed and certified facilities to meet the definition of a small business based on the department's paid claims data.

(d) The department could discern no less intrusive or less costly alternatives that would be consistent with the need to protect the health and safety of children, youth or young adults receiving treatment services for severe behavioral health diagnoses in PRTFs.

(25) List any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, the elderly, small businesses, and farmers.

There are no provisions of the final-form rulemaking specifically developed to meet the needs of affected groups or people, including minorities, small businesses or farmers.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

The minimum standards in the final-form rulemaking are needed to ensure the health, safety and well-being of children, youth or young adults who receive medically necessary behavioral health treatment in a PRTF. The minimum standards also provide for increased safety regarding the use of manual restraints. As such, the final-form rulemaking is the least burdensome method to ensure the health, safety and well-being of children, youth or young adults who receive treatment in a PRTF.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

(a) The establishment of less stringent compliance or reporting requirements for small businesses;
(b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;
(c) The consolidation or simplification of compliance or reporting requirements for small businesses;
(d) The establishment of performance standards for small businesses to replace design or operational standards required in the regulation; and
(e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

Responses:

(a) The department did not seek to establish less stringent compliance or reporting requirements for small businesses because the department considers all RTFs that currently provide behavioral health treatment in a residential setting to children, youth or young adults to be small businesses. These final-form reporting requirements are needed to maintain the health and safety of the children, youth or young adults being served.

(b) Although the department did not establish less stringent compliance schedules specifically for small businesses, the final-form rulemaking provides all existing RTFs with a 24-month implementation period to achieve compliance with the new requirements before transitioning to licensure as a PRTF. Because the Department considers all existing RTFs to be small businesses, this implementation period provides additional time to come into compliance while preserving the minimum health and safety standards established by the regulation.

(c) The department did not seek to further consolidate or simplify compliance or reporting requirements for small businesses because the department considers all of the RTFs that currently provide behavioral health treatment in a residential setting to children, youth or young adults to be small businesses. The licensure standards are the minimum requirements

for health and safety and as such the department did not consolidate or further simplify them.

(d) The department did not propose to establish performance standards for small businesses to replace design or operational standards required in the regulation because the department considers all of the RTFs that currently provide behavioral health treatment in a residential setting to children, youth or young adults to be small businesses. The licensure standards are the minimum requirements for health and safety and as such the department did not propose to replace them with other standards.

(e) The department did not seek to exempt small businesses from all or any part of the requirements contained in the regulation because the department considers all of the RTFs that currently provide behavioral health treatment in a residential setting to children, youth or young adults to be small businesses.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

Neighboring and other states' standards and regulations for treatment received in a PRTF were reviewed. Requirements and standards for Maryland, New Jersey, New York, Virginia, West Virginia, Florida, Maine, Arkansas, Minnesota and Ohio were reviewed to assist in determining staffing patterns, staff qualifications, admission processes, treatment planning and standards, quality management methods and documentation requirements.
Delaware's requirements were not reviewed because they utilize other states for a PRTF level of care.

The standards and regulations reviewed can be accessed at:
Maryland
- Pages - COMAR Search (maryland.gov)

New Jersey
- Title 10, Chapter 75 -- Chapter Notes

New York
- Browse – New York Codes, Rules and Regulations (westlaw.com)
https://govt.westlaw.com/nycrr/Document/I50375babcd1711dda432a117e6e0f345?viewType=FullText&originati onContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Ohio
- https://codes.ohio.gov/ohio-administrative-code/chapter-5122-41

Virginia
- https://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section130/

West Virginia

- https://bms.wv.gov/media/21406/download?inline

Arkansas
- https://codeofarrules.arkansas.gov/Rules/PartDocument?partID=1449.

Maine
- Ch.II- Section 107 (MaineCare Benefits Manual).

Minnesota
- Minnesota Statutes (MN) § 256B.0941, Subd. 2(3) and (4) https://www.revisor.mn.gov/statutes/2025/cite/256B.0941.

Florida
- Fla. Admin. Code Ann. R 65E-9.007(3)(a)(1) https://www.law.cornell.edu/regulations/florida/Fla-Admin-Code-Ann-R-65E-9-007.

In making the determination that the qualifications of the treatment team leader must be met by a psychiatrist, the department reviewed clinical recommendations from the American Academy of Child and Adolescent Psychiatry specified in the *Principles of Care for Treatment of Children and Adolescents with Mental Illnesses*, which recommends that "the best intervention for serious mental health issues that cannot be treated in the child's home environment is a facility that has a multidisciplinary treatment team providing safe, evidence-based care that is medically monitored. A mental health professional should lead this team. A psychiatrist with training and experience consistent with the age and problems of the children served should inform and monitor this process." https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf.

While clinical best practice would be for specifically a child psychiatrist to fulfill this role, given the limited availability of child psychiatrists, the department is only requiring a psychiatrist and not specifying a psychiatrist with specific child expertise. Current graduate medical education requirements for a resident physician training in adult psychiatry include 2 months of training in a child/adolescent psychiatry focused clinical rotation, so non-child specialized psychiatrists recently trained should still have at least 2 months of training in child/adolescent psychiatry under the Accreditation Council for Graduate Medical Education (ACGME) standards. https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/400_psychiatry_2026.pdf.

(29) Include a schedule for review of the regulation including:

A. The length of the public comment period: 30 days

B. The date or dates on which any public meetings or hearings

will be held: No public meetings or hearings will be held

C. The expected date of delivery of the final-form regulation: Fourth quarter of 2026

D. The expected effective date of the final-form regulation:

With the exception of the amendment to § 3800.3 (relating to exemptions), the final-form rulemaking will be effective upon publication in the Pennsylvania Bulletin. The amendment to § 3800.3 will be effective 24 months after publication of the final-form rulemaking.

E. The expected date by which compliance with the final-form regulation will be required:

The department will require both accredited and nonaccredited RTFs certified by the department to comply with the final-form rulemaking 24 months after promulgation.

New facilities seeking to provide behavioral health residential treatment to children, youth or young adults shall obtain a license under Chapter 5330 prior to operating a PRTF.

F. The expected date by which required permits, licenses or other approvals must be obtained:

RTFs currently licensed and certified by the department must obtain a new certificate of compliance under Chapter 5330 within 24 months after publication of the final-form rulemaking. The department will issue licenses in accordance with each RTF's license renewal date.

New facilities seeking to provide behavioral health residential treatment to children, youth or young adults shall obtain a certificate of compliance under Chapter 5330 prior to operating a PRTF.

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulations after its implementation.

Once promulgated, the department will review the rulemaking on an ongoing basis to ensure compliance with Federal and State law and assess its appropriateness and effectiveness.

The department will monitor the impact of the rulemaking through annual licensing and discussions among offices. Additionally, the department will regularly meet with representatives of PRTFs, behavioral health advocates, family advocates, the Mental Health Association of Pennsylvania, provider associations, Disability Rights Pennsylvania, BH-MCOs and counties. The department will also consistently meet with children, youth or young adults receiving PRTF treatment, their families, and others affected by the rulemaking. Any issues identified will be researched and addressed by the department as necessary.

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14-555-02	Devereux/Edward Vincent	EVINCENT@devereux.org
14-555-03	Performcare/Jack Pizzoli	jpizzoli@performcare.org
14-555-04	Sarah A. Reed Children's Center/Blane Dessy	bdessy@gmail.com
14-555-05	PA Council of Children, Youth & Family Services/Jaclyn Kreshock	JackieK@pccyfs.org
14-555-06	Kidspeace/Alicia Eby	Alicia.Eby@kidspeace.org
14-555-07	Community Behavioral Health/Andrew Kunka	Andrew.Kunka@phila.gov
14-555-08	Sarah Reed Children's Center/Larry Shallenberger	LShallenberger@sarahreed.org
14-555-09	Hoffman Homes for Youth/Rebecca Van der Groef	rvandergroef@hoffmanhomes.com
14-555-10	Beacon Light Behavioral Health System/Jennifer Gesing	jgesing@beacon-light.org
14-555-11	Community Care Behavioral Health Organization/Gail Edelsohn	edelsohnga@ccbh.com
14-555-12	Community Services Groups/Michele Myers	myersm@csgonline.org
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CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

RECEIVED

Independent Regulatory
Review Commission

October 16, 2026

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General **By:**_____ **(Deputy Attorney General)** _____ **Date of Approval** ☐ **Check if applicable Copy not approved. Objections attached.**	**Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:** **DEPARTMENT OF HUMAN SERVICES** **(Agency)** **LEGAL COUNSEL:** _____ **DOCUMENT/FISCAL NOTE NO.** 14-555 **DATE OF ADOPTION:**_____ **BY:**_____ **TITLE:** SECRETARY OF HUMAN SERVICES **(Executive Officer, Chairman or Secretary)**	**Copy below is hereby approved as to form and legality. Executive or Independent Agencies.** **BY:**_____ October 13, 2026 **Date of Approval** **(Deputy General Counsel)** ~~**(Chief Counsel, Independent Agency)**~~ **(Strike inapplicable title)** ☐ **Check if applicable. No Attorney General approval or objection within 30 days after submission.**

NOTICE OF FINAL-FORM RULEMAKING

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Psychiatric Residential Treatment Facilities

[55 Pa. Code Chapter 1330 Psychiatric Residential Treatment Facility]
[55 Pa. Code Chapter 3800 Child Residential and Day Treatment Facilities]
[55 Pa. Code Chapter 5330 Psychiatric Residential Treatment Facility]

Statutory Authority

The Department of Human Services (department), by this order, adopts the regulation set forth in Annex A under the authority of sections 201(2), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 911 and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)). Notice of proposed rulemaking was published at 54 Pa.B. 7156 (November 2, 2024).

Purpose of Regulation

The department licenses residential treatment facilities (RTFs) that serve children, youth or young adults by issuing certificates of compliance under the authority of Chapter 3800 (relating to child residential and day treatment facilities). The department also certifies a subset of the RTFs that provide medically necessary behavioral health treatment in a residential setting for children, youth or young adults under 21 years of age with a behavioral health diagnosis. In the final-form rulemaking, these RTFs are referred to as psychiatric residential treatment facilities (PRTFs).

PRTFs are the most intensive residential level of care for children, youth or young adults with severe behavioral health diagnoses. PRTFs offer a safe and structured environment to effectively deliver medically necessary intensive psychiatric treatment under the direction of a physician, which cannot be provided in less restrictive settings, such as a home or outpatient setting. PRTFs provide children, youth or young adults with the necessary treatment to improve their behavioral health and prevent further regression. The primary purpose of Chapter 5330 (relating to psychiatric residential treatment facility) in this final-form rulemaking is to provide the minimum standards to protect the health and safety of the children, youth or young adults who require medically necessary behavioral health treatment in a PRTF and to ensure that all

RTFs certified by the department and behavioral health residential treatment facilities planning to become PRTFs meet minimum Federal requirements while promoting a trauma-informed therapeutic environment. PRTFs provide short-term medically necessary behavioral health treatment in residential settings with the goal of children, youth or young adults returning to their community as quickly as possible. The final-form rulemaking will codify the minimum licensing requirements for all PRTFs across the Commonwealth. This license will simplify the department's licensing process and distinguish PRTFs that provide medically necessary behavioral health programs for children, youth and young adults with severe behavioral health diagnoses from the RTFs licensed under Chapter 3800, which generally provide a less restrictive environment without offering behavioral health treatment under a physician's supervision. Another objective of the final-form rulemaking is to reduce the length of stay for children, youth or young adults. Currently, the average stay in an RTF licensed and certified by the department is approximately 1 year.

The final-form rulemaking will also codify the Medical Assistance (MA) participation requirements and MA payment conditions for PRTFs that serve children, youth or young adults with a behavioral health diagnosis. Chapter 1330 (relating to psychiatric residential treatment facility) establishes the department's MA payment conditions and MA participation requirements for PRTFs. All PRTFs must be licensed under and comply with Chapter 5330, but only those PRTFs that want to receive MA payment must comply with Chapter 1330. Existing RTFs that intend to be licensed as a PRTF under Chapter 5330 and receive MA payment under Chapter

1330 will have 2 years after the promulgation of the final-form rulemaking to come into compliance.

Affected Individuals and Organizations

The final-form rulemaking will impact RTFs currently licensed and certified by the department to provide medically necessary behavioral health treatment to children, youth or young adults with severe behavioral health diagnoses. As of January 1, 2026, 20 providers with 77 licensed programs are accredited by the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA), while six providers with 32 licensed programs are not accredited. All RTFs seeking licensure as PRTFs will have 2 years from the date of promulgation to meet the new requirements in the final-form of rulemaking. In contrast, new providers intending to offer PRTF services will have to meet the requirements under the final-form rulemaking to operate.

Children, youth or young adults receiving treatment in a PRTF also will be affected by the final-form rulemaking. Approximately 1,600 children, youth and young adults receive treatment funded by MA in RTFs certified by the department each year. The final-form rulemaking will establish minimum standards for treatment services and will help children, youth or young adults receive services that address their clinical needs in a consistent and therapeutic manner. Additionally, children, youth or young adults will benefit from staff ratio standards and the requirement that a clinical director or mental health professional be present at the PRTF during all awake hours, increasing clinicians' availability to respond to immediate treatment needs.

The final-form rulemaking also will impact parents, legal guardians or caregivers of children, youth or young adults receiving treatment in a PRTF because it establishes a standard

for family therapy and encourages the involvement of parents, legal guardians or caregivers in treatment and discharge planning.

The final-form rulemaking will affect local governments because they may pay for room and board for children, youth or young adults in a non-accredited RTF. Under this final-form rulemaking, all PRTFs will be required to be accredited, and local governments may experience cost savings with MA covering room and board costs for these accredited facilities.

Accomplishments and Benefits

The primary benefit of the final-form rulemaking is that it will ensure that all RTFs providing behavioral health treatment and new providers seeking to become PRTFs meet Federal minimum requirements in accordance with 42 CFR Part 441, Subpart D and 42 CFR Part 483, Subpart G (relating to inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs; and condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21). The final-form rulemaking benefits children, youth or young adults with severe behavioral health diagnoses receiving medically necessary services in a PRTF by implementing changes aimed at decreasing their length of stay. It requires trauma-informed principles and highlights active engagement of children, youth or young adults in their treatment and promotes planning for discharge to begin upon admission.

This final-form rulemaking also benefits children, youth or young adults receiving treatment in a PRTF by increasing staff ratios, which enables better supervision and greater access to clinical staff during awake hours. Requiring a PRTF staff member who meets the qualifications of a clinical director or mental health professional to be present at all times during awake hours will enhance the availability of clinicians to address immediate treatment needs and

create more opportunities for family therapy. This clinical oversight also allows families to discuss concerns about their child's, youth's or young adult's treatment. Additionally, having more clinical staff on-site provides support and guidance to direct care staff.

Children, youth or young adults will also benefit from this final-form rulemaking, which sets minimum standards for the frequency and duration of individual, group and family therapy to improve behavioral health treatment outcomes for children, youth and young adults receiving treatment in a PRTF. Additionally, by establishing minimum training standards and requiring staff training in trauma-informed care, child development and cultural competency, this final-form rulemaking ensures that staff are properly trained. The staff qualifications under this final-form rulemaking will also help guarantee that services are provided by qualified personnel, leading to services that effectively address the clinical needs of children, youth or young adults in a consistent and therapeutic manner.

This final-form rulemaking will also benefit children, youth or young adults and their parents, legal guardians or caregivers because it changes the requirements for admission to a secure PRTF. Specifically, it does not require that a child, youth or young adult be alleged delinquent or adjudicated delinquent to be admitted to a secure PRTF. Instead, admission will depend on the child's, youth's or young adult's medically recommended treatment needs and must be approved by the department. Additionally, this final-form rulemaking requires increased staff ratios for secure PRTFs, which will better ensure the health and safety of the children, youth and young adults receiving services in a secure PRTF, as well as the staff.

Finally, this final-form rulemaking benefits children, youth or young adults by promoting a trauma-informed approach to crises and significantly reducing the duration of time a manual restraint may be applied. It also better protects the health and safety of children, youth or young

adults receiving services in a PRTF by prohibiting seclusion, exclusion, prone, chemical and mechanical restraints.

This final-form rulemaking will benefit parents, legal guardians or caregivers of children, youth or young adults who receive treatment in a PRTF by setting a standard for family therapy, providing support during therapeutic leave and promoting the participation of parents, legal guardians or caregivers in treatment and discharge planning. It will also benefit PRTFs by allowing for a more streamlined and codified approach to licensing.

Fiscal Impact

For the purposes of determining a fiscal impact, the department's budgetary analysis assumes that all RTFs currently meet and do not exceed the minimum licensure requirements and the standards to be certified by the department to provide medically necessary behavioral health treatment. However, each RTF currently licensed and certified by the department has its own unique staffing, training and organizational structure. In addition, the department has learned through a current cost analysis that many RTFs contracted with behavioral health managed care organizations (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. It is anticipated that RTFs that currently participate in the MA program and who intend to seek licensure as a PRTF will seek higher payment rates through the submission of cost reports, which will include costs related to complying with the new requirements in the final-form rulemaking. The department recognizes the costs associated with the new requirements and is taking steps to ensure that fee-for-service rates appropriately reflect these increased requirements. Specifically, RTFs who elect to transition to a PRTF will submit a projected cost report that will contain an additional column for new, anticipated costs, prior to the provider

actually incurring the costs of compliance with the final-form rulemaking. After the department reviews the projected cost report that includes the new costs, the RTF will be sent a proposed adjusted rate to review. Once the adjusted rate is finalized, a new rate letter will be sent to the RTF. By the end of the 24-month implementation period, the department intends to have both the fee-for-service rates and capitation rates adjusted to account for the increased costs of RTF providers that elect to transition and are licensed as a PRTF. Throughout this process, the department will ensure that all capitation rate adjustments are actuarially sound as required by Federal requirements in accordance with 42 CFR 438.4 (relating to actuarial soundness)..

Implementation of the requirements of the final-form rulemaking will result in an estimated annual cost to the MA program of approximately $24,464,000 ($10,420,000 in State funds, which reflects the estimated aggregate costs for facilities to implement the final-form rulemaking (Room and Board Expenses - $7,464,000 (State funds $3,179,000); Staffing Requirements – $15,000,000 (State funds $6,389,000); Secure PRTF - $1,000,000 (State funds $426,000); and Transportation and Living Costs - $1,000,000 (State funds $426,000)).

Based on the expected timeline for implementing the final-form rulemaking, the cost for the first fiscal year will be 3/4 of the total annual cost incurred in subsequent years after the rulemaking is promulgated. The first-year costs are approximately $18,348,000 ($7,816,000 in State funds). These costs include MA payments for room and board for children, youth or young adults in previously non-accredited RTFs; payments for costs PRTFs incur to comply with new requirements in the final-form rulemaking; costs for increased staffing in secure PRTFs; transportation and living expenses for parents, legal guardians or caregivers when they visit the PRTF and the cost to the department to hire additional staff to oversee PRTF licensing. As a result of the aforementioned costs, MA rates for the RTFs under the scope of the final-form

rulemaking will be adjusted for all new requirements RTFs are expected to satisfy to transition to a PRTF under the final-form rulemaking. The department anticipates that the RTF rate increase will be sufficient to cover the new costs of the final-form rulemaking.

The final-form rulemaking requires accreditation to be licensed as a PRTF. Non-accredited RTFs certified by the department that seek to become PRTFs will incur the cost of becoming accredited. The cost to become accredited and maintain accreditation depends on the accreditation body chosen by the non-accredited RTF and the size of the provider. The average cost for initial accreditation, as well as the cost to maintain accreditation, can be up to $10,000. This cost is an estimate that includes annual upkeep costs and fees to be accredited and reaccredited thereafter. The department estimated $3,000 per year for a 3-year accreditation and $1,000 for the on-site review. Overall, the cost can vary based on the accreditation agency chosen by the PRTF. Annual costs for accreditation are an allowable cost for payment through the cost reporting process. It is anticipated that providers will seek higher payment rates through the submission of cost reports for expenses related to becoming accredited and maintaining accreditation.

Additionally, if a child, youth or young adult who is eligible for MA receives medically necessary behavioral health treatment in an accredited RTF certified by the department, MA currently covers the costs of the behavioral health treatment, as well as the room and board costs. However, if the child, youth or young adult receives treatment in a non-accredited RTF certified by the department, MA currently only pays for the medically necessary behavioral health treatment. Another funding source, such as local governments, pays the room and board expenses. Since all PRTFs will need to be accredited under the final-form rulemaking, it is expected that MA's payment for room and board for the six non-accredited RTFs, as of January

1, 2026, and which are expected to be licensed as PRTFs will cost the department approximately $7,464,000 ($3,179,000 in State funds) annually. This annual cost was calculated by estimating the room and board component at an average of $122.90 per day. This amount was then multiplied by 60,730 billed bed days, which is the average total billed bed days yearly for the current non-accredited RTFs certified by the department.

RTFs that decide to seek licensure as PRTFs may also have costs related to changes in staff qualifications, responsibilities, ratios and training. The specific cost for each RTF depends on its current treatment approaches, organizational structure, staff qualifications and supervision and training needs. Additionally, PRTFs might incur expenses for installing an automated external defibrillator (AED) on the property. If a PRTF does not already have an AED, the purchase price can range from $1,500 to $2,500, depending on the AED type. The department expects that most RTFs seeking to be licensed as PRTFs already have an AED on-site.

The final-form rulemaking updates the current staff requirements to help PRTFs better serve the behavioral health needs of children, youth or young adults with severe behavioral health diagnoses. While it keeps the structure of a director, child care worker and child care worker supervisor, the qualifications for these roles are revised in the final-form rulemaking. The qualifications for the program director position are less stringent than the current requirements under Chapter 3800. Specifically, the final-form rulemaking allows a program director with a master's degree to have 1 year less work experience and a program director with a bachelor's degree to have 2 years less work experience. The final-form rulemaking also allows an individual with an associate's degree and 3 years of work experience or a high school diploma or equivalent and 5 years of work experience to become a program director.

Based on the comments received, the education and experience requirements for a mental health worker supervisor are revised in the final-form rulemaking and are less strict than current requirements. Specifically, the final-form rulemaking allows individuals with a bachelor's degree to have 6 months less work experience. Additionally, individuals with an associate's degree need 2 years less experience. The final-form rulemaking also revises the qualifications for individuals with a high school diploma (or the equivalent) to become a mental health worker supervisor. Under the final-form rulemaking, individuals with a high school diploma (or the equivalent) and 2 years of work experience are qualified as mental health worker supervisors. It is important to note that under the final-form rulemaking, PRTFs are not required to establish a new position for a mental health worker supervisor. Similarly, the qualifications for a mental health worker are revised from the proposed rulemaking. The final-form rulemaking requires a mental health worker to have at least 12 credits in a behavioral health field or have a high school diploma (or equivalent) and at least 6 months of experience in a behavioral health or related field. The final-form rulemaking also permits a PRTF to provide this 6-month required experience for mental health workers.

The final-form rulemaking maintains the staff positions of medical director, treatment team leader, clinical director, mental health professional and registered nurse. The department acknowledges that these requirements are more stringent than the Federal requirements but determined that these required positions support the medically necessary behavioral health treatment needs of children, youth or young adults. A medical director may serve as both the treatment team leader and clinical director if they meet the requirements for each position. If an RTF needs to hire a medical director, treatment team leader, clinical director, mental health professional or registered nurse to comply with the final-form rulemaking, the approximate

average annual cost, including benefits for each position is as follows: $468,154 for a medical director or treatment team leader; $189,814 for a clinical director unless a physician assumes the role (which would increase the salary); $117,504 for a mental health professional, unless the individual is a licensed practitioner (which would increase the salary); and $154,988 for a registered nurse. Finally, the final-form rulemaking provides requirements for licensed practical nurses and advanced practice professionals, to the extent a facility chooses to utilize these professionals. If an RTF chooses to employ a licensed practical nurse, the average annual salary, including benefits, is approximately $106,471. An advanced practice professional may be licensed as a physician assistant or a certified registered nurse practitioner. Should an RTF opt to employ an advanced practice professional, the average annual salary, including benefits, is approximately $205,499.

During the stakeholder workgroup meetings, many RTF providers stated that their staff ratios exceed existing standards and meet the requirements in the final-form rulemaking. RTF providers not exceeding the minimum staff ratio requirements will incur costs under the final-form rulemaking. The final-form rulemaking requires at least one PRTF staff person for every six children, youth or young adults during awake hours, and at least one PRTF staff person for every 12 children, youth or young adults during sleeping hours. Although the department is maintaining the staff ratio requirements from the proposed rulemaking, the department has extended the time period for compliance for those existing facilities seeking licensure as a PRTF until 24 months after publication of the final-form rulemaking. As noted above, the department has also revised the qualifications for mental health workers under the final-form rulemaking in order to assist facilities in meeting these new ratios.

Using a 16-bed provider as an example, a PRTF provider not currently exceeding the minimum staffing requirements will need to hire two additional mental health workers. The average salary, including benefits, will be approximately $89,391 for each mental health worker. The total additional cost to the provider would be $178,782. It is anticipated that RTFs that participate in the MA program will seek higher payment rates through the submission and review of cost reports, which will include costs related to changes in staffing requirements identified above. This may result in an annual cost to the MA program of approximately $15,000,000 ($6,389,000 in State funds).

In the final-form rulemaking, the department revised the training provisions to require the initial and annual training for PRTF staff who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month. If a PRTF does not provide training on the new topics and lacks the resources to provide additional training, the estimated cost for training each PRTF staff member would be approximately $1,857.50 a year. This estimate considers the cost of training PRTF staff on the new topics and assumes 35% staff turnover.

The final-form rulemaking also includes requirements for secure PRTFs. There are currently no secure PRTFs in the Commonwealth. Any MA-enrolled provider seeking to operate a secure PRTF will incur costs to meet the staffing requirements. The staff ratio requirements for secure PRTFs are more stringent than those for non-secure PRTFs. The final-form rulemaking requires that secure PRTFs have one mental health worker for every four children, youth or young adults during awake hours and one mental health worker for every eight children, youth or young adults during sleeping hours. Existing RTFs that choose to transition to secure PRTFs and do not employ staff above current requirements will need to hire additional mental

health workers. For example, a 16-bed provider not currently exceeding minimum staffing requirements will need to add three mental health workers. The average salary, including benefits, is approximately $89,391 for each mental health worker. The total additional cost to the provider would be about $268,173. A PRTF may seek higher MA payment rates through a review of the cost reports for increased costs to meet the staff-ratio requirements for a secure PRTF. The department assumes that four facilities not currently providing an RTF level of care may develop secure PRTFs, resulting in an annual cost to the MA program of approximately $1,000,000 ($426,000 in State funds).

Based on comments received, the department revised the allowable cost provision in the final-form rulemaking. Specifically, transportation and living costs associated with onsite visits by parents, legal guardians or caregivers are added as allowable expenses under the final-form rulemaking. This will result in an annual cost to the MA program of approximately $1,000,000 ($426,000 in State funds).

The final-form rulemaking maintains the proposed paperwork requirements, which are explained below. If an RTF does not currently meet the requirements of the final-form rulemaking, the one-time cost for the RTF to prepare the documents will be about $5,760. The cost is calculated based on an average hourly rate of $72.00 for a program director who needs approximately 80 hours to develop the documents. Regarding quality assurance plans, RTFs accredited by organizations such as TJC, CARF or COA are presently required by these entities to develop quality improvement plans. Considering the common practice of conducting quality assurance activities, the additional costs to the MA program for this requirement are expected to be minimal. As noted earlier, it is anticipated that a PRTF that participates in the MA program

will seek higher payment rates through the submission of cost reports for any new costs incurred to comply with the final-form rulemaking.

The department believes that implementing the requirements in the final-form rulemaking may lead to better outcomes, shorter stays at PRTFs and reduced use of higher-cost care options like hospitalizations. In addition, there may be an annual decrease in costs to local governments of approximately $7,464,000 as a result of the final-form rulemaking because they will no longer be paying for the cost of room and board for children, youth or young adults being served in nonaccredited RTFs certified by the department.

Paperwork Requirements

While Chapter 5330 retains most of the existing paperwork standards for RTFs that are licensed and certified by the Department, it also introduces new documentation requirements. The final-form rulemaking requires 20 new written policies and procedures on the following topics:

- Identification and reporting of abuse and plan of supervision for staff implicated in abuse.
- Reporting, investigating and management of reportable incidents.
- Reporting, investigating and management of recordable incidents.
- Management and disbursement of a child's, youth's or young adult's funds.
- Protecting the confidentiality and privacy of children’s, youth’s or young adults’ information.
- Therapeutic leave with legal guardians, parents or caregivers.
- Rights of children, youth or young adults and their parents, legal guardians or caregivers.
- Grievances.

- Searches of a child, youth or young adult or the child's, youth's or young adult's personal property.
- Supervision of PRTF staff.
- Monitoring of initial and annual staff training.
- Ensuring that PRTF staff that have contact with children, youth or young adults comply with mandated reporting and training requirements.
- Use of hazardous equipment.
- Fire safety monitoring if a smoke detector, fire alarm or carbon monoxide detector becomes inoperative.
- Use of drugs, alcohol, tobacco and e-cigarettes.
- Use of a level system.
- Handling of discontinued and expired medication.
- Use of manual restraints.
- Debriefing after a manual restraint.

In addition, this final-form rulemaking will require PRTFs to enter into written agreements to coordinate services with other behavioral health service providers and to have a utilization review and clinical audit process designed to ensure the most appropriate treatment is provided to children, youth or young adults receiving PRTF services.

Chapter 1330 will not result in additional paperwork for MA providers of PRTF services. This final-form rulemaking will also not require children, youth or young adults who receive treatment in a PRTF or their parents, legal guardians or caregivers to complete additional reporting, recordkeeping or other paperwork requirements.

Public Comment

While drafting the proposed and final-form rulemaking, the department updated the Mental Health Planning Council Children's Committee. The Committee advises the department on issues related to mental health, substance abuse, behavioral health disorders and cross-system disability. The department also collaborated with a stakeholder workgroup to develop the proposed rulemaking. This workgroup included family members of children, youth or young adults who received RTF services and family advocates and representatives from the following: RTF providers currently certified and licensed by the department; the Mental Health Association of Pennsylvania; Rehabilitation and Community Providers Association (RCPA); Pennsylvania Council of Children, Youth & Family Services (PCCYFS); Disability Rights of Pennsylvania; National Partnership for Juvenile Services; BH-MCOs; and county mental health departments.

The department held informational webinars before the public comment period for the proposed rulemaking. The purpose of the webinars was to inform stakeholders about the sections of the proposed rulemaking the department expected would receive the most feedback. The department conducted a webinar with stakeholders on July 23, 2024, and with BH-MCOs, primary contractors and county mental health representatives on July 25, 2024.

When the proposed rulemaking was published, the department shared a copy with stakeholders, including youth and young adults and their family members, advocates and the Mental Health Planning Council Children's Committee. Family members and family advocates orally supported the proposed rulemaking.

While drafting the final-form rulemaking, the department met with a transition-age youth and young adult subcommittee of the Mental Health Planning Council on April 8, 2025, and April 22, 2025. The subcommittee members supported the changes the department was

considering in the final-form rulemaking related to restrictive procedures and treatment requirements. The department also collaborated with PCCYFS and RCPA for an informational meeting on May 21, 2025. The meeting highlighted sections of the proposed rulemaking that received the highest number of comments during the public comment period. Approximately 216 stakeholders attended the meeting either in person or virtually. The department appreciated the opportunity to further engage with stakeholders to gather additional feedback and recommendations for the final-form rulemaking. The stakeholders included representatives from the following: RTF providers currently certified and licensed by the department, provider organizations, an executive director of the Pennsylvania Senate Health and Human Services Committee, a staff member of the Pennsylvania House Children and Youth Committee, the Pennsylvania Psychiatric Society, BH-MCOs, primary contractors, county mental health representatives and other behavioral health providers. Following the informational meeting, RCPA was updated on the final-form rulemaking on June 5, 2025, July 9, 2025, and July 16, 2025. PCCYFS was updated on June 24, 2025, July 15, 2025, and August 29, 2025.

The department kept interested parties and organizations informed throughout the drafting of this final-form rulemaking to ensure transparency. The Juvenile Court Judges Commission received an update on the final-form rulemaking on July 9, 2025. The County Commissioners Association of Pennsylvania received updates on January 15, 2025, July 16, 2025, and August 8, 2025. The Mental Health Subcommittee of the Judges State Round Table was updated on January 14, 2025, February 13, 2025, March 21, 2025, April 17, 2025, May 15, 2025, and August 18, 2025. The Montgomery County Association for Excellence was updated on January 30, 2025. The department also informed the Federal Centers for Medicare & Medicaid Services (CMS) on April 9, 2025, regarding the alignment with Federal requirements.

CMS provided positive feedback to the department. The organizations appreciated the updates provided by the department.

Written comments, suggestions and objections regarding the proposed rulemaking were requested within 30 days of publication in the *Pennsylvania Bulletin*. The Department received 35 written responses. These comments reflected feedback from a variety of stakeholders, including BH-MCOs, RTF providers, RCPA, PCCYFS, the County Commissioners Association of Pennsylvania, county representatives and transition-aged youth and young adults. Additionally, comments were received from the Independent Regulatory Review Commission (IRRC) and joint comments from Representative Doyle Heffley and Representative Perry Warren.

Discussion of Comments and Changes

Since the public comment period for the proposed rulemaking ended on December 2, 2024, the department has thoroughly reviewed feedback from 35 written responses. Comments were received from BH-MCOs, RCPA, PCCYFS, the County Commissioners Association of Pennsylvania (CCAP), county representatives, transition-aged youth and young adults, and current RTF providers. Of the 26 RTF providers within the scope of the final-form rulemaking, the Department received feedback from 13 RTF providers. Lastly, the department received written comments from IRRC and joint comments from Representatives Doyle Heffley and Perry Warren.

The department appreciated all the comments received and the many suggestions submitted. While analyzing the comments, the department gave particular attention to the sections of the proposed rulemaking that received the most significant comments. These areas

pertained to treatment services, reportable and recordable incidents, PRTF staff duties, transportation and staff training.

In the final-form rulemaking, the department made modifications to each of these areas while ensuring the medically necessary behavioral health treatment provided to children, youth or young adults was not compromised. Many concerns were raised that the proposed frequency of treatment services would create a burden on PRTFs and that they should be able to determine the frequency of treatment services based on age, diagnoses or cognitive ability. It is important to note that the children, youth or young adults receiving services in a PRTF cannot be appropriately treated at a less intensive level of care. They require 24-hour availability of residential services for diagnosis, continuous monitoring and ongoing assessment of their response to treatment. While the department appreciates the challenges providers are experiencing related to staffing, it is imperative that the children, youth or young adults in a high acuity PRTF setting have access to frequent and regular treatment services for their severe behavioral health diagnoses. Recognizing that a PRTF is a medically necessary intensive residential treatment setting, the department determined that it is appropriate to establish a minimum treatment standard but revised the minimum treatment services from weekly to monthly in the final-form rulemaking. The department also changed the requirement in the final-form rulemaking regarding psychoeducation groups, allowing the child's, youth's or young adult's treatment team to determine the frequency of these groups.

Throughout the development of the final-form rulemaking, the department has met with stakeholders and has carefully considered the balance between the new requirements on PRTFs and the behavioral health treatment needs of the children, youth and young adults in these high acuity settings. Accordingly, the department has made significant changes to the final-form

rulemaking in response to these concerns, notably in staffing, body searches, reportable and recordable incidents, transportation, elopement and training requirements, while maintaining the high level of care needed for the children, youth or young adults being recommended for medically necessary behavioral-health treatment in a PRTF. As noted previously in the Fiscal Impact discussion, the department modified the training requirements so that only PRTF staff who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month must meet the initial and annual training requirements. Furthermore, in balancing staffing concerns, the department has revised the minimum qualifications for mental health workers and for RNs and LPNs. Under the final-form rulemaking, the department removed the need to have 1 year of experience for RNs and LPNs and requires an RN or an LPN to be on grounds of the PRTF only during designated awake hours and being either on grounds or on call during designated sleep hours. The department also removed the requirement for both a driver and PRTF staff to be present for every transport, as well as the prohibition on counting the driver in the staff ratio requirement. The department also revised the 1 to 3 ratio for transportation; under the final-form rulemaking, the staff ratio for transportation was revised to a 1 to 6 ratio. In addition, the department also revised the requirement related to staff age. Under the final-form rulemaking, the minimum staff age was reduced from 21 years of age to 18 years of age but balanced with the requirement that staff be 21 years of age for purposes of staff ratios. Finally, the department extended the time period for compliance for those existing facilities that may decide to seek licensure as a PRTF. Under the final-form rulemaking, existing facilities that choose to seek licensure as a PRTF will have 24 months from the publication of the final-form rulemaking to come into compliance with the new requirements.

From the outset of developing the proposed rulemaking, RTF providers have raised concerns that the per diem rate they currently receive is not sufficient to meet the requirements. However, the department has learned that many of the RTFs contracted with BH-MCOs already receive a per diem rate that meets or exceeds the projected per diem rate for full implementation of the requirements under the new Chapter 5330. Further, when both fee-for-service rates and managed care capitation rates are considered, 18 out of 23 provider entities that submitted cost reports in SFY 2024-25 (78%) are paid more than their current reported costs. Nevertheless, the department recognizes the costs associated with the new requirements and, as noted previously in the Fiscal Impact discussion, is taking steps to ensure that fee-for-service rates appropriately reflect these increased requirements. In addition, Medicaid capitation rates are required to be actuarially sound, ensuring that managed care plans are positioned to cover all appropriate costs.

The final-form rulemaking importantly provides a pathway for the Commonwealth to comply with Federal requirements, while requiring children, youth or young adults to be better supported by trained professionals who have the knowledge, skills and abilities to meet their behavioral health needs and for children, youth or young adults to receive trauma-informed services.

The following is a summary of the comments received within the public comment period following the publication of the proposed rulemaking, the department's responses to these comments and a summary of additional changes to the final-form rulemaking.

Chapter 1330. Psychiatric Residential Treatment Facility – MA Payment

General – Payment

Comment

Several commentators raised concerns that the current payment rates for RTF providers delivering behavioral health treatment might be too low to meet the new demands outlined in the proposed rulemaking. Many of these commentators emphasized the need to increase payment rates. Additional issues highlighted include that the projected staff costs do not align with current market trends, that the proposed rulemaking included requirements that are not reimbursable and concern whether capitation rates for BH-MCOs will increase enough and precede provider rate increases.

Representatives Doyle Heffley and Perry Warren stated that any extra financial burden on RTF providers to comply with the final-form rulemaking should be supported by evidence showing that the requirement to be implemented improves the quality and delivery of behavioral health services. Additionally, the Representatives expressed concerns about the availability of additional funding to help RTF providers comply with the final-form rulemaking.

Additional comments were received from IRRC. IRRC highlighted the comments the department received and emphasized the need for and fiscal impact of specific staffing provisions to assess whether the regulation serves the public interest. IRRC suggested that the department needs to provide more details about the fiscal impact to determine if the regulation is in the public interest. IRRC also requested that the department includes information supporting the expectation that payment rates for RTF providers will be adjusted to reflect the increased PRTF costs.

Response

The department recognizes the concerns raised by commentators, the Representatives and IRRC about the current per diem rates. Under the final-form rulemaking, PRTFs are required to submit a cost report to the department to evaluate whether adjustments to the MA per diem rates are needed. It is anticipated that RTFs that currently participate in the MA program and who intend to seek licensure as a PRTF will seek higher payment rates through the submission of these cost reports. It should be noted that facilities are not required to seek licensure as a PRTF and may continue to be licensed as an RTF. PRTFs are a high acuity residential setting that will provide medically necessary behavioral health programs for children, youth and young adults with severe behavioral health diagnoses. In balancing concerns of providers against the needs of the children, youth and young adults receiving services, the department has revised many staff qualification and training concerns in the final-form rulemaking. As noted previously under the Fiscal Impact discussion, the department modified the training requirements so that only PRTF staff who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month must meet the initial and annual training requirements. Furthermore, in balancing staffing concerns, the department has revised the minimum qualifications for mental health workers and for RNs and LPNs. Under the final-form rulemaking, the department removed the need to have 1 year of experience for RNs and LPNs and requires an RN or an LPN to be on grounds of the PRTF only during designated awake hours and being either on grounds or on call during designated sleep hours. The department also removed the requirement for both a driver and PRTF staff to be present for every transport, as well as the prohibition on counting the driver in the staff ratio requirement. The department also revised the 1 to 3 ratio for transportation; under the final-form rulemaking, the staff ratio for

transportation was revised to the general 1 to 6 ratio during awake hours. In addition, the department also revised the requirement related to staff age. Under the final-form rulemaking, the minimum staff age was reduced from 21 years of age to 18 years of age as requested by providers but balanced with the requirement that staff be 21 years of age for purposes of staff ratios. Finally, as requested by providers, the department has provided an extended runway of 24 months for existing providers that intend to seek licensure as a PRTF to come into compliance with the final-form rulemaking.

To balance these reductions, the final-form rulemaking still maintains the minimum staff ratio of one staff member for every six children, youth or young adults during awake hours and one staff member for every 12 children, youth or young adults during sleeping hours. These ratios protect public health, safety and welfare and were established based on input from the stakeholder workgroup, the served population, and comparisons to neighboring states. The department recognizes that many of the RTFs subject to the final-form rulemaking currently surpass these existing staffing standards. In comparison, West Virginia has stricter staffing ratios than those in the final-form rulemaking, requiring one staff member for every three children, youth or young adults during awake hours and one for every six children, youth or young adults during sleeping hours. Additionally, New York has a more rigorous staffing ratio requirement during awake hours, with one staff member required per every five children, youth or young adults, and a less strict standard during sleeping hours, requiring one staff member per every 14 children, youth or young adults. Ohio's requirements are also stricter than those in the final-form rulemaking in that Ohio requires a staff ratio of one staff member for every three children, youth or young adults during awake hours. The ratio is even stricter if the Ohio PRTF serves children, youth or young adults with intellectual disabilities, as that ratio is one staff member for every

two children, youth or young adults during awake hours. Ohio does not have staff-ratio requirements during sleeping hours. Maryland, New Jersey and Virginia do not specify minimum staffing ratios during awake and sleeping hours.

The department has learned that many of the RTFs contracted with BH-MCOs already receive a per diem rate that meets or exceeds the projected per diem rate for full implementation of the requirements under the new Chapter 5330. Further, when both fee-for-service rates and managed care capitation rates are considered, 18 out of 23 provider entities that submitted cost reports in SFY 2024-25 (78%) are paid more than their current reported costs. Nevertheless, the Department recognizes the costs associated with new requirements and is taking steps to ensure that fee-for-service rates appropriately reflect these realities. Medicaid capitation rates are required to be actuarially sound, ensuring that managed care plans are positioned to cover all appropriate costs. Furthermore, the projected staff costs for PRTFs included in the final-form rulemaking are based on updated data from the Bureau of Labor Statistics.

The fee-for-service rates and the capitation rate adjustments will be coordinated to occur at the same time. Upon promulgation of the final-form rulemaking, the department will utilize cost reports on file with the department and projected cost reports in accordance with § 1330.39(a) (relating to annual cost reporting and independent audit) to adjust capitation rates during the annual capitation determination to account for increased costs of all RTF providers that elect to transition to a PRTF. Those increased costs will be incorporated into the annual capitation rates. In accordance with § 1330.39(a), RTFs who elect to transition to a PRTF will submit a projected cost report that will contain an additional column for new, anticipated costs, prior to the provider actually incurring the costs of compliance with the final-form rulemaking. After the department reviews the projected cost report that includes new costs the RTF will be

sent a proposed adjusted rate to review. Once the adjusted rate is finalized, a new rate letter will be sent to the RTF. By the end of the 24-month implementation period, the department intends to have both the fee-for-service rates and capitation rates adjusted to account for the increased costs of RTFs that elect to transition and are licensed as a PRTF. Throughout this process, the department will ensure that all capitation rate adjustments are actuarially sound as required by CMS Federal requirements.

§ 1330.2 Definitions

Comment

Several commentators and IRRC requested clarification on the definitions of "elopement" and "visit." Regarding the definition of "elopement," commentators and IRRC asked whether there is a specific amount of time a child, youth or young adult must be off the premises to be considered to have eloped.

Response

The department agrees with the commentators that further clarification of the current definition of "elopement" is needed. Under the final-form rulemaking, the definition was changed to "when a child, youth or young adult leaves the premises of a PRTF or a location for 1 hour or more without PRTF staff approval."

Comment

Several commentators and IRRC also sought clarity on whether the definition of "visit" includes situations where a child, youth or young adult is not supervised by PRTF staff but remains on the PRTF's grounds.

Response

The department also agreed that the definition of "visit" needed to be further clarified in the final-form rulemaking. Thus, the term "visit" was removed from the final-form rulemaking and replaced with the term "therapeutic leave." Therapeutic leave is defined in the final-form rulemaking and does not include instances where a child, youth or young adult is on the grounds of the PRTF but not under the supervision of PRTF staff. Specifically, "therapeutic leave" is defined as "a period during which a child, youth or young adult is absent from the premises of a PRTF without supervision of PRTF staff that is directly related to the child's, youth's or young adult's treatment plan."

Additional Revisions

In addition, the department added the term "licensed" to the definition of "PRTF" to provide greater clarity. The department also revised the definition of "treatment team" for clarity. Under the final-form rulemaking, "treatment team" is defined as "the PRTF staff directly involved in the child's, youth's or young adult's treatment and who are led by a treatment team leader. The treatment team also includes the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver and may include individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver" The department also modified the definition of "staff" to provide clarity to the definition and to be consistent with the definition of staff in § 5330.3 (related to definitions). The definition was changed to "individuals employed or contracted by a PRTF on a full-time or part-time basis who are responsible for care, treatment or supervision of children, youth or young adults receiving care in the PRTF. The term includes temporary staff, volunteers and interns."

Lastly, the department also added a definition for an interagency service planning team (ISPT) because ISPT meetings are required as a condition of payment by MA. Under the final-form rulemaking, an ISPT is "a group who meets to plan and coordinate services for the child, youth or young adult with behavioral health needs."

§ 1330.11 Scope of Benefits

Comment

Two commentators asked for clarification on whether the proposed rulemaking would be applicable to all types of funders.

Response

Chapter 1330 (the payment chapter) applies only to MA payments. Chapter 5330 (a licensing chapter) applies to all facilities that seek to become licensed as a PRTF, regardless of funding source.

§ 1330.21 Participation Requirements of a PRTF

Comment

Several commentators raised concerns about the need to comply with 42 CFR 482.60 (relating to special provisions applying to psychiatric hospitals). They stated that it would be difficult to recruit and retain staff to meet the requirements of this regulation.

Response

Upon further review, the department determined 42 CFR 482.60 does not apply to PRTFs and has removed the citation and revised the numbering accordingly.

§ 1330.23 Change of Ownership

The department changed the term "ownership to "owner" in subsection (b) of § 1330.23 (relating to change of ownership) to provide more clarity to the requirement.

§ 1330.31 General Payment

Comment

IRRC and three commentators expressed concern about the reasonableness of complying with the proposed rulemaking within 12 months. Specific concerns raised were that much of the providers' ability to comply with the proposed rule hinges on adequate rates being paid to the providers, and the timeframe for compliance is not sufficient given the size of some providers. Another commentator asserted that its rates will not support implementation of the higher care standards under the regulations and encouraged the department to build in enough funding. IRRC requested the department reconsider this timetable or explain why it is reasonable.

Response

After careful consideration and meeting with stakeholders, the department agreed to reconsider this requirement and reduce the administrative burden by extending the timeframe for complying with the final-form rulemaking from 12 months to 24 months under subsection (b) to allow current RTFs who seek licensure as a PRTF additional time to come into compliance with the final-form rulemaking. The department anticipates that RTFs participating in the MA program will seek higher payment rates through the submission of cost reports, which will include costs related to complying with the new requirements in the final-form rulemaking. Although the department has learned that many of the RTFs contracted with BH-MCOs already receive a per diem rate that meets or exceeds the projected per diem rate for full implementation of the requirements of the final-form rulemaking, the department also recognizes the costs associated with new requirements and is taking steps to ensure that fee-for-service rates appropriately reflect these costs. In addition, Medicaid capitation rates are required to be actuarially sound, ensuring that managed care plans are positioned to cover all appropriate costs.

By the end of the 24-month implementation period, the department intends to have both the fee-for-service rates and capitation rates adjusted to account for the increased costs for RTFs that elect to transition and are licensed as a PRTF.

§ 1330.32 Conditions for Payment

The department added to the requirement that the psychiatric evaluation specified in § 1330.32(a)(1) must be completed "no more than 30 days from the child's, youth's or young adult's admission to the PRTF." This language was added to provide consistency across payors. In addition, this is also necessary to ensure that a child, youth or young adult is served in a PRTF only when it's medically necessary by relying on a current evaluation to avoid unnecessary admissions based on outdated clinical information. The department also added "an ISPT meeting was held no more than 30 days from a child's, youth's or young adult's admission or reauthorization for continued stay in the PRTF" to paragraph (a)(2). This was added to be consistent with current practice for MA authorization and reauthorization of RTF services. The department also added that "the ISPT shall be comprised of the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver, service providers, county representatives and may be comprised of other individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver" to paragraph (a)(2) to clarify group membership and provide the opportunity for the child, youth, or young adult to identify other participants.

For clarity, the department added the citation to the applicable Federal requirement under 42 CFR 441.153 (relating to team certifying need for services) to paragraph (a)(3). The department also added the language "at least" to subsection (b) of this section to add clarity the

30-day requirement is a minimum. The department also corrected the cross-reference to paragraph (a)(4) because it was renumbered as (a)(5) in the final-form rulemaking.

The department added requirements specifically for payment for secure PRTFs in subsection (c) because the department realized that the annex in the proposed rulemaking did not include payment conditions specific to secure PRTFs. Under subsection (c), a secure PRTF has to meet the requirements of subsections (a) and (b) (consistent with the requirements for a nonsecure PRTF) and also have the admission of a child, youth or young adult approved by the department prior to admission to the secure PRTF, which is consistent with preamble of the proposed rulemaking.

§ 1330.33 Limitations on Payment

Comment

Four commentators recommended recalculating the limit of 15 hospital-reserved bed days for each PRTF admission within the same calendar year.

Response

The department supports increasing the 15-day limit on hospital-reserved bed days from 15 days within the same calendar year to 15 days for each hospitalization and has revised § 1330.33(a)(2) accordingly.

Comment

One commentator inquired whether hospital-reserved bed day holds can be utilized for overnight stays in an emergency room.

Response

The department will allow payment for a hospital reserve bed day for children, youth or young adults' hospitalization for a continuous 24-hour period, regardless of whether the child,

youth, or young adult was admitted to an inpatient unit or if the child was in an emergency department for a continuous 24-hour period.

Comment

Three commentators requested clarification on payment for visits in the final-form rulemaking because CMS already limits payment for visits.

Response

The department modified the requirement in subsection (c) by replacing the term "visit" with "therapeutic leave" and clarified how a therapeutic leave day will be calculated in subsection (d). Specifically, subsection (c) of the final-form rulemaking provides that MA will pay for up to 48 days per calendar year if a child, youth or young adult is absent from a PRTF because of therapeutic leave, which aligns with current practice specified in Medical Assistance Bulletin 01-95-13 *Update- JCAHO-Accredited RTF Services*. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/d_004811.pdf.

Under subsection (d), a therapeutic leave day is calculated as: a continuous absence from a PRTF for at least 12 hours to 24 hours is one therapeutic leave day; and a continuous absence for each additional 24-hour period will be an additional therapeutic leave day. Lastly, the department revised the structure of subsection (d) (renumbered as subsection (e)) regarding absences and payment for additional clarity. The department also modified the requirement in subsection (b) from "MA will pay for up to 2 days of elopement from a PRTF per calendar year for each child, youth or young adult" to "MA will pay for up to 2 days per calendar year if a child, youth or young adult is absent from a PRTF because of an elopement." The department made this change to clarify the requirements of this subsection.

Comment

One commentator informed the department that Federal regulations already set limitations for payment and recommended using the Federal regulations.

Response

In response to comments received, the department reviewed Federal regulations related to payment limitations specified in 42 CFR 447.40 (relating to payments for reserving beds in institutions) and found that the regulations defer to individual states to set their own payment limits. As such, the department may not rely on Federal regulations to set these limitations.

Comment

Another commentator questioned whether PRTFs would only need to hold placement for 2 days after an elopement and if the PRTF may discharge the child, youth or young adult after 2 days.

Response

The final-form rulemaking does not prevent a PRTF from discharging a child, youth or young adult after the 2-day payment limit for elopement has passed.

§ 1330.34 Allowable Costs

Comment

One commentator suggested that the department consider requesting an amendment or waiver to Pennsylvania's state plan to cover the necessary costs deemed nonallowable.

Response

Pennsylvania's state plan does not address allowable and non-allowable costs. As such, a state plan amendment is not needed.

Additional Revisions

While reviewing the requirements of this section, the department determined that more clarity was needed in explaining how costs are deemed allowable, which is specified in subsections (a) and (b). Specifically, under subsection (a), the department will use Federal Medicaid principles established by Subchapter XIX of Chapter 7 of the Social Security Act (42 U.S.C. §§ 1396 – 1396w-9) (relating to grants to states for medical assistance payments), and the accompanying regulations, policies and instructions to determine allowable costs for purposes of payment. Under subsection (b), the department will also use Federal Medicare principles established by Subchapter XVIII of Chapter 7 of the Social Security Act (42 U.S.C. §§ 1395 – 1395mmm) (relating to health insurance for aged and disabled), and the accompanying regulations, policies and instructions when the department determines that subsection (a) does not address the allowability of a specific cost item.

§ 1330.37 Related-Party Transactions

Comment

Three commentators recommended that the department consider allowing PRTFs to report related-party transactions either by direct expense or through management fees.

Response

The department agrees that PRTFs should be allowed to include in their cost report an amount for related-party transactions, whether it is a direct expense or management fee so long as the cost to the supplying organization is included and does not exceed the market price. The requirements in this section support the reporting by direct expense or through management fees, so no change is needed in the final-form rulemaking.

§ 1330.38 Nonallowable Costs

Comment

Eight commentators informed the department that costs such as clothing, hygiene and barber services are important and necessary as part of holistic care for children, youth or young adults, and should be allowable costs. IRRC noted that commentators stated that barber and beautician services are essential for self-care for children, youth and young adults and should not be an unfunded mandate. IRRC pointed out that commentators are worried they will have to cover the cost of clothing without reimbursement when parents, legal guardians or caregivers cannot provide adequate clothing. IRRC requested the department explain the reasonableness and the fiscal impact of this provision.

Response

Based on comments received, the department has removed barber, beautician services and personal hygiene items as nonallowable costs under § 1330.38(a)(xvi) and (xxii) of the final-form rulemaking. Consistent with 42 U.S.C. § 1395y(a)(1)(A), the department may not remove the requirement that clothing is a nonallowable cost because clothing in the context of a PRTF is not a medically necessary garment. As revised, this subsection balances compliance with Federal requirements and the requested allowances for inclusion of certain costs.

Comment

Seven commentators advised the department that disallowing costs for gas and hotel stays for parents, legal guardians or caregivers when they visit will make it more difficult to strengthen family engagement. Three commentators highlighted how they host family engagement events at the PRTF a few times each year and the requirements in this section will make it challenging to continue these practices.

Response

The department also recognizes the importance of family engagement and has removed transportation and living costs in § 1330.38(a)(9)(xxiv) associated with onsite visits by parents, legal guardians or caregivers as nonallowable costs under the final-form rulemaking.

Comment

One commentator suggested increasing the administrative costs specified in subsection (a)(2) as nonallowable from more than 13% of allowable MA costs to 15% of allowable MA costs. IRRC reiterated concerns raised by commentators about PRTFs having to cover additional administrative costs that the department will not reimburse.

Response

The department appreciates the comment but chose not to increase administrative costs to 15% in subsection (a)(2) because the standard of 13% maintains current practice.

Comment

Four commentators expressed concerns about complying with the requirement in subsection (a)(7), related to service costs when payment is available from other sources. IRRC also expressed that commentators were concerned about the separation of program expenses by payor, which creates an administrative burden on PRTFs and requested the department explain the reasonableness and fiscal impact of this provision.

Response

The department acknowledges the administrative work by excluding costs from the MA per diem rate if payments is available from another source under subsection (a)(7); however, the department must maintain this requirement because billing liable third parties before MA is required for all services and complies with Federal requirements specified in 42 CFR Part 433,

Subpart D (relating to third party liability). As such, this provision is reasonable and must be maintained.

Comment

Two commentators asked the department to consider removing staff gifts, awards and social functions from the list of non-allowable costs, asserting that these incentives are necessary for staff recruitment and retention.

Response

The department does not agree that staff gifts, awards or dinners and staff social functions, such as picnics and athletic teams, should be removed as nonallowable costs as these expenses are not directly related to the provision of medically necessary behavioral health services to children, youth or young adults. However, the department modified the requirement in subparagraph (xx) (renumbered as (xix)) from "meals for staff, except for meals provided during training activities documented in a child's, youth's or young adult's treatment plan" to "meals for staff, except for meals provided while caring for a child, youth, or young adult." The department made this change because staff often share meals with a child, youth or young adult, which aids in establishing and maintaining a positive rapport.

Comment

Three commentators noted that in rural areas there may be few or no health care services identified in subsection (b)(1) that contract with some private insurances, which may create barriers to scheduling appointments within timeframe specified in §§ 5330.115, 5330.116 and 5330.117 (related to dental care, vision care and hearing care) The commentators asked that the department consider reimbursing providers who must pay out of pocket for the required health care services.

Response

Private insurance coordination with MA occurs across all behavioral health services, which will include PRTFs. Children, youth or young adults with behavioral health diagnoses are typically eligible for MA. In the event a child, youth or young adult is not already enrolled in MA, PRTFs should begin this process to ensure a secondary payment source is available. MA will not pay a PRTF for out-of-pocket health care services that can be separately billed to MA by the provider who delivered those health care services. If a PRTF is unable to locate a provider willing to accept the child's, youth's, or young adult's MA coverage, they should coordinate with the BH-MCO to identify a provider of the needed health care service.

Comment

Commentators assert that youth enrolled in regular education may not be funded for some education services and that staff support is not necessarily billed to the home school district. Commentators inquired if school districts will be required to reimburse PRTFs when homebound or onsite instruction requires support from PRTF staff. IRRC also inquired regarding nonallowable education costs and how the department plans to collaborate with school districts regarding this provision. IRRC also asked the department to explain the reasonableness and fiscal impact of nonallowable costs.

Response

This provision excludes education costs which are the responsibility of the school district. Under the MA program, MA funds are not permitted to be used to pay PRTFs for educational costs in accordance with 42 CFR 441.13(b) (relating to prohibitions on FFP: Institutionalized individuals). Furthermore, in accordance with section 2l04.5 (relating to vocational and scholastic training expense) of Chapter 21 of the Provider Reimbursement Manual, the costs

attributable to vocational, scholastic, or similarly oriented training activities conducted by providers on behalf of patients are not allowable costs. For example, costs incurred by a psychiatric facility in operating an elementary or secondary school for patients are unallowable costs. This is specified in https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/p151_21.zip.

While a PRTF may not include education costs in their cost report, for a child, youth or young adult doing homebound school or cyber charter school at the PRTF, they could include the cost of PRTF staff needed to provide medically necessary active treatment services while the child, youth or young adult is participating in that educational service as included in the child, youth, or young adult's treatment plan. Additionally, Federal law obligates schools to provide free appropriate public education (FAPE) to children, youth or young adults under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §§ 1400 -1491o), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794 (relating to nondiscrimination under Federal grants and programs)), and 34 CFR 300.101 (relating to free appropriate public education). MA, which is always the payor of last resort, may not supplant other mandated payors. Under State law, generally when a child, youth or young adult is in a PRTF, the school district in which the PRTF setting is located is responsible for providing educational services, including special education services, in accordance with section 1306 of the Public School Code of 1949 (24 P.S. § 13-1306) (relating to non-resident inmates of children's institutions).

To further clarify this language, the department removed the "to be paid for by" language under paragraph (a)(5) and replaced it with language that clarifies that education costs associated with a child's, youth's or young adult's individual educational plan, individual family service

plan or treatment plan are the responsibility of the child's, youth's or young adult's school district.

Comment

IRRC questioned why expenses related to fundraising are considered unallowable when funds raised through fundraising are counted toward allowable costs. Specifically, IRRC asked the department to clarify the treatment of fundraising efforts between §§ 1330.35(7) and 1330.38(a)(9)(vi).

Response

The department determined that amounts raised through fundraising shall be utilized to offset allowable costs only if they are restricted for that purpose of paying for allowable costs. Unrestricted amounts raised through fundraising may not be utilized to offset permissible costs. Furthermore, the department may not remove fundraising as a nonallowable cost under subsection (a)(9)(vi), because its prohibition as an allowable cost is consistent with Federal requirements specified in 2 CFR 200.442 (relating to fundraising and investment management costs).

Additional Revision

Upon further review, the department clarified the requirement regarding marketing because some marketing costs are permissible in accordance with § 1330.34 (relating to allowable costs). Specifically, the term "marketing" was removed from subparagraph (a)(9)(vi) as a nonallowable cost and is captured under subparagraph (a)(9)(i) because the terms "advertising" and "marketing" are synonymous.

§ 1330.39 Annual Cost Reporting and Independent Audit

Comment

One commentator urged the department to work with RTF providers and BH-MCOs before the requirements of the final-form rulemaking take effect.

Response

As noted previously, the department has remained engaged with RTF providers and BH-MCOs throughout the development of the final-form rulemaking. The department collaborated with PCCYFS and RCPA for an informational meeting on May 21, 2025. The meeting highlighted sections of the proposed rulemaking that received the highest number of comments during the public comment period. Approximately 216 stakeholders attended the meeting either in person or virtually. The department appreciated the opportunity to further engage with stakeholders to gather additional feedback and recommendations for the final-form rulemaking. The stakeholders included representatives from RTF providers currently certified and licensed by the department, provider organizations, BH-MCOs, primary contractors, and other behavioral health providers. Following the informational meeting, RCPA was updated on the final-form rulemaking on June 5, 2025, July 9, 2025, and July 16, 2025. PCCYFS was updated on June 24, 2025, July 15, 2025, and August 29, 2025.

Comment

Another commentator noted that the MA cost report process is tedious and ineffective and asked the department to consider extending the deadline for submitting the annual cost report for the preceding fiscal year to October 31. Additionally, another commentator suggested extending the deadline for submitting a projected cost report to 6 months after promulgation of the final-form rulemaking.

Response

The department supports the request to extend the deadline for submitting the annual cost report and has changed the requirement to October 31 under subsection (j). Additionally, the department agrees with the recommendation to extend the deadline for submitting the projected cost report period to 6 months after promulgation of the final-form rulemaking and has revised subsection (a) to increase the time period accordingly.

Comment

IRRC asked the department to clarify subsection (d) by using the term "related party" rather than "affiliate" as it relates to independent audits.

Response

The department agreed with the comment from IRRC regarding subsection (d) and replaced the term "affiliate" with the term "related party.

Additional Revision

The department changed the term "inform" to "notify" in subsection (l)(2) and (3) because notify is used consistently in the final-form rulemaking.

§ 1330.40 Rate Setting

Comment

Two commentators requested that if a child, youth or young adult is hospitalized beyond the hospital-reserved bed days limit, these days be included in the calculation of per diem rates.

Response

The department does not agree that hospital-reserved bed days over the 15-day limit should be included in PRTF per diem rates, As noted above, the department already increased the 15-day limit from 15 days within the same calendar year to 15 days for each hospitalization

under § 1330.33(a)(2) in the final-form rulemaking. As such, a PRTF will be paid the per diem rate up to 15 days per hospitalization.

Comment

Three commentators stated that the rate-setting requirements in this section do not account for the need to adjust rates if unexpected expenses arise, and they suggested establishing a process for a mid-year review. Another commentator stated concerns regarding the prohibition of billing separately and providers funding items and activities necessary for self-care and basic needs. IRRC asked the department to explain the reasonableness and fiscal impacts of the per diem rates.

Response

The department does not support implementing intermittent reviews of PRTFs' per diem rates because this would be administratively burdensome for both PRTFs and the department. The MA program pays for medically necessary behavioral health treatment. Providers are currently paid through per diem rates based on allowable costs under Medicaid and Medicare principles. Per diem rates are set by review of a provider's submitted cost report that reflects a facility's actual or budgeted costs. After publication of this final-form rulemaking, facilities will have 6 months to submit a projected cost report to the department to determine if the PRTF's per diem rate should be adjusted as a result of changes required by the final-form rulemaking.

As noted above, implementation of the final-form rulemaking will result in an estimated annual cost to the MA program of approximately $24,464,000 ($10,420,000 in State funds). Based on the expected timeline for implementing the final-form rulemaking, the cost for the first fiscal year will be three-quarters of the total annual cost incurred in subsequent years after the rulemaking is promulgated. The first-year costs are approximately $18,348,000 ($7,816,000 in

State funds). These increased costs include MA payments for room and board for children, youth or young adults in previously non-accredited RTFs; payments for costs PRTFs' incur to comply with new requirements in the final-form rulemaking; costs for increased staffing in secure PRTFs; transportation and living expenses for parents, legal guardians or caregivers when they visit the PRTF. The benefits of this final-form rulemaking outweigh these costs because these high acuity residential settings are needed to provide medically necessary behavioral health programs for children, youth and young adults with severe behavioral health diagnoses.

As to self-care and basic needs, the department agrees that, to the extent permitted under Federal requirements and where not covered by other payors, the MA rates for a PRTF should cover the basic needs for children, youth and young adults. The department removed barber and beautician services under § 1330.38(a)(9)(xvi) and personal hygiene items under § 1330.38(a)(9)(xxii) as nonallowable costs to support the basic needs and self-care of children, youth, and young adults in PRTFs. In addition, the department removed transportation and living costs for family engagement under § 1330.38(a)(9)(xxiv) as nonallowable costs to support family engagement for children, youth, and young adults in PRTFs. Other basic needs such as education and clothing are not permitted to be included in the MA rates, and it is necessary for PRTFs to coordinate with the appropriate entities responsible for covering those costs for the children, youth and young adults they are serving.

Additional Revision

The department changed the requirement in paragraph (4)(ii) from "September 30" to "October 31" to be consistent with the change made to § 1330.39(j) (relating to annual cost reporting and independent audit).

§ 1330.41 Third-Party Liability

Comment

One commentator indicated that Medicare Part B does not cover treatment in a PRTF and should not be included in subsection (a).

Response

The department agreed with the commentator and has removed this reference from § 1330.41(a) and (d)(2).

§ 1330.43 Financial Records

The department revised the term "invoice" to "claim" in § 1330.42 (a) – (d)(relating to billing requirements) because "claim" is a more widely understood term for providers and the department.

Chapter 5330. Psychiatric Residential Treatment Facility – Licensure/Certificate of Compliance

General Comments

Several commentators supported the proposed rulemaking. These included transition-aged youth with lived experience in RTFs, BH-MCOs, RTF providers, members of the Children's Committee of the Mental Health Planning Council and a county representative. Specific areas of support for the proposed rule included the incorporation of trauma-informed care approaches; requiring participation in behavioral health treatment by children, youth, young adults, and their parents, legal guardians or caregivers, a specific time limit on the use of restrictive procedures, the requirements for secure PRTFs and strengthening statewide requirements for PRTF treatment modality, frequency, quality and clinical supervision.

Response

The department thanks those commentators for supporting the proposed rulemaking.

Comment

Several commentators asserted an increased administrative burden, particularly regarding the difficulties in recruiting and retaining staff. One commentator pointed out that the proposed rulemaking fails to balance providing access to quality behavioral health treatment with the costs providers face to comply with the proposed rulemaking. Additional comments were received from Representatives Doyle Heffley and Perry Warren. They commented that the proposed rulemaking lacks clarity on whether the increased administrative and training expectations will improve care for children, youth or young adults. The Representatives urged the department to reconvene with stakeholders to better understand the current challenges faced by RTF providers. They also reiterated concerns from commentators that the existing workforce shortage and the higher staff requirements could make it difficult for providers to comply with the final-form rulemaking or maintain bed capacity, and they requested that the department provide more information to assess whether providers can meet the requirements in the final-form rulemaking.

IRRC highlighted the general concerns from commentators and encouraged the department to review the fiscal impacts and reasonableness of the staffing and treatment services requirements.

Response

The department carefully reviewed the comments related to the administrative concerns expressed by RTF providers, State Representatives and IRRC. In response to these concerns and after careful consideration, the department revised staffing, training, reportable incidents, recordable incidents, treatment and quality assurance requirements to address these concerns, which are discussed below. These changes reduce administrative burdens, while balancing the health and safety standards for the children, youth or young adults with severe behavioral health

diagnoses who receive intensive psychiatric treatment in these facilities. In addition to these revisions, the department has also extended the compliance period to 24 months from the publication of the final-form rulemaking for those facilities that intend to seek licensure as a PRTF. The department also considered the fiscal impact of the final-form rulemaking. These costs are outweighed because these high acuity residential settings are needed to provide medically necessary behavioral health treatment to children, youth and young adults with severe behavioral health diagnoses.

Throughout the development of the proposed rulemaking, the department sought ways to balance the workforce shortage affecting RTFs with the need to comply with Federal staffing requirements for inpatient psychiatric services be provided under the direction of a physician as specified in 42 CFR 441.151 (a)(1) (relating to general requirements) and team development and plan of care requirements as specified in 42 CFR 441.156 (relating to team developing individual plan of care) and to ensure children, youth or young adults receive quality treatment. In response to comments received and to balance providers' interests against the health and safety concerns for the children, youth and young adults being served, the department made revisions to the staffing provisions in the final-form rulemaking. Specifically, the department modified the requirements in § 5330.41(a) (relating to supervision of staff) to allow PRTFs flexibility in supervising staff according to their organizational structure. The department also changed the requirements in § 5330.42(a) and (b) (relating to staff requirement) by allowing an individual who is at least 18 years of age to work in a PRTF, but that individual may not be counted in the staff ratio requirements specified in this section until the PRTF staff member is at least 21 years of age. The department also agreed to remove the requirement specified in § 5330.47 subsection (a) (related to registered nurse) that a PRTF have an "RN who is either onsite or available at all

times when not onsite," and replace it with the requirement that an RN or an LPN "be present" during designated awake hours, which is specified in § 5330.42 (c) (renumbered as subsection (d)). Furthermore, the department modified the requirement in § 5330.42(d) (renumbered as subsection (e)) that permits an RN or an LPN to be "present at the PRTF or on call" during designated sleeping hours. The department also removed the requirement for RNs to have 1 year of experience working with children, youth or young adults in § 5330.47 in the final-form rulemaking.

To further address concerns with administrative burdens, the department increased the caseload requirement specified in § 5330.48(d) (relating to mental health professional) from no more than eight children, youth or young adults be assigned to a mental health professional to no more than ten children, youth or young adults under the final-form rulemaking. This change may support PRTFs by reducing the number of mental health professionals needed to meet the caseload requirement. The department also provided additional flexibility by permitting staff who meet the qualifications of either a mental health professional or a clinical director to be present during awake hours in § 5330.42(d)(3).

Similarly, the department agreed to reduce the experience required to qualify as a mental health worker supervisor, which is specified in § 5330.50 (5)(i) (formerly paragraph (7)) (relating to additional staff positions) in the final-form rulemaking. The department also agreed to remove the requirement that LPNs must have 1 year of experience in the final-form rulemaking in former § 5330.50(5). Furthermore, the department revised the final-form rulemaking to specify that only PRTF staff who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month will be required to meet the initial staff training requirements in § 5330.51(c) (relating to initial staff training) and

the annual staff training requirements in accordance with § 5330.52(b) (relating to annual staff training). The department maintained the requirement that PRTF staff complete initial training on the Adult Protective Services Act, which protects young adults with physical or mental impairments. However, the department clarified in § 5330.51(b)(3) of the final-form rulemaking that only PRTFs that provide treatment to young adults must ensure this requirement is met.

The department also agreed to modify the requirements specified in § 5330.151(formerly subsections (c) and (d)) (relating to transportation) by removing the requirement that both a driver and PRTF staff be present during every transport. The department also removed the language from former subsection (b) that prohibits a driver from being counted in the staff ratio requirement for transport. The department also agreed to remove the prohibition of a manual restraint being used on a child, youth or young adult during a transport in former subsection (e).

Regarding reportable incidents, the department addressed provider concerns by changing the requirement in § 5330.14(b) from "call the department" to "notify the department." This change broadens the methods that PRTFs may use to contact the department. Based on the comments received, the department also increased the timeframe to complete an incident report from 12 hours to 24 hours under § 5330.14(c) of the final-form rulemaking. The department also moved the requirement in subsection (c)(5) regarding incidents of physical assault, to a recordable incident in § 5330.15(a)(6), and revised the language to "any occurrence of intentionally striking or physically injuring a child, youth or young adult" under a new paragraph (6).

The department also carefully reviewed the comments surrounding treatment. In response to comments received and to reduce administrative burdens, the department revised the provision in § 5330.144(d)(1) (formerly § 5330.145) to require a "meeting" with the treatment team leader

for at least 1 hour each month in the final-form rulemaking, (in contrast to the child, youth or young adult having 1 hour of therapy each month). This change occurred because the treatment team leader's primary role is to meet with the child, youth or young adult to assess how treatment is progressing. Based on comments received, the department also revised the minimum treatment services in § 5330.144 (formerly § 5330.145) from a weekly minimum to a monthly minimum standard to allow PRTFs more flexibility in meeting the requirements as PRTFs serve children, youth or young adults with various behavioral health diagnoses and cognitive abilities. The department also reduced the minimum standards for individual therapy based on comments from commentators and engagement with stakeholders. Under § 5330.144(d)(2) of the final-form rulemaking, individual therapy with a mental health professional is required for at least 6 hours each month (instead of 2 hours each week). Similarly, group therapy is required for at least 12 hours each month (instead of 3 hours each week) under § 5330.144(d)(3) and family therapy is required for at least 4 hours each month (instead of 1 hour each week) under § 5330.144(d)(4)(iii). The department also revised the psychoeducation group requirement under § 5330.144(d)(5) to be provided at the direction of the treatment team to allow them to meet the needs of the current population of children, youth or young adults in the PRTF.

In determining these standards, the department compared the hourly minimum standard for the frequency of individual, group and family therapy session with a number of other states. The department observed that several states have minimum treatment standards that mirror or are more stringent than the 6 hours each month for individual therapy (average 1.5 hours per week), 12 hours each month for group therapy (average 3 hours per week) or 4 hours each month for family therapy (average 1 hour per week) in the final-form rulemaking. The final-form

rulemaking is requiring a total of 22 hours of treatment time per month or an average of 5.5 hours of treatment time per week.

States with similar or more stringent requirements include Arkansas, Ohio, Maine, Minnesota and West Virginia. Arkansas requires the following minimum standard for its treatment services: "a total of forty (40) hours per week of documented treatment services must be provided, not to include education/classroom time." This equates to 160 hours of treatment services each month. Section 210.000.F. of the Arkansas Provider Manual, Section II – Psychiatric Residential Treatment Facility Services for Under Age 21. https://codeofarrules.arkansas.gov/Rules/PartDocument?partID=1449.

Ohio requires individual counseling, not less than twice a week, for a total of at least 90 minutes each week and that group therapy occur for at least 5 hours each week (20 hours each month) in accordance with the Ohio Administrative Code Chapter 5122-41-07(F)(2) and (3) https://codes.ohio.gov/ohio-administrative-code/chapter-5122-41.

Maine requires that individual therapy occur for at least 2 hours each week (8 hours each month), group therapy occurs once per day (30 hours each month), and family therapy occurs at 2 hours each week (8 hours each month). Maine Administrative Code 10-144, Ch. 101, Ch.II-Section 107.05 (MaineCare Benefits Manual).

Similarly, Minnesota requires that individual therapy be provided a "minimum of twice per week" with "active treatment seven days per week that may include individual, family, or group therapy as determined by the individual care plan." Minnesota Statutes (MN) § 256B.0941, Subd. 2(3) and (4). If the department assumes one 30-minute group therapy session each day of the week, this will result in 15 hours of group therapy each month, which is more stringent than the final-form rulemaking. If the department assumes 1-hour family therapy

sessions each week, this will result in 4 hours of family therapy sessions each month, which mirrors what is in the final-form rulemaking. Minnesota Statutes § 256B.0941.

West Virginia requires individual therapy for at least 1 hour each week, group therapy for at least 3 hours each week and family therapy for at least 2 hours each month. Virginia requires that individual therapy be provided 3 times each week but does not specify the duration of each session. Additionally, Virginia mandates that group and family therapy be provided when indicated. Ohio requires that individual therapy occur for at least 30 minutes each week, group therapy occur for at least 5 hours each week and family therapy occur in accordance with the child's, youth's or young adults treatment needs. Maryland, New Jersey and New York do not have requirements regarding minimum standards for the frequency of individual, group and family therapy sessions.

All of these revisions in the final-form rulemaking reduce administrative and fiscal burden, while still balancing and maintaining the needed treatment standards for high acuity residential setting that provide medically necessary behavioral health services for children, youth and young adults with severe behavioral health diagnoses.

Comment

Another concern raised by multiple commentators was the need for further stakeholder engagement by the department. Representatives Heffley and Warren urged the department to reconvene with stakeholders to better understand the current challenges faced by RTF providers. Based on the volume of objections, concerns and questions on the proposed rulemaking, IRRC recommended that the department engage with stakeholders to reach a consensus on balancing the protection of public health, safety and welfare with the feasibility, reasonableness and fiscal impacts of implementing regulatory requirements. IRRC suggested the department issue an

Advance Notice of Final Rulemaking and engage stakeholders to reach consensus on how to balance protection of the public health, safety and welfare with the feasibility, reasonableness and fiscal impacts of implementation of the regulatory requirements. Two commentators suggested that the proposed rulemaking be withdrawn until the department has sufficient time for meaningful stakeholder engagement.

Response

Following the publication of the proposed rulemaking, the department continued engaging with stakeholders. The department met with a transition age youth and young adult subcommittee on April 8, 2025, and April 22, 2025. The subcommittee members supported the requirements in the proposed rulemaking related to restrictive procedures and treatment. The department collaborated with PCCYFS and RCPA to hold an informational meeting on May 21, 2025. About 216 stakeholders participated either in person or virtually. The meeting highlighted sections of the proposed rulemaking that received the most comments during the comment period. It also provided an opportunity for the department to discuss and gather additional suggestions, recommendations and insights into the financial impact of the final-form rulemaking. Stakeholders were encouraged to continue sharing their suggestions and any concerns. Additionally, the department continues to actively engage with the Mental Health Planning Council Children's Committee, PCCYFS and RCPA.

The department kept interested parties and organizations informed throughout the drafting of this final-form rulemaking to ensure a transparent process. The Juvenile Court Judges Commission was updated on July 9, 2025. The County Commissioners Association of Pennsylvania was updated on January 15, 2025; July 16, 2025; and August 8, 2025. The Mental Health Subcommittee of the Judges State Round Table was updated on January 14, 2025;

February 13, 2025; March 21, 2025; April 17, 2025; May 15, 2025; and August 18, 2025. The Montgomery County Association for Excellence was updated on January 30, 2025. The department also provided updates during a standing public quarterly stakeholder call held by the Office of Mental Health and Substance Abuse Services on five occasions between January 2025 and August 2026. These stakeholder calls are open to any member of the public and attendees include county mental health administrators, HealthChoices primary contractors, BH-MCOs, behavioral health care providers, and individuals and families of those receiving behavioral health services. The department also informed CMS on April 9, 2025, of the final-form rulemaking and its purpose to establish licensing requirements in the Commonwealth that align with Federal requirements and Commonwealth standards. CMS provided positive feedback to the department. Due to the continual stakeholder engagement, the department did not issue an Advance Notice of Final Rulemaking.

§ 5330.2 Scope

Comment

One commentator requested that the department consider that there are RTF providers under the scope of the final-form rulemaking who serve various populations of children, youth or young adults with physical and intellectual disabilities. The treatment requirements in the final-form rulemaking are seen as a one-size-fits-all approach and may not be appropriate, potentially impacting treatment success. The commentator also stated that without the flexibility to have a waiver for programs that serve specialized populations, there could be a reduction in bed capacity, creating another gap in the residential care continuum.

Response

The department reviewed all RTF providers under the scope of the final-form rulemaking, which are providers who serve children, youth or young adults with a behavioral health diagnosis. Treatment standards are the minimum requirements for the health and safety of those being served. Based on comments received and in consideration of balancing behavioral health treatment needs against providers' administrative concerns, the department revised the treatment requirements in the final-form rulemaking. As discussed previously in response to comments regarding administrative burdens, the department revised the treatment team leader provision. As revised under § 5330.144(d)(1) (formerly subsection (c)), the final-form rulemaking requires a "meeting" with the treatment team leader for at least 1 hour each month instead of 1 hour of therapy each month. The department revised the minimum treatment services from a weekly minimum to a monthly minimum standard to allow PRTFs more flexibility in meeting the requirements as PRTFs serve children, youth or young adults with various behavioral health diagnoses and cognitive abilities. The department also reduced the minimum standards for individual therapy based on comments from commentators and engagement with stakeholders. Under § 5330.144(d)(2) of the final-form rulemaking, individual therapy with a mental health professional is required for at least 6 hours each month (instead of 2 hours each week). Similarly, group therapy is required for at least 12 hours each month (instead of 3 hours each week) under § 5330.144(d)(3) and family therapy is required for at least 4 hours each month (instead of 1 hour each week) under § 5330.144(d)(4)(iii). The department revised the psychoeducation group requirement under § 5330.144(d)(5) to be at the direction of the treatment team which will allow them to meet the needs of the current population of children, youth or young adults in the PRTF.

If PRTFs that serve specialized populations need additional time to adjust their program to come into compliance with the final-form rulemaking, they may submit a written request to the department for a waiver of a specific requirement in this chapter, as detailed in § 5330.231 (related to waivers). Further, no facility is required to transition from an RTF to a PRTF.

§ 5330.3 Definitions

Comment

Several commentators either sought further clarification of definitions or requested that the department consider defining specific words used in the regulations. Clarifications were requested for the terms "staff," "elopement," "intimate sexual contact," "visit" and "reportable illness."" The department also received comments from IRRC seeking clarification on the definitions of "elopement" and "visit." IRRC specifically inquired whether the term "visit" includes scenarios when a child, youth or young adult is under the approved temporary supervision of an individual on the premise of the PRTF and whether it includes therapeutic leave.

Response

As previously provided in the response to § 1330.2 (relating to definitions), the department modified the definition of "elopement" and removed the term "visit" and replaced it with the term "therapeutic leave" in the final-form rulemaking. The definitions of "elopement" and "therapeutic leave" were revised in the final-form rulemaking to be consistent with the changes in § 1330.2. Under the final-form rulemaking, "elopement" is defined as "when a child, youth or young adult leaves the premises of a PRTF or a location for 1 hour or more without PRTF staff approval" and "therapeutic leave" is defined as "a period during which a child, youth

or young adult is absent from the premises of a PRTF without supervision of PRTF staff that is directly related to the child's, youth's or young adult's treatment plan."

The department also reviewed the concerns about other definitions raised by the commentators and IRRC. The department modified the definition of "staff" in accordance with the commentator's recommendation. The department has limited the definition of "staff" to individuals who are responsible for care, treatment or supervision of children, youth or young adults receiving care in the PRTF. Specifically, the definition of "staff" mirrors the definition in Chapter 1330 and is defined as "individuals employed or contracted by a PRTF on a full-time or part-time basis who are responsible for care, treatment or supervision of children, youth or young adults receiving care in the PRTF. The term includes temporary staff, volunteers and interns." The department also clarified the definition of "intimate sexual contact" by replacing "intimate body parts" with "private body parts" because commentators sought clarification about the term "intimate." The department also removed "skin to skin" from the definition because sexual contact can occur without being skin to skin. The department also removed "involuntary emergency" from the definition of "reportable illness" because all PRTFs are required by § 5330.14 (related to reportable incidents) to report any incidents where a child, youth or young adult requires hospitalization. Lastly, the department removed definition of "first aid" from the definition of "reportable injury" and defined the term "first aid" separately.

Comment

Commentators asked the department to consider adding definitions for "excessive medication" and "visual body search."

Response

The department agreed with the commentators' recommendations to add definitions for "excessive medication" and "visual body search." Under the final-form rulemaking, "excessive medication" is defined as "prescription and over the counter medication that is beyond what is medically necessary to treat a child's, youth's or young adult's documented medical condition, including amount and duration of the medication." "Visual body search" is defined as "viewing of a child's, youth's or young adult's body after the child, youth or young adult has removed clothing to expose underwear or private body parts for the purposes of checking for contraband."

Comment

One commentator stated that the terminology for RTF and PRTF were confusing and inquired whether an existing RTF is forced to become a PRTF under this rulemaking.

Response

The final-form rulemaking applies to an RTF that may seek to become a PRTF. The department is not requiring an existing facility to seek licensure under Chapter 5330.

Additional Revisions

The department revised the definition of "emergency safety situation" to be consistent with the definition in Federal requirements, which is specified in 42 CFR 483.352 (relating to definitions). Under the final-form rulemaking, an "emergency safety situation" is "an unanticipated child, youth or young adult behavior that places a child, youth, young adult or others at serious threat of violence or injury if no intervention occurs and that calls for the use of a restrictive procedure." The department also removed the "sleeping hours" language from the definition of "seclusion" because seclusion is prohibited in a PRTF at all times. Lastly, as previously explained in the response to comments to § 1330.2, the department revised the

definition of “PRTF” and “treatment team.” Under the final-form rulemaking, “PRTF” is “a licensed residential facility that provides services to treat the behavioral health needs of children, youth or young adults under the direction of a psychiatrist” and “treatment team” is “the PRTF staff directly involved in the child's, youth’s or young adult's treatment and who is led by a treatment team leader. The treatment team also includes the child, youth or young adult and the child's, youth’s or young adult's parent, legal guardian or caregiver and may include any individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver.

§ 5330.4 Certificate of compliance

Comment

Two commentators requested that the department consider extending the timeframe for compliance with the proposed rulemaking to 24 months.

Response

The department supports the recommendation from the commentators and has increased the time period facilities seeking licensure as a PRTF have to come into compliance with the final-form rulemaking. Under § 5330.4(b) of the final-form rulemaking, the department increased this time period from 12 months to within 24 months from publication of the final-form rulemaking.

In addition, the department revised the term “license” to “certificate of compliance” in this section because a certificate of compliance is the document a PRTF receives upon meeting the minimum standards. The department also changed subsection (d) from “the Department will issue a new certificate of compliance for each physical location that qualifies for a certificate of compliance” to “a new certificate of compliance will be issued for each physical structure that

qualifies for a certificate of compliance." This change clarifies that a certificate of compliance will be issued for each qualifying physical structure.

Comment

One commentator had a question regarding accreditation and whether facilities that choose to remain nonaccredited would be able to maintain program options under children & youth and juvenile probation funding should they not seek licensure as a PRTF.

Response

The final-form rulemaking relates to MA provider participation requirements and licensure for PRTFs. The availability of child welfare funding is outside the scope of this rulemaking. The final-form rulemaking does not require an RTF to transition to a PRTF.

§ 5330.7 Exemptions

Comment

One commentator, which was an RTF provider primarily serving children, youth or young adults with autism or an intellectual disability, requested that the department consider exemptions for providers serving individuals with autism or an intellectual disability, because the treatment model differs from many of the requirements in the proposed rulemaking.

Response

The department did not exempt facilities that primarily serve children, youth or young adults with co-occurring autism or intellectual disability from the requirements of this chapter when they serve individuals under 21 years of age that meet the medical necessity criteria for a PRTF level of care, have a primary behavioral health diagnosis, and who cannot be effectively treated in their home and community. Facilities will need to meet the minimum requirements under this final-form rulemaking for the health, safety and behavioral health treatment needs of

those being served, along with meeting Federal requirements, even if they serve individuals who have co-occurring autism spectrum disorder or an intellectual disability as their primary population. A provider serving individuals with autism or intellectual disability that is not co-occurring with a behavioral health diagnosis would not qualify for PRTF licensure.

§ 5330.11 Service Description

Comment

Two commentators asked for clarification on whether the requirements in subsection (a)(2) refer to the PRTF's contact information or the contact information of the accreditation agency.

Response

As requested, the department clarified the requirement in subsection (a)(2) to reflect that it is requesting the PRTF's contact information.

Comment

One commentator requested that the department clarify the requirements in subsection (a)(12) regarding the expectation that will be used to encourage active involvement in the treatment process by the parent, legal guardian or caregiver.

Response

The department clarified the language in subsection (a)(12) by removing the term "expectations" and added the term "processes" to it. As revised, a facility is required to submit to the department the processes that will be used to encourage active involvement in the process by the parent, legal guardian or caregiver.

Comment

Two commentators suggested that the department consider adding a requirement in subsection (b) stating that the department has 60 days to approve the PRTF's service description.

Response

The department did not add a requirement for the department to review and approve the service description within 60 days. While the department strives to approve service descriptions within 60 days whenever feasible, having an approved plan to safely deliver services is necessary before delivering those services. Therefore, the department does not agree to set a timeline for service description review which could endanger the health and safety of children, youth and young adults. Completion and approval of a service description is a collaborative process with providers. Various circumstances, such as amount of time providers need to complete changes based on department feedback, need for clinical consultation for elements of the service description, availability of personnel and volume of service descriptions received by the department could prevent review and approval to occur within 60 days. However, the department will continue to review and approve service descriptions as timely as possible without jeopardizing the health and safety of the children, youth and young adults being served.

Additional Revisions

The department modified the requirements in subsection (a)(13) by adding the term "curriculum or procedure models" to replace the language "procedure." The department also added "for staff training" to this subsection. This language was added to clarify that restrictive procedure techniques should not be included in the service description; instead, the restrictive procedures curriculum or procedure models for staff training are to be included.

§ 5330.12 Coordination of Services

Comment

Three commentators indicated that updating written agreements with other service providers annually is excessive and suggested that updates should only be required when changes to the agreements are necessary.

Response

The department appreciates the commentators' recommendations. In response to this comment and to reduce administrative burdens, the department revised the requirement to update written agreements from an annual basis to at least every 5 years in subsection (b). In addition, the department removed "with other service providers" from subsection (b) to be consistent with the requirement in subsection (a). The department, however, maintained the obligation to also update agreements when they are no longer accurate. The department also revised subsection (a) to provide further clarity for written agreement requirements. Under the final-form rulemaking, a PRTF shall have written agreement describing the accessibility to and availability of the various service providers and programs.

Comment

The department received a recommendation from a commentator that a PRTF should demonstrate ongoing efforts to develop relationships with the service providers listed in this section but not be held accountable if no formal agreement exists, and that the list of service providers should be a recommendation rather than an exhaustive list. Another commentator stated that the PRTF has no control over whether a hospital admits a child, youth or young adult, and that the language should reflect reasonable efforts to obtain a written agreement.

Response

Because PRTFs provide the most intensive residential level of care for children, youth or young adults with severe behavioral health diagnoses, the department did not remove the requirement for PRTFs have written agreements to access the services listed in this section. For the same reason, the department did not revise the provision to allow for demonstration of ongoing efforts to develop relationships with the service providers instead of written agreements describing the accessibility to and availability of providers and programs.

Comment

The department also received a request from another commentator to remove the words "in a timely manner" from the requirements in subsection (c)(1) that a child, youth or young adult be transferred from a PRTF to a hospital and admitted in a timely manner.

Response

The department reviewed the requirement in subsection (c)(1) and determined that it is consistent with the Federal requirement under 42 CFR 483.372 (relating to medical treatment for injuries resulting from an emergency safety intervention). However, for further clarity and safety, the department revised the language to "immediately" require transfer to a hospital when a transfer is medically necessary.

Additional Revisions

During the review of this section, the department added "if the PRTF serves youth or young adults" to subsection (a)(3) because peer support services are currently only available to youth and young adults ages 14 and older in Pennsylvania. The department also changed "drug and alcohol" to "substance use disorder" in subsection (a)(5) because the term "substance use disorder" is more widely understood and used. The department also added "crisis intervention

programs" to the list of services with which a PRTF must have written agreements because these services provide needed support for children, youth, young adults and PRTF staff.

§ 5330.13 Abuse

Comment

Two commentators requested that the department include the word "alleged" or "subject to the" before the term "abuse."

Response

After careful consideration, the department revised subsection (a) of the final-form rulemaking to add the word "alleged" before abuse where appropriate. The department also revised subsection (a) for further clarity. As revised in the final-form rulemaking, a PRTF shall have a written policy and procedure governing: (1) abuse identification, reporting and investigation; (2) implementation of a plan of supervision for any PRTF staff implicated in the alleged abuse; and (3) implementation of a plan for the protection of the child, youth or young adult who was subject to the alleged abuse.

Comment

Three commentators indicated that the requirement to comply with the Adult Protective Services Act specified in subsection (c) creates an administrative burden, as staff will need additional annual training. IRRC acknowledged the concerns from commentators and asked the department to address the fiscal impact and reasonableness of the administrative and training burden in complying with the Adult Protective Services Act.

Response

The department maintains the requirement for compliance with the Adult Protective Services Act, as PRTFs must adhere to State laws. Under the Adult Protective Services Act, an

"adult" is defined as "a resident of this Commonwealth between 18 and 59 years of age who has a physical or mental impairment that substantially limits one or more major life activities." See 35 P.S. § 10210.103. Because PRTFs may serve young adults who are between 18 and 22 years of age, the Adult Protective Services Act may apply, depending on the age of the population served. The fiscal impact to meeting this requirement is included in the overall estimated costs to provide all additional trainings, which is $1,857 annually. In consideration of the potential fiscal impact of the training requirements, the department has revised subsection (c) to clarify that the requirement applies only to PRTFs serving young adults 18 years of age and older.

§ 5330.14 Reportable Incidents

Comment

The department received numerous comments on this section. Several commentators mentioned that the requirements increase administrative burdens for providers. Two commentators stated that reporting incidents and completing written reports are redundant and detract from caring for children, youth and young adults. Several commentators requested that other communication methods, such as email, be allowed to contact the department, parents, legal guardians or caregivers.

Response

The department appreciates the review and comments received regarding this section. RTFs are currently required to comply with reportable incident requirements under Chapter 3800. Furthermore, reporting and documenting incidents can alert department licensing staff to potential threats to the health, safety and well-being of children, youth or young adults receiving services in PRTFs to assist the department in responding to those threats timely.

Based on the comments received and to reduce the administrative burden, the department revised various provisions of this section. For clarity, the department changed the requirement from "call the department" to "notify the department" in subsections (b), (d) and (i). This change broadens the methods that PRTFs may use to contact the department., parents, legal guardians and caregivers. As discussed in further detail below, the department also increased the reporting time in subsection (c) to the requested 24 hours.

Comment

Six commentators indicated unfamiliarity with the state-designated protection and advocacy system outlined in subsections (e) and (f). IRRC also asks the Department to clarify the phrase "State designated protection and advocacy system."

Response

Facilities are required to report the incidents specified in subsection (e) to the state designated protection and advocacy system in accordance with the Federal requirement under 42 CFR 483.374 (b) (relating to facility reporting). Currently, Disability Rights Pennsylvania is the Commonwealth's state-designated protection and advocacy system. The department added the cross-reference to 42 CFR 483.374 (b) to § 53310.14(e) for further clarity.

Comment

Six commentators also asked the department to clarify the requirements related to physical assault and sexual contact and whether there will be age parameters with consensual sexual encounters.

Response

Based on comments received, the department removed incidents of physical assault from paragraph § 5330.14 (c)(5) as a reportable incident and replaced it with "serious injury to a child,

youth or young adult." The department then added the lesser offense of "any incident of intentionally striking or physically injuring a child, youth or young adult" as a recordable incident in § 5330.15(a)(6) (relating to recordable incident). The revised language requiring the reporting of striking or physically injuring a child as a recordable incident is modeled after the reporting in § 3800.17(3).

The department also added the terms "consensual or nonconsensual" to the requirement in subsection (c)(7) for the purpose clarifying that all types of sexual contact is a reportable incident. There is not an age parameter for this reporting.

Comment

Four commentators urged the department to consider a 24-hour deadline for submitting written reports, with immediate reporting required only for deaths or serious injuries. IRRC also noted that commentators questioned the need to shorten the timeframe for reporting or notifying of reportable incidents. IRRC advised the department to explain how the shorter timeframe is reasonable and balances protecting public health, safety and welfare.

Response

Based on comments received and to further ease administrative burden, the department increased the timeframe to complete an incident report from 12 hours to 24 hours under subsection (c) of the final-form rulemaking. This increase balances the minimum health and safety requirement for reporting against a provider's competing interest in reducing administrative burdens.

Comment

The department received feedback from two commentators representing BH-MCOs supporting the requirement that medication errors remain as a reportable incident in paragraph (c)(13).

Response

The department appreciates this comment. The department considered removing medication errors as reportable incidents in the final-form rulemaking but decided to maintain it for health and safety. Removing the requirement to report medication errors would hinder both the detection of medication errors and the promotion of safe medication administration to the children, youth or young adults served. As such, the department agreed that medication errors should remain as a reportable incident.

Comment

IRRC requested that the department clarify "elopement" as the term relates to incident reporting.

Response

As noted previously in response to the comments to §§ 1330.2 and 5330.3 (relating to definitions), the department agreed with concerns about the definition of "elopement" as it pertains to incident reporting and has added to the definition of "elopement" that a child, youth or young adult shall be considered eloped from the PRTF if the child, youth or young adult is missing for a minimum of 1 hour. Under the final-form rulemaking, the department moved a child's, youth's or young adult's elopement from paragraph (c)(4) to paragraph (b)(3) to maintain the reporting of an elopement within 12 hours after the incident due to the significance and safety concerns with elopement.

Additional Revisions

While reviewing the comments regarding this section, the department determined that the requirement specified in subsection (b)(1) need to be expanded to include other types of events that would result in children, youth or young adults sheltering in place or relocating, thus the term "fire" was replaced by "any event" requiring a child, youth or young adult to shelter in place or relocate. The department also determined that a "serious injury to child, youth or young adult" does not require notification prior to completing an incident report and subsequently moved this condition to subsection (c)(5). For further clarity and consistency, the department revised the language in subsection (c)(1) to provide that all reportable incidents in subsection (b) require an incident report through the department's information management system, which is distinct from notification under subsection (b).

For clarity and simplicity, the department also removed the language "and inform the parent, legal guardian or caregiver" in subsection (d) because the language was redundant. The department also removed "and the name and title of the individual from the department who was notified of the reportable incident" from subsection (i) because, as noted earlier, the department agreed to broaden the term from "call" to "notify," thus, depending on the PRTF's preference for notification, a PRTF may not speak directly to someone from the department to meet this requirement.

§ 5330.15 Recordable Incidents

Comment

The department also received responses from ten commentators stating that the recordable incidents identified in this section happen often and expressing concerns about the administrative burden this requirement may create, which will lead to PRTFs needing to hire

more staff. One commentator stated that a 24-hour period to contact a parent, legal guardian or caregiver should be allowed. IRRC also highlighted those commentators who questioned the need for and fiscal impacts of reducing the timeframe from the current 24 hours to 12 hours to contact a parent, legal guardian or caregiver. IRRC asked the department to explain how the timeframe balances the protection of public health, safety and welfare with the reasonableness and fiscal impacts of the requirement.

Response

Based on the comments received and to assist with the reduction of administrative burdens, the department added a definition of "visual body search" and revised the requirement in paragraph (a)(4) of the final-form rulemaking to "visual body search of a child, youth or young adult" from a "search of a child, youth or young adult or the child's, youth's or young adult's property." This type of visual search should help reduce administrative burden related to the search.

The department, however, did not extend the notification timeframe for parents, legal guardians and caregivers from 12 hours to 24 hours as these specific recordable incidents (such as seizures, suicidal gestures or threats, significant property damage, visual body searches, reportable injuries and illness while on therapeutic leave and intentional strikings) are significant events in which it is reasonable to expect a parent, legal guardian or caregiver to be notified within 12 hours of the PRTF knowing of the incident.

Additional Revisions

The department also changed the requirements in subsection (a)(1) from "medical seizure that requires medical attention" to "seizure that requires medical attention" because all seizures are required to be recorded. The department revised the requirements in subsection (a)(5) by

replacing the term "visit" with "therapeutic leave," because the term "visit" was removed from the final-form rulemaking.

As noted above, the department moved and modified the requirement in § 5330.14(c)(5) to paragraph (a)(6) of this section. The requirement now states "any incident of physically injuring or intentionally striking a child, youth or young adult" shall be maintained as a recordable incident. This language is modeled after the reporting in § 3800.17(3). Lastly, the department modified the requirement in subsection (b) by removing the language "after a recordable incident occurs" and replacing it with "after a recordable incident is known to a PRTF." The department made this change because a facility will not always be aware of when a recordable incident actually occurred and this revision will provide a PRTF a reasonable and measurable time frame for reporting.

§ 5330.17 Consent to Treatment

Comment

One commentator suggested that specific consents should be documented for all experiences involving children, youth or young adults while in the PRTF, such as medication, manual restraint, searches and sharing a bedroom. Another commentator asked that all Federal and State laws, regulations and policies be included in the final-form rulemaking. The department received feedback from one commentator seeking clarification on whether consent to treatment also covers medication consent.

Response

The department carefully considered the recommendations from the commentators. The department does not agree to expand this provision to include either a specific list of treatment services or add other instances, such as searches or sharing a bedroom requiring consent.

Subsections (a) and (b) clearly provide that consent needs to be obtained in accordance with law prior to a child, youth or young adult receiving a service. To provide further clarity in the final-form rulemaking, the department added the term "treatment" to subsection (b). In addition, the department removed "caregiver" from this section because a caregiver is not permitted to consent for a child's, youth's or young adults' treatment services in a PRTF. The department did not codify in the final-form rulemaking all laws and regulations governing consent due to their evolving nature; however, the department specifically added the act of February 13, 1970 (P.L. 19, No. 10), (35 P.S. §§ 10101–10105) regarding minors' consent to medical care for additional clarity. Lastly, separate consent for medication is not required, as it is included in consent to treatment, which is specified in subsection (a).

§ 5330.18 Confidentiality of records

Comment

One commentator requested that the department list all other applicable statutes and regulations specified in paragraph (a)(11). IRRC also asked the department to specify any other statutes and regulations that apply to confidentiality of records.

Response

The department enumerated various statutes and regulations requiring confidentiality in paragraphs (a)(1) – (11), including the addition of 42 CFR Part 2 (relating to confidentiality of substance use disorder patient records). This Federal regulation was added because it applies when a child, youth or young adult is receiving substance abuse treatment. To ensure enforceability, the department is maintaining the catchall language under subsection (a)(11) (renumbered as paragraph (a)(12)) to encompass enforcement of all confidentiality statutes or

regulations. For clarity, the department revised the language to require compliance with "applicable confidentiality statutes and regulations."

Comment

Two commentators indicated that this section of the final-form rulemaking is more restrictive than the current Health Insurance Portability and Accountability Act.

Response

The department agrees with the commentators' recommendation not to be more restrictive and the Federal Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat, 1936)) and has removed subsections (b) and (c) relating to sharing of information, as they are more restrictive than the Federal law. The department has renumbered the section accordingly.

Comment

One commentator stated that a PRTF program cannot ensure that a child's, youth's or young adult's or a staff member's social media does not contain identifying information about a child, youth or young adult at a PRTF.

Response

Based on the comment received, the department revised the language regarding social media by clarifying that a PRTF shall have a written policy and procedure to protect a child's, youth's or young adult's confidentiality and privacy through social media use under paragraph (b)(3) in the final-form rulemaking.

Comment

Another commentator clarified that, for the requirements in paragraphs (d)(1)-(3), they are not allowed to treat a child, youth or young adult if the youth or young adult or the child's, youth's or young adult's parent, legal guardian, or caregiver refuse to provide consent.

Response

Paragraphs (d)(1)-(3) (renumbered (b)(1)-(3)) pertain to the developing policies and procedures to protect the confidentiality and privacy of a child, youth or young adult. These provisions do not relate to consent to treatment. As noted above, the act of February 13, 1970 (P.L. 19, No. 10) (35 P.S. §§ 10101-10105) addresses minor consent to medical care.

§ 5330.20 Therapeutic leave (§ 5330.20 Visits in proposed rulemaking)

Comment

Ten commentators expressed concern about the requirement to contact a parent, legal guardian or caregiver each day a child, youth or young adult is on a visit. Additional commentators question what is "contact"? What type of mode of contact is sufficient? Concerns were raised about the holiday season, staff being ill equipped, daily interruptions and potential legal liability. IRRC also commented that the department should explain the need and reasonableness of requiring contact with a parent, legal guardian or caregiver every 24 hours and address the fiscal impact of this requirement.

Response

The department appreciates and carefully considered the varied feedback from the commentators and IRRC. In response to comments and to reduce the burden on PRTFs and parents, legal guardians and caregivers, the department removed the requirement in subsection (g) that the PRTF contact the parent, legal guardian or caregiver every 24 hours if the visits last

longer than 24 hours. Under subsection (g) (as revised), the department added a requirement that a PRTF review and respond to any concerns in the therapeutic leave plan upon a child's, youth's or young adult's return to the PRTF.

Comment

One commentator asked the department if all a child's, youth's or young adult's prescribed medication would be transported for a visit and returned after the visit.

Response

Based on the comment received, the department added paragraph (c)(4) to require that the therapeutic leave plan include "medications taken by the child, youth or young adult, including dosage of the medication for the duration of the therapeutic leave and instructions on how to administer the medication." Although the department cannot require a child, youth, young adult, parent, legal guardian or caregiver to return unused medications as the final-form rulemaking pertains only to requirements for PRTFs, as noted above PRTFs are required to have a policy and procedure specified in subsection (a) which will include handling and return of medications. Additionally, the therapeutic leave requirements apply only in situations where the therapeutic leave occurs in the community or the home of the parent, legal guardian or caregiver.

Comment

Another commentator sought clarification on whether "visit" has the same meaning as "therapeutic leave." Three commentators asked if visits can occur at the PRTF and in the community. IRRC also inquired whether the term "visit" included scenarios when a child, youth or young adult is on a visit on the premises of the PRTF and does the term "visit" also mean therapeutic leave.

Response

As noted in § 5330.3 (related to definitions), the department changed the term "visit" to "therapeutic leave" throughout the final-form rulemaking to provide clarification. Specifically, the department revised the section heading and subsections (a) – (h) accordingly. Under the final-form rulemaking, "therapeutic leave" is "a period during which a child, youth or young adult is absent from the premises of a PRTF without supervision of PRTF staff that is directly related to the child's, youth's or young adult's treatment plan."

Additional Revisions

For clarity, the department further revised the requirement in subsection (b) by replacing "punishment and coercion" with "coercion, discipline, convenience or retaliation." This change was made because the requirement was limited in scope and did not encompass other scenarios in which a therapeutic leave is prohibited from being denied. The department also removed the language "when the child, youth or young adult is not under the supervision of PRTF staff" in subsection (c) because the language is duplicative of the definition of "therapeutic leave." Furthermore, the department added the requirement for a therapeutic leave plan to include "a communication section for the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver to communicate strengths relating to the therapeutic leave or concerns about the therapeutic leave," which is specified in subsection (c)(3). The department determined that this requirement was needed to assist PRTF staff in addressing concerns that arose while the child, youth or young adult was on a therapeutic leave in response to a public comment.

The department also clarified and cross-referenced that "a therapeutic leave shall be part of the child's, youth's or young adult's treatment plan in accordance with § 5330.142(e)(7)

(relating to treatment planning),” which is specified in a new subsection (h). This provision was clarified because a child’s, youth’s or young adult’s therapeutic leave is associated with the objectives, goals and outcomes set forth in the child’s, youth’s or young adult’s treatment plan.

Lastly, the department removed the term “prescribed” from subsection (e) to clarify that the acknowledgment applies to all medications during therapeutic leave.

§ 5330.21 Awake Hours and Sleeping Hours

As explained in further detail below, the department removed § 5330.21 (relating to awake hours and sleeping hours) because the section was limited in scope. Instead, the department clarified that a PRTF shall have designated awake and sleeping hours under § 5330.42(d) and (e) (formerly subsections (c) and (d)) (relating to staff requirements).

§ 5330.31 Rights

Comment

Five commentators suggested that the department reconsider the provision allowing the treatment team to prevent visits or contact between a child, youth or young adult and their parent, legal guardian or caregiver because a PRTF is a voluntary placement, and only a court order can prevent a visit.

Response

In the final-form rulemaking, the department removed the language from subsection (b)(17) and (18) and (d)(2) that prevented private communications or visits with parents, legal guardians or caregivers as determined by the child’s, youth’s or young adult’s treatment team. However, the department retained in paragraph (b)(19) of the final-form rulemaking the ability of the PRTF to prohibit visitors chosen by the child, youth or young adult if the treatment team determines that a visitor will negatively impact the child’s, youth's or young adult’s treatment,

safety or well-being because it is consistent with the regulations implementing the Mental Health Procedures Act (50 P.S. §§ 7101—7503) as specified in § 5100.53 (relating to bill of rights for patients).

Comment

One commentator noted that regarding subsection (b)(10), utilizing additional communication support requires financial resources and asked for clarification on how a PRTF would be reimbursed for these supports.

Response

For further clarity, the department also added the term "communication devices" to subsection (b)(10) because a child, youth or young adult may use this method to communicate. This term was also added to subsection (d)(1) because a child's, youth's or young adult's parent, legal guardian or caregiver may also use this method to communicate. Additionally, the communication supports required by this section are required by the Americans with Disabilities Act of 1990 (Pub. L. No. 101-336, 104 Stat. 328). Communication devices may be paid through insurance or MA as durable medical equipment when medically necessary and PRTFs may coordinate with insurance or MA when a child, youth, or young adult in a PRTF level of care has a need for a medically necessary communication device.

Comment

Another commentator pointed out that the right for a child, youth or young adult to be compensated for work done for the PRTF exists in other programs, has been interpreted differently and should be clarified in the final-form rulemaking.

Response

The department agreed with the comment about the right for a child, youth or young adult to be compensated for work done for the PRTF and accordingly modified the requirement to be consistent with other behavioral health providers. The requirement now states that a child, youth or young adult has the right "to be paid in compliance with 29 CFR 525.4 (relating to patient workers) for all work performed that is of consequential economic benefit to the PRTF except for personal housekeeping tasks related directly to the child's, youth's or young adult's personal space or possessions and shared responsibilities for regular household chores among children, youth or young adults.

Comment

A few commentators noted that a child's, youth's or young adult's right to clean and appropriate clothing does not mean that the PRTF will be reimbursed for the cost of the clothing. Additionally, three commentators proposed changing the requirement in subsection (b)(5) to specify clean and seasonal clothing suitable for the child's, youth's or young adult's age and gender identity. Other commentators asserted that listing clothing in this section elevates this need to a right. IRRC requested that the Department explain how requiring a PRTF to provide clothing without reimbursement is reasonable and to also address the fiscal impact.

Response

The department agreed with the commentator regarding payment. As discussed previously in response to comments to § 1330.38 and consistent with 42 U.S.C. § 1395y(a)(1)(A),the department may not reimburse providers with MA funding for the cost of clothing because clothing in the context of a PRTF is not a medically necessary garment as the items do not meaningfully contribute to treating a patient's illness or injury or the functioning of

the malformed body member are not covered items. The department, however, did not change the language of paragraph (b)(5) because gender appropriate clothing includes clothing consistent with the child's, youth's or young adult's gender identity. Further, PRTFs should coordinate with the child's, youth's or young adult's parent or legal guardian to assist in providing clean and appropriate clothing to the child, youth or young adult in the PRTF. In instances when a parent or legal guardian is unable to meet the clothing needs of the child, youth or young adult, PRTFs are encouraged to identify and utilize community resources or extended family supports to provide clothing and other personal items to children, youth or young adults in need.

Comment

Four commentators urged the department to consider revising the requirement in subsection (b)(21) to include language stating that calls should be made during times established by the PRTF.

Response

The department agreed with the recommendation to add language in subsection (b)(21) and has added a requirement in the final-form rulemaking that access to a telephone be during times established by the PRTF.

Comment

One commentator recommended adding language to subsection (e) stating that a written acknowledgment of receipt of the policy on the rights of children, youth or young adults must be received before the child, youth or young adult's admission to the PRTF.

Response

The department agreed with this recommendation to include that the written acknowledgment of the policy and procedure on the rights of children, youth or young adults be ideally received "prior to admission but not later than 7 days after admission" and has revised subsection (e) accordingly. The department also added the language "or document the efforts to obtain written acknowledgement" that the policy and procedure was received and reviewed to subsection (e) because a parent, legal guardian or caregiver may not promptly respond to efforts to obtain a written acknowledgement within the required timeframe.

Comment

One commentator requested clarification on the meaning of the right to peacefully assemble.

Response

Modeled after the requirements in the regulations implementing the Mental Health Procedures Act under § 5100.53, the "right to peacefully assemble" under paragraph (24) means the right to peacefully assemble and to join with other children, youth or young adults to peacefully organize a body or participate in the government of the PRTF, when it has been determined feasible. The department removed the language "by the PRTF" since feasibility should not be the lone determination of the facility.

Comment

IRRC also asked the department to clarify the term "excessive medication."

Response

The department agreed with this recommendation and defined "excessive medication" in the final-form rulemaking. Under the final-form rulemaking, "excessive medication" is

"prescription or over the counter medication that is beyond what is medically necessary to treat a child's, youth's or young adult's documented medical condition, including amount and duration of the medication."

Additional Revisions

While reviewing this section, the department added the term "vision, hearing" to subsection (b)(2) for consistency because the final-form rulemaking includes requirements specific to vision and hearing. See §§ 5330.116 and 5330.117 (relating to vision care; and hearing care). Similarly, for clarity the department revised the language "discharge" to "recommended for discharge" in subsection (b)(25) because the intent of the requirement was that once the child, youth or young adult has successfully completed the goals outlined in their treatment plan and PRTF services are no longer medically necessary, the PRTF should recommend that the child, youth or young adult be discharged.

Lastly, the department removed "or determined by the child's, youth's or young adult's treatment team that the active participation would negatively impact the child's, youth's or young adult's treatment, safety or well-being" from subsection (d)(3) because only a court order can prevent a parent, legal guardian or caregiver from participating in their child's, youth's or young adults' treatment.

§ 5330.32 Grievance Procedures

The department added subsection (b)(3) to § 5330.32 (relating to grievance procedures). The requirement ensures that PRTFs have a process for reviewing grievances and informing individuals who submit grievances of the outcome as soon as possible, but no later than 7 days after submission of the grievance. The department also added the language "or document the efforts to obtain written acknowledgment" that the grievance policy and procedure was received

and reviewed to subsection (e) because a parent, legal guardian or caregiver may not promptly respond to efforts to obtain a written acknowledgment within the required timeframe. Furthermore, the department added the language “prior to the child’s, youth’s or young adult’s admission” but no later than 7 days after” admission to subsection (e) because the department supports a PRTFs effort to obtain the acknowledgement prior to admission.

§ 5330.34 Searches

Comment

Five commentators sought clarification on “unclothed body searches of a child, youth or young adult,” and suggested that it be defined. Some offered definitions for the department to consider. Two commentators stated that prohibiting unclothed body searches would limit the PRTFs' ability to prevent contraband from entering the facility. One suggested that unclothed body searches occur under a physician’s order and be carried out by two staff members of the same gender as the child, youth or young adult.

Response

The department reviewed the comments and supports the recommended changes. Under the final-form rulemaking, the department will allow visual body searches of a child, youth or young adult when ordered by a physician and conducted by two PRTF staff members of the same gender that the child, youth or young adult identifies. The department also added a definition of “visual body search” to the final-form rulemaking for further clarity. Under the final-form rulemaking, a “visual body search” is defined as the “viewing of a child’s, youth’s or young adult’s body after the child, youth or young adult has removed clothing to expose underwear or private body parts for the purposes of checking for contraband.”

§ 5330.41 Supervision of Staff

Comment

Seven commentators suggested not requiring the medical director to supervise PRTF staff. Commentators also expressed concerns that these supervision requirements are excessive, with no clinical or operational benefit and outside the scope of their work. Six commentators recommended that the supervision of mental health workers continue to be by the program director. Three commentators suggested that a director of nursing or an equivalent should oversee the nurses at the PRTF, not the medical director. Three commentators suggested the department should allow PRTFs to decide who should conduct the monthly supervision. One commentator asked the department to consider that supervising staff requires removing staff from supervising children, youth and young adults, which could increase costs due to the need for additional staff to meet staff ratio requirements. IRRC also reiterated concerns from the commentators that the medical director will be operating outside the medical director's scope of work, and the additional time needed for supervision and observation will reduce the time the medical director has available as the treatment team leader and to manage medications. Similar concerns regarding supervision by a medical director, clinical director or mental health professional were raised regarding time demands and detracting from other responsibilities. Additionally, IRRC reiterated the commentators' concerns that the time requirements in this section decrease the amount of time staff can dedicate to other roles within their positions. IRRC requested that the department explain how the staff supervision requirements are reasonable, how they protect the health and safety of children, youth and young adults and the fiscal impact of the staff supervision mandate.

Response

Based on the comment received and after careful consideration, the department revised the final-form rulemaking to allow PRTFs to exercise flexibility in meeting the supervision requirements based on the PRTF's supervisory structure. This change will allow PRTFs to choose between individual and group supervision to meet the observation requirement. Due to the intensive treatment and supervision required in these settings, which serve children, youth or young adults with severe behavioral health diagnoses, the department is maintaining the minimum level of in-person supervision. Under the final-form rulemaking, each PRTF is required to have a written policy and procedure that provides for each PRTF staff person to be supervised by a qualified PRTF staff person for at least 2 hours each month, with one of those hours being in-person supervision. In addition, each PRTF staff person shall have 1 hour of observation of the provision of service by a qualified PRTF staff person every 6 months, with each occurrence of observation being at least 30 minutes. Each PRTF may develop a policy and procedure that meets the supervision requirements without a financial burden or significantly reducing staff availability. The revised requirement has been added to ensure children, youth or young adults in a PRTF are receiving the medically necessary behavioral health treatment they are prescribed to receive. In addition, the department added that the "medical director and the treatment team leader are not required to be supervised in accordance with the requirements of this section." This was added because the director of the clinic and the treatment team leader must be a psychiatrist and there is no other staff person who is more qualified in a PRTF setting who could appropriately supervise these roles which require both advanced education and experience.

While reviewing commentators' concerns, the department determined that an “annual performance review of each PRTF staff person” should be added to paragraph (a)(3) because it serves as a key function of the revised supervision requirements and is consistent with the annual evaluation requirements specified in § 5320.44 (relating to staff supervision). Furthermore, the department modified the documentation requirement in subsection (b) by removing the documentation requirement “about each supervision session” and replacing it with required documentation “of the completion of the requirements in subsection (a).” This change was made to better align with the other changes to this section.

Comment

Three commentators stated that the requirement for “direct observation” is excessive, and other supervision methods, such as videotaped sessions, are standard practice in other settings. One commentator said that in-person supervision is not consistent with telehealth guidance provided by the department and the requirements should be revised to allow more flexibility.

Response

The department agreed with the commentators and removed the language “direct observation” throughout § 5330.41 and changing the requirement from “direct observation” to “observation” in paragraphs (b)(1) – (3), which enables a PRTF to comply with this requirement through video. Similarly, the department modified the requirement in subsection (c) by removing the term “face-to-face" and replacing it with “observation.” This revision was added to align with other changes to this section and for consistency. The department also clarified the language of this requirement by adding “with the exception of in-person supervision” and for observation and supervision to be “conducted” through secure, real-time, two-way audio and video transmission.

§ 5330.42 Staff Requirements

Comment

Fifteen commentators asked the department to reconsider the requirement that a mental health professional be present at the PRTF during all awake hours. The commentators indicated that this requirement increases staffing costs and makes it difficult to retain mental health professionals to meet this requirement and expressed concern that PRTFs would struggle to recruit and retain mental health professionals willing to work non-traditional hours to meet the requirement. One commentator requested that the department consider allowing PRTFs to develop their own plans for how mental health professionals are integrated with the rest of the treatment team and how they will have a good understanding of the behaviors within the current population. IRRC reiterated statements from commentators and asked the department to justify the reasonableness of requiring a mental health professional to be at the PRTF during waking hours and how this requirement balances reasonableness with the protection of public health, safety and welfare.

Response

The department thanks the commentators. The department understands the workforce shortage concerns. In consideration of those concerns, along with other requirements, the department has extended the effective date of the final-form rulemaking until 24 months after publication of the final-form rulemaking in the *Pennsylvania Bulletin*. The extended time period will provide facilities with additional time to come into compliance with the final-form rulemaking. Importantly, the staffing model in the final-form rulemaking supports the need to have a safe and structured environment to effectively deliver intensive psychiatric treatment to these vulnerable children, youth or young adults with severe behavioral health diagnoses.

The department recognizes the concerns raised by the commentators and IRRC regarding the presence of a mental health professional at the PRTF during awake hours. In response to these comments, the department revised paragraph (d)(3) of the final-form rulemaking (formerly paragraph (c)(3)) to instead require that staff who meet the qualifications of either a mental health professional or clinical director be present during all awake hours. The department determined that given the high level of treatment needs and supervision in this setting, it is reasonable to require a PRTF staff member qualified as either a mental health professional or a clinical director to be on site during awake hours. This was further supported by members of the transition age youth and young adult (TAYYA) subcommittee of the Mental Health Planning Council. Many TAYYA members believed that having a mental health professional or a clinical director available during evening hours would be beneficial, as that is when many children, youth or young adults face conflicts or emotional challenges.

Comment

Commentators submitted comments regarding the minimum staff ratios in paragraphs (c)(1) and (d)(1) (renumbered (d)(1) and (e)(1) in the final-form rulemaking), including inquiring what the impact would be, requesting the staff ratio remain unchanged and commenting regarding the workforce shortage and fiscal impact for implementation. Conversely, another commentator supported the increase in staffing requirement but had concerns regarding barriers and access to care.

Response

The final-form rulemaking sets a minimum staff ratio of one staff member for every six children, youth or young adults during awake hours and one staff member for every 12 children, youth or young adults during sleeping hours. This ratio was established based on input from the

stakeholder workgroup, the served population and comparisons to neighboring states. The department recognizes that many of the RTFs subject to the final-form rulemaking currently surpass these existing staffing standards. In comparison, West Virginia has stricter staffing ratios than those in the final-form rulemaking, requiring one staff member for every three children, youth or young adults during awake hours and one for every six children, youth or young adults during sleeping hours. Additionally, New York has a more rigorous staffing ratio requirement during awake hours, with one staff member required per every five children, youth or young adults, and a less strict standard during sleeping hours, requiring one staff member per every 14 children, youth or young adults. Ohio's requirements are also stricter than those in the final-form rulemaking in that Ohio requires a staff ratio of one staff member for every three children, youth or young adults during awake hours. The ratio is even stricter if the Ohio PRTF serves children, youth or young adults with intellectual disability, as that ratio is one staff member for every two children, youth or young adults during awake hours. Ohio does not have staff-ratio requirements during sleeping hours.

During the stakeholder workgroup meetings, many RTF providers stated that their staff ratios exceed existing standards and meet the requirements in the final-form rulemaking. Although the department is maintaining the staff ratio requirements from the proposed rulemaking, the department has extended the time period for compliance for those existing facilities seeking licensure as a PRTF until 24 months after publication of the final-form rulemaking. As noted above, the department has also revised the qualifications for mental health workers under the final-form rulemaking in order to assist facilities in meeting these new ratios. Further, no facility is required to transition from an RTF to a PRTF.

Comment

Five commentators expressed concern that the requirement for a PRTF staff member to be 21 years of age could negatively impact the facility's ability to recruit staff through practicums and internships. IRRC requested the department explain how the minimum age requirement for staff is reasonable and effectively protects public health, safety and welfare.

Response

In response to comments regarding PRTF staff being at least 21 years of age, the department lowered the minimum age to be employed at a PRTF to 18 years of age in subsection (a) of the final-form rulemaking; however, a PRTF staff person will still need to be at least 21 years of age under new subsection (b) to count toward the staff-ratio requirements specified in this section. The department determined that requiring a PRTF staff to be at least 21 years of age for staff ratios is appropriate and protects the health, safety and welfare of both staff and the young adults receiving treatment given that PRTFs provide treatment to young adults up to the age of 22.

Comment

Three commentators asked the department to consider removing the requirement in subsection (b) (renumbered subsection (c)), which requires staff members trained in manual restraints to be present on site at all times. The commentators noted that this requirement conflicts with the staff ratio supervision requirements in paragraphs (c)(1) and (d)(1) (renumbered paragraphs (d)(1) and (e)(1)) and would lead to additional costs. IRRC asked the department to clarify the requirement that two staff members trained in manual restraints must always be present at the facility and to further explain the reasonableness of the number and type of staff needed to supervise children, youth or young adults.

Response

The department acknowledges the concerns raised by commentators and IRRC regarding the requirement to have two staff trained in manual restraints always present at the PRTF. The department, however, is maintaining this requirement in the final-form rulemaking because it is needed to comply with the Federal staffing requirement in 42 CFR 483.362 (relating to monitoring of the resident in and immediately after restraint), which requires that "clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and safe use of restraint throughout the duration of the emergency safety intervention." This requires that while one trained staff member is conducting a restraint, a second trained staff member is observing the restraint to assess safety; requiring at a minimum two staff members to be present during a restraint. Furthermore, keeping this requirement in the final-form rulemaking ensures that another staff member is always available to support an emergent situation and is protective of the public health, safety and welfare of both those being served and staff. Lastly, ratios to supervise children, youth and young adults are distinct from the requirements to having two staff persons trained in the use of manual restraints present and available.

Comment

Seven commentators indicated that PRTFs would be unable to maintain compliance with the requirement that staff providing supervision remain within auditory and visual range under paragraphs (c)(2) and (d)(2) (renumbered as (d)(2) and (e)(2)). Additionally, IRRC reiterated concerns from commentators that it is not feasible for PRTF staff to remain constantly within both auditory and visual range of children, youth or young adults. IRRC requested the

department to clarify this provision to ensure that the final-form rulemaking protects public health, safety and welfare and is feasible.

Response

The department appreciates the concerns with staff being in both "auditory and visual" range of children, youth or young adults at all time. In response to those comments and to provide greater feasibility, the department revised the requirement in paragraphs (d)(2) and (e)(2) of the final-form rulemaking to be either in "auditory or visual" range. This is specified in subsection (c)(2) (renumbered as subsection (d)(2)) and subsection (d)(2) (renumbered as subsection (e)(2)). In addition, the department added "children, youth or young adults" to subsection (c)(2) (renumbered as subsection (d)(2)) to clarify the requirement is specific to supervising children, youth or young adults.

Comment

Five commentators stated that PRTFs would not be able to meet the requirements in subsection (e) (renumbered subsection (f)), which are related to supervisory staff ratios. Four commentators supported the enhanced staff requirements outlined in this section but questioned how those requirements can be met given the current workforce challenges. Another commentator questioned the organizational structure.

Response

The department also acknowledges the administrative concerns raised by commentators regarding the requirement in subsection (e) (renumbered as subsection (f) in the final-form rulemaking), relating to the supervisory staff ratio. The department continues to support that supervisory staff must be physically present at the PRTF at all times because PRTFs provide the most intensive residential level of care for children, youth or young adults with severe behavioral

health diagnoses. However, the department revised the requirement in this section to remove the ratio requirements and, instead, the final-form rulemaking requires only that at least one PRTF supervisory staff person be physically present at the PRTF at all times. Furthermore, it is vital that PRTFs offer a safe and structured environment to effectively deliver medically necessary intensive psychiatric treatment. The reduced supervisory staff requirement still maintains a safe and structured environment, but balances the health and safety of the children, youth and young adults against the programmatic workforce concerns.

Additional Revisions

While reviewing this section, the department added the term "designated" to subsections (c) and (d) (renumbered as subsections (d) and (e) respectively) because the PRTF, not the department, determines awake and sleeping hours.

As previously mentioned in the Fiscal Impact discussion and in response to comments on administrative burdens, the department agreed to reduce the requirement in § 5330.47 (related to registered nurse) from "an RN who is either onsite or available at all times when not onsite" to the requirement that either "an RN or an LPN shall be present" during designated awake hours and for an RN or an LPN to be present at the PRTF or on call during designated sleeping hours and added the requirements to this section.

Furthermore, the department clarified the requirement that "PRTF staff providing supervision to a child, youth or young adult shall remain awake at all times," which is specified in subsection (d)(4) (renumbered as subsection (e)(4)). For the sake of the health and safety of the children, youth or young adults in a PRTF, the staff providing supervision shall remain awake throughout their scheduled shift.

§ 5330.43 Medical Director

Comment

Commentators pointed out that the requirement for a medical director is problematic due to the shortage of healthcare professionals, including the National shortage of psychiatrists. Additionally, requiring the medical director to be a psychiatrist worsens this issue. Another commentator suggested the department reconsider the necessity of having a medical director, treatment team leader and clinical director, as there is a high likelihood of overlapping duties among these roles. IRRC requested the department to explain how the final-form rulemaking balances the feasibility and fiscal impact of treatment standards with the protection of the public health, safety and welfare.

Response

After reviewing the qualifications and roles of the medical director, treatment team leader and clinical director, the department concluded that each of the three positions serves a unique purpose and will remain in the final-form rulemaking. The medical director is responsible for the oversight of behavioral health services and programming and coordination and supervision of PRTF staff on clinical and medical matters, including prescribing and monitoring psychotropic medication. The treatment team leader is responsible for the direction of the child, youth or young adult's treatment team and leads monthly treatment plan meetings for each child, youth or young adult. The clinical director is responsible for the oversight of treatment assessments, services, therapeutic activities and program schedules in a PRTF. However, as discussed previously in the Fiscal Impact discussion, a medical director may serve as treatment team leader in accordance with § 5330.43(d) (relating to medical director), and the medical director may also

serve as a clinical director in accordance with § 5330.45(d) (relating to clinical director), thus not requiring three separate positions.

The department is also maintaining the requirements that the medical director and the treatment team leader be a board-certified or board-eligible psychiatrist. In making this determination, the department reviewed clinical recommendations from the American Academy of Child and Adolescent Psychiatry specified in the Principles of Care for Treatment of Children and Adolescents with Mental Illnesses, which recommends that "the best intervention for serious mental health issues that cannot be treated in the child's home environment is a facility that has a multidisciplinary treatment team providing safe, evidence-based care that is medically monitored. A mental health professional should lead this team. A psychiatrist with training and experience consistent with the age and problems of the children served should inform and monitor this process."
https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf. While clinical best practice would be for specifically a child psychiatrist to fulfill this role, given the limited availability of child psychiatrists, the department is requiring only "a psychiatrist" and not specifying a psychiatrist with specific child expertise. Current graduate medical education requirements for a resident physician training in adult psychiatry include 2 months of training in a child/adolescent psychiatry focused clinical rotation, so non-child specialized psychiatrists recently trained should still have at least 2 months of training in child/adolescent psychiatry under the Accreditation Council for Graduate Medical Education (ACGME) standards.
https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/400_psychiatry_2026.pdf.

§ 5330.44 Treatment Team Leader

Comment

One commentator noted that requiring psychiatric evaluations to be completed within 7 days of admission is unreasonable and suggested that the department consider extending this to 14 days.

Response

The department reviewed the concern from the commentator and revised this requirement to "a psychiatric evaluation must be completed within 7 days of a child's, youth's or young adult's admission to a PRTF *if the psychiatric evaluation was not completed within 30 days prior to admission." (emphasis added)*. For further clarity, this language was removed from paragraph (b)(6) and added to § 5330.142(a)(2) (relating to treatment planning). Subsection (b) was renumbered accordingly.

Comment

Three commentators pointed out that the responsibilities assigned to a psychiatrist who is a treatment team leader are beyond their usual duties of a psychiatrist.

Response

As noted previously in response to the comments to § 5330.43, the department has determined that the qualifications of the treatment team leader must be met by a psychiatrist. In making this determination, the department reviewed clinical recommendations from the American Academy of Child and Adolescent Psychiatry specified in the *Principles of Care for Treatment of Children and Adolescents with Mental Illnesses,* which recommends that "the best intervention for serious mental health issues that cannot be treated in the child's home environment is a facility that has a multidisciplinary treatment team providing safe, evidence-

based care that is medically monitored. A mental health professional should lead this team. A psychiatrist with training and experience consistent with the age and problems of the children served should inform and monitor this process."

https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf. While clinical best practice would be for specifically a child psychiatrist to fulfill this role, given the limited availability of child psychiatrists, the department is requiring only a psychiatrist and not specifying a psychiatrist with specific child expertise. Current graduate medical education requirements for a resident physician training in adult psychiatry include 2 months of training in a child/adolescent psychiatry focused clinical rotation, so non-child specialized psychiatrists recently trained should still have at least 2 months of training in child/adolescent psychiatry under the Accreditation Council for Graduate Medical Education (ACGME) standards. https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/400_psychiatry_2026.pdf.

The department also reviewed how other states meet this requirement. Ohio specifies that "If the medical director is not a board certified or board eligible psychiatrist, the PRTF will also employ or contract with a psychiatrist who meets this qualification," which is specified in the Ohio Administrative Code, Rule 5122-41-06(a) (relating to staffing, staffing qualifications, and staff ratios). Several of Ohio's PRTFs are currently enrolled in the Commonwealth's MA program and serve many children, youth or young adults from the Commonwealth. The department also reviewed the requirements in West Virginia, which specifies that "The facility must appoint a medical director to be responsible for coordinating medical services and directing member treatment. The medical director must be a board eligible or board-certified psychiatrist

(experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry. West Virgina Chapter 531.2.3. – Covered Services, Limitations and Exclusions for Psychiatric Residential Treatment Facility Services. https://bms.wv.gov/sites/default/files/2025-06/bms-manuals-chapter_531_PRTF.pdf. Of note, the final-form rulemaking is less restrictive than West Virginia's requirements as it does not require the psychiatrist to have specific experience in child/adolescent psychiatry.

Similarly, Florida also requires that residential treatment center providers have on staff or under contract a psychiatrist who is board certified or board eligible in child and adolescent psychiatry to serve as medical director for the program and such position shall oversee the development and revision of the treatment plan and the provision of mental health services provided to children. Fla. Admin. Code Ann. R 65E-9.007(3)(a)(1). Arkansas also requires that PRTF services "be under the direction of a psychiatrist or physician with oversight by a psychiatrist (contracted physicians are acceptable)." Section 212.000.F. of the Arkansas Provider Manual, Section II – Psychiatric Residential Treatment Facility Services for Under Age 21. https://humanservices.arkansas.gov/wp-content/uploads/PRTF-under-Age-21-Medicaid-Provider-Manual.docx.

Comment

One commentator recommended changing the requirement in subsection (b)(3) so that the treatment team leader be responsible for oversight of the treatment plan.

Response

The department supports the recommended changes to subsection (b)(3) and revised the language used in subsection (b)(3) to provide for the treatment team leader to oversee the development and implementation of the treatment plan.

Additional Revisions

While reviewing this section, the department clarified the requirement in subsection (a) that each child, youth or young adult receiving medically necessary behavioral health treatment in a PRTF has an assigned treatment team leader. The department also added the language "with input from the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver" to subsection (b)(5) because, consistent with other provisions of the final-form rulemaking, their voice is paramount to developing a discharge plan that addresses the needs of the child, youth or young adult when they return to the community.

§ 5330.45 Clinical Director

Comment

Two commentators asked the department to consider expanding the qualifications for a clinical director to include a board-certified behavior analyst (BCBA) or a licensed behavior specialist. Five commentators requested that the department consider not requiring the clinical director to be licensed, as this would exclude qualified professionals who are not licensed. One suggestion was that a professional with at least 2 years of clinical experience and no license could qualify as a clinical director.

Response

The department carefully considered the recommendations from the commentators and the education and experience of a BCBA or a licensed behavior specialist and did not make a change to allow a BCBA or licensed behavior specialist to qualify as a clinical director. The department determined that the clinical oversight of behavioral health needs for children, youth or young adults in a PRTF exceeds what a BCBA or a licensed behavior specialist can provide. The department determined that the minimum education, experience and licensure for the

clinical director are needed to best guide the medically necessary behavioral health treatment needs of children, youth or young adults residing in the PRTF. In addition, upon further review, the department determined that a licensed social worker (LSW) is not qualified as a clinical director because of the lack of necessary clinical training or experience to qualify as a clinical director and has removed LSW from paragraph (c)(6).

Comment

Three commentators sought clarification on whether the clinical director can have duties that cover multiple licensed PRTFs. Two commentators recommended that the department grant PRTFs more flexibility regarding the responsibilities of the clinical director.

Response

The department requires a clinical director for every licensed PRTF. However, an individual meeting the requirements of this section may serve as the clinical director for additional PRTF licenses so long as the requirements are met. The specific roles required for the clinical director (oversight of treatment, services, activities and program schedules) are essential to meeting Federal requirements specified in 42 CFR 441.156 (relating to team developing individual plan of care) and to perform key functions, such as oversight of treatment assessments, services and therapeutic activities and program schedules in a PRTF. Furthermore, the medical director may also serve as a clinical director in accordance with subsection (d).

§ 5330.46 Program Director

Comment

One commentator recommended adding the terms “clinical field work” and “lived experience" to the qualifications of the program director.

Response

Based on the comments received, the department reviewed the roles and qualifications of the program director. The department did not add the terms “clinical field work” and “lived experience” to the qualifications. While individuals with lived experience have a significant role in supporting the behavioral health needs of children, youth or young adults, the department did not add lived experience to the qualifications of a program director because of the level of acuity of the children, youth or young adults served in a PRTF. Similarly, clinical field work may vary depending on the discipline of study. Further, based on other comments received regarding concerns about workforce shortage and administrative burdens, the department does not want to further limit the availability of qualified personnel. The qualifications of the final-form rulemaking were determined utilizing the current Commonwealth standards. It is the Department’s hope that PRTFs value an applicant's lived experience as well as clinical experience when making staffing decisions.

Comment

Another commentator agreed with the responsibilities identified in paragraphs (b)(1)-(5) of this section but suggested that the department consider allowing PRTFs to decide who is responsible for these duties if the qualifications are met. In contrast, a different commentator questioned the department’s approach of having less stringent qualifications than those currently required for a program director. The commentator pointed out that even with the workforce shortage, the department still needs to ensure that less experienced professionals receive adequate clinical supervision.

Response

After careful review and consideration, the department concluded that the roles outlined in this section are appropriate for this level of care. As noted above, the qualifications in the final-form rulemaking were determined utilizing the current Commonwealth standards.

Additional Revision

While reviewing this section, the department also removed "business administration" from the qualifications for a program director from subsection (c)(3) because these associate and undergraduate degrees fail to align with the behavioral needs of children, youth or young adults in a PRTF.

§ 5330.47 Registered Nurse

Comment

Nine commentators requested that the department consider eliminating the requirement that RNs have at least 1 year of experience treating children, youth or young adults. One commentator suggested that instead of requiring 1 year of experience, the department consider allowing the PRTF to provide records of each nurse's measured competencies. If the competencies reveal a deficit, the PRTF would be required to provide the nurse with additional training.

Response

The department agreed with the commentators and removed the requirement for RNs to have 1 year of experience working with children, youth or young adults in the final-form rulemaking under subsection (c). This removal will assist providers in maintaining workforce requirement. As noted previously in the Fiscal Impact discussion and in response to comments on administrative burdens, to further assist with potential workforce issues, the department

removed the requirement in subsection (a) that an RN be "onsite or available at times when not on site" and added the requirement that either an RN or an LPN be present at the PRTF during awake hours, which is specified in § 5330.42(c)(4) (renumbered as subsection (d)(4)). The department also added that either an RN or an LPN be present at the PRTF or on call during sleeping hours, which is specified in § 5330.42(d)(5) (renumbered as subsection (e)(5)).

§ 5330.48 Mental Health Professional

Comment

Six commentators requested that the department consider removing the limit of eight children, youth or young adults being assigned to a mental health professional. Some suggested that the PRTF should have the discretion to determine an appropriate ratio based on the needs of the children, youth or young adults. Three commentators explained that PRTFs need flexibility at times to meet staffing requirements because of difficulties in recruiting and retaining qualified personnel.

Response

As discussed above, the department increased the caseload requirement from no more than eight children, youth or young adults be assigned to a mental health professional to no more than ten children, youth or young adults be assigned to a mental health professional under subsection (d). This increase may support PRTFs by reducing the number of mental health professionals needed to meet the caseload requirement.

Comment

Commentators assert that requiring non-traditional hours will make recruiting and retention of mental health professionals more difficult. IRRC requested the department explain

the reasonableness of the requirements for awake hours and how the regulation balances reasonableness with protection of the public health, safety and welfare.

Response

The department acknowledges the concerns from commentators and IRRC regarding recruiting and retaining mental health professionals to work non-traditional hours. In response to these comments, the department has expanded the requirement in the final-form rulemaking to permit PRTF staff who would meet the qualifications of either a mental health professional or a clinical director to be present during awake hours. The department revised the qualifications of a mental health professional based on the comments received to assist with any potential workforce issues. Specifically, in paragraph (e)(2), the department added the additional qualification of a "behavior specialist, associate marriage and family therapist or associate professional counselor" to broaden the qualifications for the mental health professional. However, the department removed "mental health direct service" from this subsection because as a condition of employment a clinical practicum is needed to work with the children, youth or young adults in this high acuity residential setting. The department also revised the number of credits needed in subsection (e)(3) and subsection (e)(4) from "9" credits to "12" to balance the change in qualifications to protect the health and safety of those being served. In addition, the change in credit hours aligns with the requirements for individuals providing other behavioral health services licensed by the department.

Comment

About six commentators asked the department to consider internships, including those with lived experience and practicums, to fulfill the educational requirements of a mental health professional.

Response

The department did not make the change to add the terms “internships” or “lived experience” to the qualifications because internships and lived experiences would not be sufficient to meet the clinical treatment needs of children, youth or young adults at this intensive level of care.

Additional Revision

The department added the language “with input from the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver” to subsection (c)(1) as the department determined that their voice is paramount to developing a treatment plan that can effectively address the child’s, youth’s or young adult’s behavioral health needs. The department also revised the terminology “foreign” and “foreign college or university” to “another country” or “from a college or university outside the United States” in subsection (e)(2), (3) and (4).

§ 5330.49 Mental Health Worker

Comment

Thirteen commentators expressed concern that the qualifications for the mental health worker will significantly reduce the number of available applicants for the mental health worker position. Two commentators suggested that the department either remove the 1 year of experience requirement and provide training or finalize the Direct Support Professional (DSP) certification initiated by the department.

Response

The department considered the concerns expressed by commentators and also the intensity of the medically necessary behavioral health treatment provided in a PRTF setting. In balancing those competing considerations, the department revised the final-form rulemaking to

require that a mental health worker has 12 credits in a behavioral health field under paragraph (c)(1) or have a high school diploma (or its equivalent) and at least 6 months of experience working in a behavioral health or related field under paragraph (c)(2). To assist with workforce issues, the department also added subsections (d) and (e) that a PRTF may provide 6 months of experience through formal training, so long as the training is separate and distinct from initial and annual staff training. For the 6-months of experience for those with a high school diploma, new subsection (e) of the final-form rulemaking requires the PRTF to have a written plan of supervision on how the experience will be obtained. However, under subsection (f), the mental health worker participating in the 6-months of experience may not be counted in the staff ratio requirements specified in § 5330.42 (relating to staff requirements) until completion. The department believes that these revisions, along with the extended period of compliance until 24 months from the publication of the final-form rulemaking, balance workforce concerns with the intensity of the medically necessary behavioral treatment provided in a PRTF setting and the need for qualified and trained staff.

§ 5330.50 Additional Staff Positions

Comment

One commentator appreciated the increased flexibility for the qualifications for the mental health worker supervisor position. Four commentators reiterated the difficulty of retaining mental health workers after 1 to 2 years of employment and asked the department to consider reducing the required experience to qualify as a mental health worker supervisor.

Response

The department appreciates the commentator's support regarding the qualifications for a mental health worker supervisor and acknowledges concerns about retaining mental health

workers. Therefore, the department agreed to reduce the experience required to qualify as a mental health worker supervisor in the final-form rulemaking. This is specified in paragraph (7)(i)–(iii) (renumbered as paragraph (5)(i)–(iii)). Specifically, under the final-form rulemaking, a mental health worker supervisor shall have one of the following:

(i) At least 6 months of experience in the delivery of behavioral health services to children, youth or young adults and a bachelor's degree in psychology, sociology, social work, counseling, education, human services, public administration or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from college or university in another country that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The department will accept a general equivalency report from the listed evaluator agencies to verify a degree or its equivalency from a college or university outside the United States.

(ii) At least 1 year of experience in the delivery of behavioral health services to children, youth or young adults and an associate's degree in psychology, sociology, social work, counseling, education, human services, public administration or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a college or university in another country that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential

Evaluation Services. The department will accept a general equivalency report from the listed evaluator agencies to verify a degree or its equivalency from a college or university outside the United States.

(iii) At least 2 years of experience in the delivery of behavioral health services to children, youth or young adults and a high school diploma or the equivalent of a high school diploma.

As noted previously in response to the comments to § 5330.46, the department also removed ‘business administration” from the qualifications of a mental health worker supervisor specified in paragraph (7)(i) and (ii) (renumbered as paragraph (5)(i) and (ii)). The department also revised the terminology “foreign” and “foreign college or university” to “another country” or “from a college or university outside the United States” from paragraph (7) (renumbered as paragraph (5).

Comment

Six commentators sought clarification on whether individually licensed PRTFs need to have an LPN on-site for each licensed PRTF. Four commentators requested that the department consider requiring an RN to be on call for any licensed PRTF rather than for each licensed PRTF. One commentator stated that requiring an LPN at the PRTF when an RN is not present would be difficult to enforce. Six commentators asked the department to consider removing the 1-year experience requirement for LPNs.

Response

The department also agreed to remove the requirement that LPNs must have 1 year of experience in the final-form rulemaking (formerly paragraph (5)). This change was made to better support PRTFs in recruiting and retaining an LPN. In response to the request to clarify

whether an LPN is needed for each licensed PRTF, the PRTF is not required to employ an LPN. Should a PRTF have an LPN, an individual meeting the requirements of this section may serve as the LPN for additional PRTF licenses so long as the requirements are met. Additionally, after further consideration, the department agreed to remove the requirement that an LPN or RN be on the PRTF grounds at all times and removed paragraph (4) in the final-form rulemaking. As such, the department revised the final-form rulemaking to require an RN or LPN to be present during a PRTF's designated awake hours and either on-site at the PRTF or on call during the designated sleeping hours under § 5330.42 (relating to staff requirements).

Additional Revisions

The department revised the duties and qualifications of an advanced practice professional (APP). Paragraph (1)(ii) was changed from the requirement to review, update, sign and date treatment plans to may "participate in monthly treatment plan meetings for children, youth or young adults" because an APP is not a required position in the final-form rulemaking. Paragraph (2) was also changed to an APP needing to have at least 1 year of experience working with children, youth or young adults, and obtaining a mental health certification within 2 years of being hired by the PRTF. The department removed the requirement to "be licensed in this Commonwealth and" from this paragraph because it is duplicative of the definition of APP, which is specified in § 5330.3 (relating to definitions).

The department also added "accept verbal orders for medication" to paragraph (3) for consistency so long as its within of the LPN's scope of practice.

§ 5330.51 Initial Staff Training

Comment

One commentator supported increased training requirements to improve the quality of care in a PRTF. About ten commentators expressed concern that mandatory training for all PRTF staff could lead to higher costs and discourage individuals who do not have regular and direct contact with children, youth or young adults from working in a PRTF. One commentator asked the department to consider defining the phrase "regular and direct contact" as someone whose duties include the direct supervision and treatment of a child, youth or young adult. IRRC also reiterated feedback from commentators about the fiscal impact of the enhanced training requirements on PRTFs and asked the department to consider whether it is reasonable to apply the training requirements to all PRTF staff. Additionally, IRRC instructed the department to explain how the initial training requirements are reasonable and how they balance the fiscal impacts of PRTF staff training with the protection of public health, safety and welfare.

Response

The department appreciates the comments from the commentators and IRRC regarding initial staff training requirements. In response to these concerns, the department revised subsection (c) of the final-form rulemaking to limit initial staff training to only PRTF staff who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month. Any PRTF staff person, including a medical director, who provides treatment for 30 or more hours in any month must meet the initial training requirements of this section because of the intensive behavioral health treatments of the children, youth or young adults being served. Furthermore, the initial training requirements provide PRTF staff with knowledge, skills and abilities to work with children, youth or young adults with behavioral health needs.

Comment

One commentator noted that the need to complete training under the Adult Protective Services Act outlined in subsection (c)(3) will add extra costs to the PRTF. Three commentators raised concerns about the requirement for the medical director to complete the training described in subsection (c), as it could become a barrier to hiring psychiatrists.

Response

As discussed previously, the department maintained the requirement that PRTF staff complete initial training on the Adult Protective Services Act, which provides protection for young adults with physical or mental impairments. However, the department clarified in paragraph (c)(3) that the final-form rulemaking applies only to PRTFs that provide treatment to young adults.

Additional Revisions

The addition of "cross-system collaboration that include system of care values or child and adolescent service system program principles" was added to the paragraph (c)(14) of the PRTF staff training requirements to ensure that PRTF staff understand the importance of cross-system collaboration. Many of the children, youth or young adults who receive care in a PRTF are involved with other provider agencies prior to and following admission. These values and principles have been a foundation in the Commonwealth's approach to working with children, youth, young adults, their parents, legal guardians, caregivers and the providers involved. Understanding these values and principles may ensure a seamless transition for the child, youth, or young adult back into the community.

While reviewing this section, the department added the language "prior to working directly with children, youth or young adults" to subsection (c) and removed the language from

subsection (d) to clarify that the training not only has to be completed within 120 days, but the PRTF staff may not work directly with a child, youth or young adult until the requirement is met. The department also clarified the training requirement in subsection (c)(10) to state "the impact of trauma on a child, youth or young adult and how trauma-informed care promotes resiliency and recovery of a child, youth or young adult." This revision clarifies the training approach the PRTF must take to better support PRTF staff in working with children, youth or young adults who have been significantly impacted by trauma. Lastly, the department added "copy of materials distributed to PRTF staff" and "copy of materials that were used during the training" to paragraphs (e)(6) and (7) (renumbered as paragraphs (d)(6) and (7)) to clarify paperwork requirements related to curriculum.

§ 5330.52 Annual Staff Training

Comment

Six commentators asked the department to consider removing the requirement that all PRTF staff receive annual training. Three commentators expressed concern about the requirement for the medical director to complete the training outlined in subsection (c) because they believe it will create a barrier to hiring psychiatrists. IRRC reiterated feedback from commentators about the fiscal impact the enhanced training requirements will have on PRTFs and asked the department to consider whether it is reasonable for the training requirements to apply to all PRTF staff. Additionally, IRRC asked the department to explain how the annual training requirements are reasonable and how they balance the fiscal impacts of PRTF staff training with the protection of public health, safety and welfare.

Response

Similar to the revisions to initial staff training requirements in § 5330.51 and in response to the comments received, the department revised the final-form rulemaking to remove the requirement for annual training for all staff and to specify in subsection (b) that only PRTF staff who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month will be required to meet the annual staff training requirements. Because of this change, the department condensed and revised this section. As a result, the additional 10 hours of training were combined in subsection (b) and subsection (c)(1) was renumbered as subsection (b)(1), and the remaining requirements were renumbered accordingly. It is necessary that any PRTF staff person, including a medical director, who is involved in providing treatment for 30 or more hours in any month meets the annual training requirements because of the intensive behavioral health treatments of the children, youth or young adults being served. Furthermore, the training requirements provide PRTF staff with continued knowledge, skills and abilities to work with children, youth or young adults with behavioral health needs.

Comment

Another commentator requested the department to clarify training on the requirements of the Adult Protective Services Act and how such training differs from children's service training.

Response

The training focuses on the responsibilities under the Adult Protective Services Act (35 P.S. §§ 10210.101 – 10210.704). Specifically, the Adult Protective Services Act supports vulnerable adults (at least 18 years old), while Child Protective Services support children and youth. Adult Protective Services addresses adult safety and support, while Child Protective Services investigates child welfare concerns, which may remove children and youth from unsafe

environments. Because PRTFs may serve young adults who are between 18 and 22 years of age, the Adult Protective Services Act may apply, depending on the age of the population served.

Additional Revision

In addition, similar to the initial training requirements, the department clarified documentation requirements for annual staff training requirements by adding that the "copy of materials distributed to PRTF staff" and "copy of materials that were used during the training" to subsection (d) (renumbered as subsection (c)) are required to be maintained.

§ 5330.66 Ventilation

Comment

One commentator requested that the department clarify the requirement that a window "must be securely screened when open."

Response

The term "securely screened" is necessary in subsection (b) because without the requirement, any screen, whether secure or not, would be acceptable. An insecure screen would pose a safety risk for children, youth, or young adults.

§ 5330.68 Surfaces

Comment

One commentator proposed an exception from the requirement that areas be free of damage or hazards for areas that have experienced recent property damage, allowing time for repair.

Response

The department did not include the suggested language in the final-form rulemaking. If there is a hazardous condition, the PRTF will be responsible for correcting it to ensure the safety of children, youth young adults and PRTF staff.

§ 5330.71 Communication System

Comment

One commentator asked the department to clarify whether the requirement mandates PRTFs have radios available to all PRTF staff on shift or if they can be shared within each unit.

Response

Under subsection (b), PRTFs must have communication equipment always available to PRTF staff to call for assistance during emergencies. PRTFs are not required to specifically have radios. The department has removed the phrase "such as a hand-held two-way radio" from subsection (b) to avoid confusion and provide additional clarity.

§ 5330.77 First Aid Supplies

Comment

Three commentators pointed out that requiring first aid kits to include opioid reversal medication and be on every floor of a PRTF is excessive. IRRC also reiterated the commentators' concerns about the additional costs of requiring that a first aid kit be available on every floor of the PRTF and include opioid overdose reversal medication. IRRC asked the department to explain how the first aid kit requirements balance the reasonableness and fiscal impact of the requirements with the protection of public health, safety and welfare.

Response

The department carefully considered the concerns and recommendations from the commentators and IRRC. In balancing the costs against health and safety concerns, the department agreed to eliminate the requirement for opioid reversal medication in all first aid kits but will still require that opioid reversal medication be available at the PRTF and accessible to PRTF staff, as specified in subsection (e). Furthermore, opioid reversal medication will need to be stored in accordance with section § 5330.161(relating to storage of medication). The department also agreed to limit the requirement that a first-aid kit be on every floor of the PRTF. Instead, in the final-form rulemaking, a first aid kit is required on only those floors where a child, youth or young adult may be present. This is specified in subsection (a).

Comment

Another commentator asked the department to consider removing the requirement in subsection (b), which states that a first aid kit must be available when activities are conducted outside on the PRTF grounds or away from the PRTF, because it is overly precautionary as first-aid supplies are readily accessible.

Response

The department agreed and removed the requirement from subsection (b) that a first aid kit be present if an activity is conducted outside on the grounds of the PRTF or away from the PRTF and renumbered the section accordingly.

Comment

One commentator mentioned that AEDs should be in obvious, easily accessible locations, and the requirement in subsection (f) contradicts that.

Response

The department agreed and removed subsection (f) that prohibited an AED from being accessible to children, youth or young adults. In addition, a PRTF will be required to "maintain the AED in accordance with the manufacturer's operational guidelines," which is specified in subsection (g). This ensures that the AED remains functional for PRTF staff.

Additional Revision

For clarity, the department added language in a new subsection (f) to require a PRTF to replenish the first aid kit at least once a month. This ensures that the first aid kits are readily stocked. The department also clarified that the PRTF must document their compliance with requirements in subsections (f) and (g), which is specified in a new subsection (h).

§ 5330.81 Firearms and Weapons

The department added the term "on the premises" to § 5330.81 (relating to firearms and weapons) to clarify that the provision providing that a PRTF is not required to permit firearms, weapons and ammunition is specific to the physical location of the PRTF.

§ 5330.82 Bedrooms

Comment

A commentator requested that the department reconsider the requirement in subsection (c) regarding no more than four children, youth or young adults sharing a bedroom. They suggested adopting a more trauma-informed approach that prioritizes privacy, given the children's, youth's or young adult's vulnerabilities.

Response

The department reviewed the concern from the commentator and is not making the requested change to reduce this ratio. The final-form rulemaking maintains the requirement of no

more than four children, youth or young adults sharing a bedroom because this provision balances provider capacity, the health and safety of the children, youth and young adults and is consistent with the current requirement under § 3800.102(c) (relating to child bedrooms).

Additional Revision

The department also revised subsection (h). Bunk beds will be prohibited under the final-form rulemaking due to existing practice and also due to the severe health and safety concerns with having bunk beds in the most intensive residential level of care for children, youth or young adults with severe behavioral health diagnoses. Bunk beds are not allowed in other inpatient levels of care due to risks of falls, injuries, and the decrease in visibility which could hide inappropriate actions and contraband items. Significantly, bunk beds also pose a ligature risk. No RTFs currently licensed and certified by the department use bunk beds. Due to the substantial health and safety concerns, the department is prohibiting the use of bunk beds in PRTFs in the final-form rulemaking. The department also removed subsections (i) and (j) from this section because they relate to bunk beds and renumbered the section accordingly.

§ 5330.92 Unobstructed Egress

Comment

Three commentators noted that the 15-second delay requirement in subsection (c) is more restrictive than the International Building Code, which permits a delay of no more than 30 seconds for doors with delayed egress. One commentator pointed out that the requirements in subsections (b) and (c) conflict because locking systems can use keys or electronic cards. IRRC also reiterated commentators' concerns that the 15-second delay requirement would pose an additional safety risk. IRRC asked the department to explain how the 15-second delay is reasonable and protects the public health, safety and welfare.

Response

The department agreed that these requirements should be revised based on the comments received. In the final-form rulemaking, the department removed the phrase “from the PRTF” in subsection (b). The requirement that doors used for egress from rooms cannot be fitted with key-locking devices, electronic card-operated systems or other controlled devices remains. The department also revised subsection (c) by removing the requirement that doors with delayed egress from a PRTF must be equipped with a mechanism that unlocks after no more than 15-seconds. As revised, doors with delayed egress from a PRTF must meet the International Building Code standards in subsection (c). The department also added a requirement that “doors without delayed egress from a PRTF may not be equipped with key-locking devices, electronic card-operated systems or other PRTF staff-controlled devices that prevent immediate egress by a child, youth or young adult from the PRTF,” which is specified in a new subsection (d). This requirement was added to clarify the requirements in this section.

§ 5330.101 Detectors and Alarms

Comment

One commentator requested that the department consider requiring detectors for children, youth or young adults who are impaired.

Response

The department agreed with the commentator's recommendation and has added a requirement that if a PRTF serves a child, youth or young adult with a sight or hearing impairment, the PRTF must make accommodations to alert the child, youth or young adult of an emergency. This is specified in a new subsection (j).

Additional Revisions

While reviewing this section, the department added "carbon monoxide alarms" to subsection (d) for clarity and consistency. This language was added because a carbon monoxide alarm must also be approved for use in a PRTF. The department also moved the requirement for a carbon monoxide alarm to be within 15 feet of any fossil fuel-burning device or appliance from subsection (g) to subsection (c) for readability and renumbered the section accordingly. Lastly, the department added the term "carbon monoxide alarms" alongside the requirements for smoke detectors and fire alarms in subsections (c), (e) and (f) (renumbered subsections (d), (f) and (g)) and a new subsection(i) because they must all follow the same requirements.

§ 5330.111 Health and Behavioral Health Services

Comment

One commentator emphasized the need for proper medical care in a PRTF.

Response

The department agrees that children, youth or young adults should receive adequate medical care while in a PRTF. With that in mind, the department reviewed the requirements of this section and determined that the current standards support the physical health needs of children, youth or young adults and further determined that no additional edits are needed.

Comment

Another commentator urged the department to consider setting age limits for lead screening.

Response

As noted, this section requires medically necessary physical and behavioral health treatment, including blood lead level. The department, however, did not place an age limit on

lead screening because if there is no documentation or laboratory history of a child, youth or young adult receiving lead screening, a lead screening may be ordered by a physician. In response to this comment and to provide further clarity, a requirement was added to the final-form rulemaking at § 5330.112(b)(13) (relating to initial medical assessment) for the initial medical assessment to include laboratory tests history, including prior tests of blood level or sickle cell, if applicable.

§ 5330.112 Initial Medical Assessment

Comment

Nine commentators expressed concern about the requirement for a physician to sign the initial medical assessment within 3 days of admission. Many of the commentators indicated that this requirement would have financial impact on PRTFs.

Response

The department reviewed the requirement in subsection (e) (renumbered subsection (d)), which concerns the time a physician must review and sign the initial medical assessment. Based on that review and the request to reduce the burden of the proposed requirement, in the final-form rulemaking, the department increased the signing period from 3 days to 7 days from the date the initial medical assessment was completed.

Additional Revisions

As noted previously in the response to comments in § 5330.111, the department added that an initial medical assessment must include "laboratory tests history, including prior tests of blood lead level or for sickle cell, if applicable" under paragraph (b)(13). The department also added a "review history of prohibited manual restraints, because of the child's, youth's or young adult's medical condition, if applicable" to the requirements for initial medical assessments

under a new paragraph (b)(14). These requirements were added because they support the health and safety of the child, youth or young adult.

For clarity and readability, the department moved the requirement for an initial medical assessment within 24 hours of admission in subsection (c) to subsection (a) and renumbered the section accordingly. The department also removed the former subsection (a), which required a written policy and procedure on the initial medical assessment, due to concerns of administrative burden. Upon further review, the department determined it was not necessary to have a PRTF develop a written policy and procedure given the remaining prescriptive requirements of the section.

§ 5330.113 Health and Safety Plan

The department clarified § 5330.113 (relating to health and safety plan) by adding "or the child's, youth's or young adult's most recent psychiatric evaluation" to subsection (a) to require a written health and safety plan to be developed if an initial medical assessment or current psychiatric evaluation identifies a health or safety risk to a child, youth or young adult. This term was added as this document can be used as a resource to identify health and safety risks associated with a child, youth or young adult.

§ 5330.114 Medical Examination

Comment

Three commentators requested that the department consider revising the requirement that a medical examination be completed within 15 days of admission under subsection (a).

Response

The department is maintaining the requirements in subsection (a) regarding the time by which a child, youth or young adult receives a medical examination. RTFs are currently required

to complete a health examination within 15 days of admission under § 3800.143 (relating to child health examination), and the department has determined that this health and safety requirement aligns with the need for children, youth or young adults to receive timely and appropriate medical care.

Additional Revision

While reviewing the requirements of this section, the department removed "caregiver" from subsection (b)(4) because a caregiver is not permitted to provide consent to a child's, youth's or young adult's medical examination.

§ 5330.115 Dental Care

Comment

One commentator asked the department to consider changing the requirement in subsections (b) and (c) to evaluate children, youth or young adults within 60 days after admission, instead of 30 days after admission.

Response

RTFs are currently required to meet this 30-day dental requirement under § 3800.144(b) (relating to dental care), and the department has determined that the requirement is appropriate for children, youth or young adults receiving timely dental care. As such, the department is not making this requested change.

§ 5330.118 Use of Drugs, Alcohol, Tobacco and E-cigarettes

Comment

One commentator asked the department to change "drugs" to "illegal drugs."

Response

The department agreed with the commentator's recommendation and added the term "illegal drugs" to subsection (a) – (c) of the final-form rulemaking to clarify the requirements.

Additional Revisions

While reviewing this section, the department also modified the requirement in subsection (a) to clarify the contents of the PRTF's policy and procedure. Accordingly, the department determined that the policy and procedure must include the utilization of illegal drugs, alcohol, tobacco and e-cigarettes by children, youth and young adults, and staff use of medications. The department also modified the requirement in subsection (d)(1) by adding the term "outside" to clarify the outside areas where it is permissible to use tobacco or e-cigarettes. This addition was made to provide additional clarity as to where the designated areas for tobacco or e-cigarettes can be located. For further clarity, the department also removed the language regarding permitted PRTF staff use of tobacco and e-cigarette products under subsection (d) to encompass any permitted use of tobacco and e-cigarette products.

§ 5330.121 Staff Assessment

Comment

One commentator noted that requiring staff to have a physical every 2 years under subsection (a) adds extra administrative work.

Response

The department is not making a change to the requirement that staff have a physical exam every 24 months under subsection (a). RTFs are currently required to meet this standard for staff health statements under § 3800.151 (relating to staff health statement), and the department has

determined that this health assessment requirement supports the health and safety of children, youth, young adults and PRTF staff.

§ 5330.131 Daily Meals

Comment

One commentator indicated that providing a meal after the child, youth or young adults misses a meal or declines a meal is not always feasible because there may not be anyone in food services to provide the meal and food may not be able to be saved due to food safety concerns.

Response

The department is not making a change to the requirements of this section. A child, youth or young adult needs to have access to food when a meal is missed or declined. The department understands that during times of distress, a child, youth or young adult may not want to eat or drink at designated mealtimes. This situation should not prevent a child, youth or young adult from having access to food when it is requested. The department also revised the language relating to a child's, youth or young adult's refusal to eat a meal and updated the language to "declines," "denial," and "declining" under subsections (d) and (e).

§ 5330.141 Treatment Planning Requirements

Comment

One commentator expressed that the treatment team leader does not have the time to ensure training occurs and stated that it should be the responsibility of the training department. IRRC also questioned why the department requires that the treatment team leader ensure that only PRTF staff who are trained and experienced can participate in the treatment plan for the child, youth or young adult, and asked the department to explain the reasonableness of excluding non-professionals such as parents, youth and others from the treatment planning process.

Response

The department agreed that the requirements in subsection (b) need to be further clarified and broadened. As such, the department changed the requirement to “a treatment team leader shall ensure that treatment team members participate in the development, implementation and review of the child’s, youth’s or young adult’s treatment plan.” The revised language in subsection (b) includes individuals other than PRTF staff in the development, implementation and review of the child’s, youth’s or young adult’s treatment plan. Specifically, the department revised this language to “treatment team members" in the final-form rulemaking. Under the final-form rulemaking, “treatment team” is defined as” the PRTF staff directly involved in the child’s, youth’s or young adult’s treatment and who is led by a treatment team leader. The treatment team also includes the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver and may include individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver” This change clarifies the list of individuals who can be part of the development, implementation and review of the treatment plan, including the child, youth or young adult, as well as their parents, legal guardian or caregiver.

Comment

One commentator indicated that the requirements in subsection (d) to maintain a communication log for each child, youth or young adult will result in duplicating information that is already electronically entered into the medical record. Another commentator noted that the requirements do not consider the contributions that individuals with lived experience, such as advocates, peers or direct support professionals, may have to a child’s, youth’s or young adult’s treatment. One commentator also warned that the communication log requirements of subsection

(d) encourage staff and providers to document information about the child, youth or young adult at a high level outside of an electronic record. IRRC asked the department to clarify whether subsection (d) is a duplication of the record-keeping requirements, and if it is, to address the reasonableness and fiscal impacts of maintaining a communication log for each child, youth or young adult.

Response

The department reviewed subsection (d) requirements and deleted the subsection in the final-form rulemaking. The department modified the requirement to "PRTF staff shall document daily observations about the child's, youth's or young adult's behaviors that can be used by the treatment team in the treatment planning process." This requirement was moved to § 5330.145 (b) (relating to treatment services) (renumbered as § 5330.144 (b)) for additional clarity in the final-form rulemaking. A PRTF has the discretion to determine how best to meet this requirement through the record-keeping process it utilizes, which may be either in written or electronic form.

§ 5330.142 Treatment Planning (Treatment Plan in proposed rulemaking)

Comment

Four commentators expressed concerns regarding the requirement in subsection (a)(1) that assessments and screenings be completed within 48 hours of a child's, youth's or young adult's admission to the PRTF. The commentators felt that this timeframe was too short given the need to first establish a therapeutic relationship and allow time for the child, youth or young adult to adjust to the PRTF. IRRC also requested the department to explain the need for and the reasonableness of the timeframe to complete assessments and screenings within 48 hours of a child's, youth's or young adult's admission to the PRTF.

Response

After careful consideration of the comments received and to address concerns regarding administrative burden, the department increased the timeframe for completion of a multi-disciplinary assessment and screening from 48 hours after admission to a PRTF to 7 days after admission. Furthermore, the department added that the multi-disciplinary assessment and screening would need to be completed 7 days after admission only if the multi-disciplinary assessment and screening was not completed within 30 days prior to admission. This is specified in paragraph (a)(1). This language was also added to the psychiatric evaluation specified in paragraph (a)(2) in the final-form rulemaking.

Comment

One commentator recommended that the department consider allowing PRTFs to update the initial psychiatric evaluation within 30 days of admission to the PRTF.

Response

The department did not make the change to extend initial psychiatric evaluations within 30 days of admission because initial treatment plans must be developed and implemented within 14 days of admission in accordance with Federal requirements at 42 CFR 441.154 (relating to active treatment). A psychiatric evaluation supports the development of the initial treatment plan.

Comment

One commentator suggested that the department develop a uniform assessment and treatment plan template. Another commentator asked if the assessment must be conducted across multiple domains, including home, community and school settings. IRRC and commentators also inquired regarding the phrase “multi-disciplinary assessment and screening.” IRRC asked the

department to clarify whether it refers to psychological assessment or to various treatment members providing unique assessments within their disciplines.

Response

The department does not support the implementation of a uniform assessment and treatment plan template because the medically necessary behavioral health treatment a child, youth or young adult receives in a PRTF is individualized and must be appropriate for the needs of the child, youth or young adult. The phrase "multi-disciplinary assessment and screening" applies to various treatment members providing unique assessments within their disciplines. The department did not dictate a specific assessment or screening tool that a PRTF must utilize in the final-form rulemaking. Similarly, the department defers to a PRTF to determine the evaluation, assessment and screening needs of a child, youth or young adult to gain clarity on their behavioral health needs. PRTFs will be able to utilize assessments and screening tools that best meet the population of the children, youth or young adults being served in the PRTF.

Comment

Another commentator asked what will happen if someone refuses to agree with the initial treatment plan, and what will occur in terms of supporting engagement.

Response

To address this concern, the department clarified incidents where a child, youth or young adult refuses to participate in treatment. In the final-form rulemaking, the department added language in a new subsection (i) that "if a child, youth or young adult declines to participate in the multi-disciplinary assessment, screening, psychiatric evaluation or treatment planning, the refusal must be documented in the child's, youth's or young adult's record, including the reason

for the refusal." In terms of how to support engagement with the child, youth or young adult, the department will defer to the PRTF's policies and procedures.

Additional Revisions

The department added the term "screening" to subsection (b) to be consistent with the requirements of this section. In addition, the department added the language "the child's, youth's or young adult's legal history, including legal guardianship, medical rights, educational rights or any other legal matters" to a new paragraph (b)(8) as it is imperative that the treatment team understand the role of each team member which includes who has the legal rights to make medical and educational decisions on behalf of a child, youth or young adult.

In addition, the department also revised the requirement in subsection (e)(2) by including the terms "goals" and "modalities," as they are generally understood terms used by PRTF staff and added clarity to the requirement. The department also added the term "therapeutic leave" to paragraph (e)(7) because of the changes made to the requirements specific to therapeutic leave being part of the child's, youth's or young adult's treatment plan. The department further clarified that a treatment plan must "include all medications the child, youth or young adult is prescribed," as specified in paragraph (e)(11). This was clarified because the child's, youth's or young adult's treatment plan must contain all pertinent information specific to the child, youth or young adult.

The department also revised the requirement in subsection (g) to provide additional clarification on meeting the requirement. The requirement was changed to provide that "a copy of the child's, youth's or young adult's treatment plan and updates to the treatment plan must be provided to the treatment team and placed in the child's, youth's or young adult's record." The department also moved the requirement from subsection (f) that "a PRTF shall document in the

child's, youth's or young adult's record the participation of treatment team members in the development of the child's, youth's or young adult's treatment plan." In the final-form rulemaking, this is specified in a new subsection (h). The department also moved the requirement for treatment team members to sign and date the treatment plan to subsection (f). If a treatment team member objects to the treatment plan or refuses to sign the treatment plan, the reason must be documented in the child's, youth's or young adult's record.

§ 5330.143 Maintenance of Treatment Plan

Comment

One commentator asked the department if treatment plans need to be changed every month. Another commentator said that revising the treatment plan every 30 days might not be realistic or appropriate, depending on the goals set for the child, youth or young adult. One commentator recommended that the term "revised" should be changed to "reviewed."

Response

In response to comments received, the department clarified the language in subsection (a) by removing the term "revised" and adding the terms "reviewed, updated and signed by the members of the child's, youth's or young adult's treatment team" in the final-form rulemaking. The requirement for reviewing the plan every 30 days is in accordance with Federal regulation at 42 CFR 441.155(c) (relating to individual plan of care).

§ 5330.144 Copies of Treatment Plan

Comment

One commentator suggested that the term "provided" be replaced with the term "presented."

Response

After further review of this section, the department added these requirements to § 5330.142(g) for clarity and deleted this section. In addition, the department agreed with the commentator and changed the requirement from "provided" to "offered and provided" in § 5330.142(g) of the final-form rulemaking.

§ 5330.144 Treatment Services (§ 5330.145 in proposed rulemaking)

Comment

Thirty-one commentators urged the department to consider allowing the child's, youth's or young adult's treatment team to determine the frequency of individual, group and family therapy. One commentator supported requiring the individual therapy hours to be calculated monthly rather than weekly. IRRC also reiterated concerns from commentators that the therapy requirements in this section should be based on each child's, youth's or young adult's treatment needs. IRRC asked the department to justify the reasonableness of the minimum number of treatment hours and to provide data supporting these treatment requirements. Specifically, IRRC asked the department to justify the reasonableness of requiring at least 2 hours of individual therapy per week with the child's, youth's or young adult's mental health professional and how this protects public health, safety and welfare. IRRC further requested an explanation for the reasonableness of requiring at least 3 hours each week of group therapy and 3 hours each week of psychoeducation group therapy, along with how these requirements balance fiscal impacts with the protection of public health, safety and welfare.

Response

The department carefully reviewed the comments from commentators and IRRC. The department determined that for purposes of health and safety, minimum treatment standards are

required for individual, group and family therapy in the final-form rulemaking because a PRTF is an intensive residential treatment setting where a child, youth or young adult with a severe behavioral health diagnosis receives medically necessary treatment that cannot reasonably be provided in the community. These minimum treatment standards ensure that the behavioral health needs of children, youth or young adults are met to support their discharge to the community as soon as possible. In response to comments received and based on engagement with stakeholders, the department revised the minimum treatment services from a weekly minimum to a monthly minimum standard to allow PRTFs more flexibility in meeting the requirements as PRTFs serve children, youth or young adults with various behavioral health diagnoses and cognitive abilities. Under the final-form rulemaking, individual therapy with a mental health professional is required for at least 6 hours each month (instead of 2 hours each week) under paragraph (c)(2) (renumbered (d)(2)). Similarly, group therapy is required for at least 12 hours each month (instead of 3 hours each week) and family therapy is required for at least 4 hours each month (instead of 1 hour each week) under paragraphs (c)(3) and (c)(4)(iii) (renumbered (d)(3) and (d)(4)(iii). The department also revised the psychoeducation group requirement under paragraph (c)(5) (renumbered (d)(5)) to be at the discretion of the treatment team and allow them to meet the needs of the current population of children, youth or young adults in the PRTF.

Family-based mental health services (FBMHS), which is one of the most intensive community-based services for children, youth or young adults in the Commonwealth, currently requires a high-intensity treatment schedule, which ranges from 3 to 10 hours of in-home therapy sessions each week. Similar minimum monthly treatment standards are needed for PRTFs, which provide a more intensive level of care. PRTFs serve children, youth or young adults whose needs

surpass what can be safely managed in community-based services and therefore treatment standards should exceed or at least match the treatment expectations seen in FBMHS. The minimum treatment standards in the final-form rulemaking ensure that children, youth or young adults in PRTFs receive treatment at a frequency that is consistent with the service hours provided in FBMHS.

Furthermore, the Department observed that several states have minimum treatment standards that mirror or are more stringent than the 6 hours each month for individual therapy (average 1.5 hours per week), 12 hours each month for group therapy (average 3 hours per week) or 4 hours each month for family therapy (average 1 hour per week) in the final-form rulemaking. The final-form rulemaking is requiring a total of 22 hours of treatment time per month or an average of 5.5 hours per week. As noted previously in the response to comments on administrative burdens, states with similar or more stringent requirements include Arkansas, Ohio, Maine, Minnesota and West Virginia. Maryland, New Jersey and New York do not have requirements regarding minimum standard for the frequency of individual, group and family therapy sessions.

Comment

Ten commentators noted that due to a nationwide shortage of psychiatrists, PRTFs may struggle to meet the requirement that a child, youth or young adult receive at least 1 hour of therapy with a psychiatrist monthly. IRRC also requested an explanation from the department regarding the reasonableness and fiscal impacts of the requirement for 1 hour of therapy each month with the child's, youth' or young adult's treatment team leader.

Response

In response to comments received, the department revised the provision under paragraph (c)(1) (renumbered (d)(1)) to require a "meeting" with the treatment team leader for at least 1 hour each month in the final-form rulemaking; instead of the child, youth or young adult having 1 hour of therapy each month. This change reflects the treatment team leader's primary role to meet with the child, youth or young adult to assess how treatment is progressing.

Comment

Three commentators urged the department to permit families to use telephones for family therapy. Additionally, three requested that the department consider allowing telehealth for therapy.

Response

The department supports families engaging in family therapy by telephone if attending in person is a hardship, and allows the child, youth or young adult to include individuals they identify in family therapy. As such, the department revised subsection (f) (renumbered subsection (g)) in the final-form rulemaking. Specifically, family therapy may be provided in person or through one of the following:

(1) Real-time interactive audio and video communication using technology that conforms to industry-wide standards and is in compliance with Federal and State laws, guidance and requirements.

(2) Real-time interactive audio-only telecommunication, provided that the use of audio-only telecommunication technology is in compliance with Federal and State laws, guidance and requirements.

Lastly, due to the level of care provided by a PRTF, the department does not support using telehealth to meet the minimum treatment standards for the child's, youth's or young adult's meeting with the treatment team leader, individual therapy and group therapy, which is specified in subsection (e) (renumbered as subsection (f)), which requires in-person standards.

Comment

Another commentator suggested that the department consider expanding family therapy to include individuals identified by the child, youth or young adult.

Response

The department agreed that family composition varies and extended natural supports can be chosen family members that may be beneficial to include in family therapy sessions. The regulation does not define family, providing flexibility to PRTFs, children, youth, and young adults, and their parents or legal guardians to make individualized decisions about who should be included in family therapy to maximize the benefit to the child, youth, or young adult.

Additional Revisions

The department changed the daily document requirement (previously in § 5330.141(d) in the proposed rulemaking) and moved it to a new subsection (b) of this section as the daily observations of a child's, youth's or young adult's behaviors are important when guiding the individual treatment plan. The requirement for a "communication log", however, was removed from the requirement as many PRTFs have a current system that they utilize to keep track of a child's, youth's or young adult's daily behaviors.

The department also added clarity to the documentation requirements in subsection (g) (renumbered as subsection (h)). The added requirements provide clarity on what specifically needs to be documented when a child, youth, young adult or parent, legal guardian or caregiver

receives a treatment service. This includes efforts to conduct treatment services. The added requirements include the date and time a service was provided, its duration and setting, along with identification of the related goal, outcome of the service and signature of the PRTF staff providing the service. These are specified in paragraph (1)-(4) of subsection (g).

§ 5330.145 Education (§ 5330.146 in proposed rulemaking)

Comment

One commentator noted that education decisions are not made solely by the educational host district and urged the department to require the PRTF to involve guardians.

Response

The department agrees with the commentator. However, no change is needed in the final-form rulemaking because subsection (c) specifies that educational decisions must include input from the treatment team, which is defined to include parents, legal guardians or caregivers.

§ 5330.146 Discharge(§ 5330.147 in proposed rulemaking)

Comment

One commentator indicated that peers can be helpful in planning and supporting discharge and suggested adding peer support to subsection (b).

Response

The department agreed that peer support can be beneficial in discharge planning; however, peer support is currently offered only to youth and young adults aged 14 and older and is not offered in every county. For this reason, the department did not include peer support in the final-form rulemaking.

Comment

Three commentators explained that the requirements in this section do not account for discharges against medical advice or situations where a PRTF lacks control over discharges. IRRC also reiterated concerns from the commentators regarding discharges against medical advice or circumstances outside the control of the PRTF and asked the department to clarify procedures related to these types of discharges.

Response

In response to comments received, the department revised this section regarding unexpected discharges and added a new subsection (d), which provides that "in the event of an unplanned or emergency discharge, the PRTF shall complete the discharge summary and provide a copy to the child, youth, young adult, or the child's, youth's or young adult's parent, legal guardian or caregiver no later than 7 days after discharge." The department removed the 30-day advance notice of pending discharge specified in subsection (b), as discharge planning begins at admission, as required by subsection (a). The department revised the remainder of the section accordingly. Additionally, the department agreed that the PRTF should choose who they want to coordinate discharge planning and has changed the requirement for who must coordinate discharge from "mental health professional" to "PRTF" in subsection (e) (renumbered subsection (f)).

Comment

Another commentator asked that the department allow PRTFs to assign case coordination to appropriate team members.

Response

The department agreed with the commentator and has amended the final form rulemaking to remove the requirement specified in subsection (e) (renumbered subsection (f)) that a mental health professional specifically coordinates a child's, youth's, or young adult's discharge with community providers. The language was replaced with "PRTF." This amendment will give the PRTF discretion to determine the most appropriate staff member to coordinate the child's, youth's or young adult's discharge.

Additional Revisions

While reviewing this section, the department replaced the term "plan for" with "discharge summary" in subsection (c) (renumbered as subsection (b)) because a discharge summary is the physical document the PRTF must develop, whereas a plan for discharge is merely the approach the PRTF must take to develop the discharge summary. The department also added the language "including the dates and time of scheduled appointments" to paragraph (5) of this subsection for additional clarity. The department also added "the name, address and contact information of a local crisis intervention services provider" to paragraph (6) of this subsection as contact information for crisis services can be a valuable resource to support a child, youth or young adult transitioning home or to the community. The department also clarified the requirement in subsection (d) (renumbered as subsection (e)) by adding the term "discharge summary" and replacing the term "documented" with "included." These revisions clarify that the discharge summary must also be included in the child's, youth's or young adult's record.

§ 5330.147 Level System (§ 5330.148 in proposed rulemaking)

Comment

One commentator asked how a policy and procedure that utilizes trauma-informed care principles to provide incentives under paragraph (1) can be reviewed and monitored.

Response

The department reviewed the requirements in paragraph (1) related to trauma-informed principles and decided that the language should be removed from that paragraph, as the policy and procedure would not utilize trauma-informed principles. Instead, the department added the language "utilize trauma-informed principles" to paragraph (2) as the level system must utilize trauma-informed care principles, be individualized and not be used as a punishment for children, youth or young adults.

Comment

Another commentator noted that the level system should not influence a child's, youth's or young adult's visits.

Response

The department agreed that the level system should not influence a child's, youth's or young adult's therapeutic leave or visits with their parent, legal guardian or caregiver. Paragraph (5) states that the level system may not be punitive. A PRTF, however, is not required to have a level system.

Comment

One commentator asked how a level system supports evidenced-based practices for mental health treatment in a PRTF.

Response

The department acknowledges that there are clinical differences of opinion on the utility of level systems. For this reason, the department is not requiring a PRTF to utilize a level system. However, should a PRTF choose to use a level system, the final-form rulemaking includes requirements to ensure that level systems are not being used punitively, but are used only as developmentally appropriate for each child, youth or young adult to meet treatment objections in a trauma informed manner under paragraphs (2) – (5). The final-form rulemaking also requires that a PRTF opting to use a level system has written policies and procedures for the level system under paragraph (1).

§ 5330.151 Transportation

Comment

Thirteen commentators commented that requiring both a driver and a PRTF staff person for every transport is unreasonable. IRRC also highlighted the fiscal impact and reasonableness concerns from commentators that increasing the staff-to-child, youth or young adult ratio for transports will have a significant financial impact and will only make it more difficult to meet the ratio requirements on PRTF grounds.

Response

Based on the comments received, the department removed the requirement to have both a driver and PRTF staff for every transport in subsection (b) of the final-form rulemaking. After careful consideration, the department also removed the language that prohibits a driver from being counted in the staff ratio requirement for transport and also the language that requires a driver and a PRTF staff member be present in a vehicle during a transport in subsections (c) and (d) of the final-form rulemaking. The department also removed the requirement that a PRTF staff

person be present for every 3 children, youth or young adults, which was specified in subsection (d). In turn, the department added that the staff ratio requirements specified in § 5330.42 must be met. This is specified in subsection (b). The section was renumbered accordingly. These changes in the final-form rulemaking balance fiscal impact concerns.

Comment

Ten commentators asked for clarification on the requirement in subsection (e) regarding manual restraint of a child, youth or young adult during transport. One commentator expressed significant concern about the prohibition of manual restraints during transports, as it could pose a risk to the child, youth or young adult and PRTF staff.

Response

The department understands the concerns expressed by the commentators and has removed the requirement that a manual restraint may not be used on a child, youth or young adult during transport, as specified in subsection (e), but has clarified that the restrictive procedure requirements in §§ 5330.181 -- 5330.188 continue to apply.

§ 5330.161 Storage of Medication

The department changed the term "nonprescription" to "over the counter" in subsections (a) – (c) due to over-the-counter medication being a generally understood term.

§ 5330.162 Labeling of Medication

The department changed the term "nonprescription" to "over the counter" in subsection (b) due to over-the-counter medication being a generally understood term.

§ 5330.163 Use of Medication (Use of prescription medication in proposed rulemaking)

Comment

One commentator noted that eliminating the use of pro-re nata (PRN) medications to control a child's, youth's or young adult's episodic behavior could create an access barrier for PRTF services because many children, youth or young adults were previously treated in inpatient settings where PRN medications are allowed. Similarly, another commentator pointed out that PRN medications may be a preferred restrictive procedure over a manual restraint or sending a youth to the emergency department.

Response

The final-form rulemaking retains the prohibition that PRN medications may not be used to control a child's, youth's or young adult's episodic behaviors in subsection (b) (renumbered subsection (c)). Prohibiting PRN medications helps prevent over-reliance on medications in the PRTF and supports the use of therapeutic approaches and coping mechanisms that can be replicated at home and in the community. As such, the department is not making the requested change. Instead, for clarity, the department added "over the counter medication must be used only to treat a medical condition associated with the medication," which is specified in a new subsection (b). This requirement was added as there was no clarification of when over the counter medication was to be used.

Additional Revisions

The department also added that "naloxone or other medications that can be used to reverse a substance overdose can be used as indicated without a prescription if needed by a child, youth or young adult." This requirement was added in a new subsection (d) because opioid reversal medication must be available and accessible to PRTF staff. The department also revised

the section heading to remove “prescription” because the section applies to both prescription medications and over the counter medications.

§ 5330.164 Medication Record (Medication log in proposed rulemaking)

Comment

Four commentators expressed concern about the amount of information required to be included in the medication log. Three commentators sought clarification on what a medication log is.

Response

The department reviewed the language in this section and agreed clarification is needed. In the final-form rulemaking, the department removed the term “medication log” and replaced it with “medication record” in the section heading and subsections (a) – (c). Further, it is important to include detailed information on medication in the medication record, as it helps ensure the child’s, youth's or young adult’s medication is administered correctly and monitored. As such, the department did not make the requested change to reduce the amount of information in the medication record. The department revised the language “time” to “date and time” in subparagraphs (c)(2)(v) and (x) of this subsection because the date that a medication is scheduled to be administered and actually administered is a vital part of medication administration protocol that must be recorded.

Comment

One commentator informed the department that nonprescribed medications are not administered in RTF settings.

Response

The department thanks the commentator for this comment and has amended various provisions of the final-form rulemaking to utilize the term "over the counter" rather than "nonprescription."

Comment

One commentator mentioned that some pharmacies may not be able to provide the medication's brand name and generic name as required by subsection (c)(2)(i).

Response

The department agreed. The department removed the language "including brand name and generic name" from subsection (c)(2)(i).

Additional Revisions

The department changed the term "nonprescription" to "over the counter" in subsections (a) and (b) and paragraph (c)(2) due to over-the-counter medication being a generally understood term. Additionally, the department added the phrase "if applicable" to subparagraph (2)(viii) regarding contraindicated medication because not all medications may have contraindicated medications.

§ 5330.165 Medication Error

Comment

One commentator asked why individual medication errors that do not result in a negative outcome must be reported and urged the department to consider allowing the current practice of only documenting this information in the medication record. In contrast, two commentators expressed concern that removing medication errors from the list of reportable incidents would not align with the goals of detecting medication errors and promoting safe medication

administration, and they recommended that the department keep medication errors as a reportable incident.

Response

The department did not make the requested changes related to reporting only those medication errors resulting in negative outcomes. The department will continue to classify a medication error as a reportable incident because medication errors are preventable and they can impact the health, safety and well-being of children, youth or young adults receiving care in a PRTF. In addition, the department revised this section for clarity by including the language "prescription or over the counter medication" in subsection (a). Similarly, the department also added the term "one of" to subsection (a) because all of the scenarios do not need to be met for a medication error to occur. The department also updated the language "medication log" to "medication record" in subsection (b).

§ 5330.166 Medication Refusal

Comment

Five commentators noted that the timeframe for notifying the treatment team leader specified in subsection (c) is too short. One commentator suggested that the treatment team leader be notified when medication is refused if the refusal could cause an adverse reaction or require medical treatment. Two commentators recommended that the PRTF notify the treatment team leader as soon as possible, but no later than 2 or 4 hours after the refusal of the medication. One commentator pointed out that providers often develop protocols for missed medication and advised that there be a broader expectation for treatment teams to review and adjust treatment plans as necessary. IRRC also highlighted concerns from commentators that the timeframe for reporting a refusal to take a medication to the treatment team leader is excessively restrictive and

asked the department to explain the reasonableness of the notification period for medication refusal.

Response

Based on the comments received, the department revised the timeframe for reporting medication refusals to the treatment team leader specified in subsection (c). Under the final-form rulemaking, the department changed the timeframe in subsection (c) from "1 hour" to "prior to the next scheduled dosage, but no later than 12 hours after the medication refusal." Since PRTFs are centered on physician-directed care, notifications and monitoring of medication refusals must be reported to the treatment team leader. In addition, the department changed the term "inform" to "notify" in subsection (a) to be consistent with changes made throughout the final-form rulemaking. The department also updated the language "nonprescription" to "over the counter" and "medication log" to "medication record" in subsections (a) and (b).

§ 5330.167 Adverse Reaction

Comment

One commentator recommended a uniform reporting period of 24 hours for all adverse reactions to medication.

Response

The department reviewed the timeframe in this section and revised the notification timeframes for adverse reactions. Under subsection (b) of the final-form rulemaking, the department adjusted the timeframe to notify a parent, legal guardian or caregiver to "prior to the next scheduled dose but no more than 24 hours after the adverse reaction" for instances that do not require immediate medical attention. For adverse reaction requiring immediate medical attention, the department increased the notification period to require notification "prior to the

next scheduled dosage, but no later than 12 hours after the adverse reaction." The department changed these timeframes because notifying the child's, youth's or young adults' parents, legal guardians or caregivers while the adverse reaction was occurring could be a health risk to the child, youth or young adult and impose an administrative burden on the PRTF.

Additionally, the department reviewed all notification timeframes to evaluate whether a consistent timeframe could be applied and determined that each notification requirement should remain individualized depending on the severity of the adverse reaction requiring notification.

The department also updated the language "nonprescription" to "over the counter" and "medication log" to "medication record" in subsections (a) - (d).

§ 5330.168 Medication Administration

Comment

One commentator suggested that the department consider unifying all medication handling and administration regulations under Title 55 because providers are often licensed for different levels of care.

Response

The department did not consolidate medication handling and administration under a new chapter in Title 55. Medication administration under Title 55 is tailored to the level of care being provided, the type of facility being regulated and the needs of the populations served. Further, this final-form rulemaking codifies only the minimum licensing and treatment standards, along with MA participation requirements and payment conditions, for PRTFs. It is outside the scope of this rulemaking to codify all medication handling and administration requirements for all department-regulated facilities.

The department also updated the language “nonprescription” to “over the counter” in subsections (a) and (b).

§ 5330.169 Medication Administration Training

The department clarified and revised the requirements in subsection (a) in § 5330.169 (relating to medication administration training) from “PRTF staff who have completed and passed a Department-approved medication administration course within the past 2 years are permitted to administer oral, inhaled, topical, eye and ear drop medications, diabetes medications and epinephrine injections for insect bites or other allergic reactions” to “PRTF staff who have completed and passed a Department-approved medication administration course within the past 2 years are permitted to administer oral, inhaled, topical and injectable medications.” This change removed the enumeration of specific medications and focuses on how medications may be administered. This same change was made in subsection (a) in § 5330.170 (relating to self-administration).

§ 5330.170 Self-Administration

Comment

One commentator indicated that the requirements for self-administrating medications result in more interaction with physicians than necessary, which will have a fiscal impact.

Response

The department did not modify this section regarding documentation from a prescribing physician. PRTFs provide primarily physician-directed care in intensive residential treatment for children, youth or young adults with severe behavioral health diagnoses. The existing standards involving a physician are necessary for this level of care. For clarity, the department added the

term “to supervise” to paragraph (3) to require a staff person to supervise the self-administration and not merely be present.

Additional Revision

As noted above, the department clarified and revised the requirements in subsection (a) from self-administration of “oral, inhaled, topical, eye and ear drop medications, diabetes medications and epinephrine injections for insect bites or other allergic reactions” to “oral, inhaled, topical and injectable medications.” This change removed the enumeration of specific medications and focuses on how medications may be self-administered. The department also updated the language “nonprescription” to “over the counter” and “medication log” to “medication record” in paragraph (2) and updated the language “medication log” to “medication record” in paragraph (3).

§ 5330.181 Use of Manual Restraints

Comment

Three commentators emphasized that a monthly review of the performance improvement process for manual restraints is unnecessary and might lead to superficial reviews. IRRC also highlighted concerns from commentators that requiring a review of a performance improvement process related to the use of manual restraints every 30 days is unnecessarily frequent and noted commentators’ concerns regarding the fiscal impact and reasonableness of this requirement.

Response

The department agreed with commentators and IRRC regarding the review of the performance improvement process related to using manual restraints every 30 days. As such, the department has removed the requirement for a review every 30 days under paragraph (e)(3) to

give PRTFs the ability to establish a timeframe to review their performance improvement process in accordance with their policies and procedures.

Comment

One commentator suggested that restrictive procedures should include escort and timeout durations exceeding 30 minutes.

Response

The department determined that a timeout exceeding 30 minutes should not be included under restrictive procedures because a timeout must always be voluntary. As such, the department did not make this suggested revision. Furthermore, the department concluded that escorting a child, youth or young adult for the purposes of assisting in activities does not qualify as a restrictive procedure.

Comment

One commentator advised that the restrictive procedure policy be provided before admission, not just on the day of admission.

Response

The department agreed that the restrictive procedure policy may be provided before admission. Subsection (f) of the final-form rulemaking was revised to require a PRTF to provide a copy of the restrictive procedure policy "prior to admission or within 24 hours of admission."

Comment

IRRC also requested that the department clarify the term "approved State protection and advocacy organization."

Response

In accordance with 42 CFR 483.356(d) (relating to protection of residents), a PRTF is required to provide contact information, including the phone number and mailing address for the appropriate State protection and advocacy organization, which is currently Disability Rights Pennsylvania for the Commonwealth.

Additional Revisions

While reviewing the requirements of this section, the department revised the requirements under subsection (b) to clarify all of the conditions that must be met before a manual restraint may be applied to a child, youth or young adult. Under the final-form rulemaking, a manual restraint may be used only if: the child, youth or young adult poses an imminent threat to physically harm themselves or others; every attempt has been made to de-escalate the child's, youth's or young adult's behavior; and less intrusive techniques and resources appropriate to address the child's, youth's or young adult's behavior have been tried and failed. These requirements reflect a trauma-informed approach to manual restraints and further support the health, safety and well-being of children, youth, young adults and PRTF staff.

The department removed "releasing" from subsection (e)(2) and replaced it with "defusing" for accuracy. The department also modified the requirement in subsection (f)(2) by adding that a PRTF is required to inform the child, youth or young adult and their parent, legal guardian or caregiver of the restrictive procedure policy "in a language that the child, youth or young adult and the parent, legal guardian or caregiver understands, including American Sign Language, and when necessary, through interpreters, translators or communication devices." This language was added to be consistent with § 5330.31(b)(10), which requires communication

in a language that the child, youth or young adult understands. The department also corrected the "or" to "and" in subsection (c) and added "PRTF's" to paragraph (f)(1) for consistency.

§ 5330.182 Ordering a Manual Restraint

Comment

Ten commentators stated that the 30-minute time limit specified in subsection (i) is more restrictive than Federal regulations and recommended that the department reconsider this requirement. One commentator noted that notifying a treatment team leader within 48 hours if someone else ordered the manual restraint is counterintuitive because the treatment team leader would have someone covering for them if they are off and not on call. IRRC also asked the department to clarify how the timeframe for ordering and applying a manual restraint is reasonable and safeguards public health, safety and welfare, and if the timeframe does not change, to address the fiscal impacts of additional reporting and debriefing requirements.

Response

The department did not revise the 30-minute time limit specified in subsection (i) in the final-form rulemaking because many children, youth or young adults who meet the medical necessity criteria for a PRTF level of care have experienced significant trauma. Throughout the final-form rulemaking, the department is focusing on providing trauma-informed care in PRTFs. The 30-minute limit of a manual restraint takes into consideration both the health and safety of children, youth or young adults residing in the PRTF and the health and safety of PRTF staff involved in manual restraints. The department acknowledges that the requirements of this section may result in additional reporting and debriefing but has determined the safety benefits outweigh the reporting and debriefing. Further, the department does not anticipate a fiscal impact because PRTF providers must currently meet this requirement.

The department also reduced the timeframe to notify the treatment team leader from "48 hours" to "24 hours" in subsection (i) as treatment team leaders are responsible for the medically necessary behavioral health treatment provided to children, youth or young adults in a PRTF.

The department does not agree that contacting the treatment team leader is counterintuitive if the individual ordering the manual restraint is not the team leader. Even if the treatment team leader is not immediately available, in order to effectively lead the child's, youth's, or young adult's care, the treatment team leader should be aware when a manual restraint is ordered to guide future treatment decisions.

Additional Revisions

Additionally, the department changed the requirement for a treatment team leader to be contacted and informed" in subsection (h) to a treatment team leader "must be notified about the use of a manual restraint" for consistency. Furthermore, the revision to "notify" clarifies that the PRTF may use various communication methods to inform the treatment team leader to ease any administrative burden.

In addition, the department revised the requirement in § 5330.187(c) (relating to documentation of a manual restraint) and moved it to this section because the verification relates to the ordering of a manual restraint. This is specified in a new subsection (m). Under the final-form rulemaking, the requirement was changed to "the qualified PRTF staff who ordered a manual restraint shall sign the order for a manual restraint as soon as possible, but no later than 3 days from the date the manual restraint was ordered." The department removed "verbal order" from the requirement because the language was redundant.

While reviewing the requirements of the section, the department also clarified the term "psychiatric" to "behavioral health" in subsection (b)(6) to be consistent with the use of that

language in the final-form rulemaking and corrected the word “plan” to “planning” in paragraph (b)(1). Additionally, for consistency, the department revised the language in subsection (c) to correspond with the changes made in § 5330.181(b) (relating to use of manual restraints) and specifically added this cross-reference for consistency. Lastly, the requirement in subsection (j)(5) was moved to § 5330.187(b)(12) because the department determined that the requirement better aligned with the requirements in that section.

§ 5330.184 Restrictive Procedure Plan

Comment

One commentator pointed out that requiring a restrictive procedure plan to be written within 24 hours of admission could reduce the plan's individualization and suggested the department adopt the requirements outlined in 55 Pa. Code § 3800.204 (relating to unanticipated use). IRRC also asked the department to explain the reasonableness of the timeframe for developing a restrictive procedure plan within 24 hours of admission.

Response

After careful consideration, the department revised subsection (a) in the final-form rulemaking. However, the department does not support the recommendation to require PRTFs to follow what is currently required in § 3800.204 because it requires a restrictive procedure plan to be completed for a child, youth or young adult only if they are placed in a restrictive procedure at least four times within any 3-month period. Under the final-form rulemaking, a restrictive procedure plan is required to be completed for all children, youth or young adults because the plan better addresses the physical health and emotional wellbeing of children, youth or young adults in a PRTF. Based on the comments received, the department increased the timeframe to

complete a restrictive procedure plan from within 24 hours of admission to within 7 days of admission under subsection (a) of the final-form rulemaking.

Comment

Another commentator mentioned that it is impractical for all team members to sign the restrictive procedure plan as specified in subsection (c).

Response

The department determined that it is reasonable to maintain the requirement for all team members to review, sign and date a child's, youth's or young adult's restrictive procedure plan in accordance with subsection (c) because the requirement can be met during the child's, youth's or young adult's treatment plan meeting, which is specified in § 5330.143(a) (relating to maintenance of treatment plan).

§ 5330.185 Application of a Manual Restraint

Comment

Nine commentators recommended that the department consider changing the requirement in subsection (k) (renumbered as subsection (l)) relating to notifying a parent, legal guardian or caregiver within 1 hour after the manual restraint ends because it creates an administrative burden and does not take into account a parent's, legal guardian's or caregiver's choice as to how and when they would like to be notified. Additionally, IRRC asked the department to justify the need for and reasonableness of the 1-hour timeframe to notify a parent, legal guardian or caregiver, and how this regulation balances public protection and safety.

Response

In consideration of the comments received, the department increased the time period for notification to parents, legal guardians or caregivers. Under subsection (k) (renumbered

subsection (l)) of the final-form rulemaking, a PRTF has 24 hours to notify a parent, legal guardian or caregiver of the use of a manual restraint.

Comment

Eight commentators expressed concerns about the requirement in subsection (i), which requires the completion of a face-to-face assessment within 30 minutes of initiating a manual restraint. IRRC also requested an explanation of the necessity and reasonableness of requiring a face-to-face assessment within 30 minutes of starting a manual restraint, and how this regulation balances public protection with other concerns.

Response

After reviewing comments from the commentators and IRRC, the department revised the requirement to provide that an in-person assessment be completed no later than 1 hour, instead of 30 minutes of initiating a manual restraint. This revision aligns with Federal requirements in 42 CFR 483.358(f) (relating to orders for the use of restraint or seclusion), which requires a face-to-face assessment within 1 hour of the initiation of an emergency safety intervention.

Comment

Seven commentators suggested removing the requirement in subsection (a), which states that a PRTF must have at least two PRTF staff present during a manual restraint. One commentator recommended removing the requirement in subsection (c), which states that a PRTF staff member who completed the manual restraint training and was not involved in applying the restraint should be present to assess the child, youth or young adult. IRRC also asked the department to explain the reasonableness of requiring at least two staff members during the application of a manual restraint and how the regulation balances the protection of the public, health, safety and welfare with fiscal impacts.

Response

The department did not remove the two-person presence requirements in subsections (a) and (c) for the protection of children, youth and young adults, and also for the protection of PRTF staff. In addition, these provisions are consistent with Federal requirements, which are specified in 42 CFR 483.362, which requires that "clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and safe use of restraint throughout the duration of the emergency safety intervention." This requires that while one trained staff member is conducting a restraint, a second trained staff member is observing the restraint to assess safety, requiring a minimum two staff members to be present during a restraint. The final-form rulemaking also clarifies that the staff persons are required to have successfully completed the required manual restraint training under subsection (a), which provides protection and safety to the children, youth, young adults and staff.

Additional Revisions

For further clarity, the department revised subsection (e). In the final-form rulemaking, the department changed the term "both" to "one" because all of the requirements within this subsection may not occur within a 10-minute increment. The department also added that "if a manual restraint continues beyond the time limit of the order for the use of the manual restraint, an RN or LPN must immediately contact the PRTF staff who ordered the manual restraint to receive further instructions." This is specified in subsection (i). The requirement was added for clarity and consistency in accordance with 42 CFR 483.362(b). The department also added the term "successfully" to subsection (c) to clarify that the PRTF staff person must not only complete the training requirements but also demonstrate competency in the training. Throughout

the final-form rulemaking, the department changed the term “face-to face” to the term “in-person.” This change was made to subsection (i) (renumbered subsection (j)) of this section to provide further clarity regarding the requirements that cannot be met through video or audio communication.

The department also revised subsection (i)(1)—(4) (renumbered as subsection (j)(1)—(4)) as the department determined that additional clarifying language was needed to clarify that the post-restraint assessment supports the health and safety of the child, youth or young adult. Under the final-form rulemaking, the in-person assessment must address: (1) the child's, youth’s or young adult's physical and psychological condition and if there is a need for medical or psychological treatment or intensive emotional support; (2) the child's, youth’s or young adult's behavior; (3) appropriateness of the implementation of the manual restraint; and
(4) complications caused by the use of the manual restraint .

§ 5330.187 Documentation of a Manual Restraint

Comment

Eight commentators stated that requiring all staff involved in a manual restraint to submit written statements create an administrative burden. Some commentators noted that this requirement is more stringent than Federal regulations. IRRC also reiterated the concerns expressed by commentators that requiring all staff involved in a manual restraint to submit a written statement will create an administrative burden on PRTFs and noted commentators’ concerns regarding the fiscal impact and reasonableness of this requirement.

Response

Based on the comments received, the department updated the language of the final-form rulemaking to specify that “a PRTF staff person who was directly involved or who observed the

manual restraint" must submit a written statement describing the events prior to, during and following the manual restraint under paragraph (b)(10). This change aligns with Federal regulations at 42 CFR 483.358(h).

Additional Revisions

The department modified the requirement in subsection (a) by removing the language "by the end of shift" and added "within 24 hours." The department made this change because the requirement as written was too restrictive and created an administrative burden on providers. The department also updated the citation in paragraph (b)(3), updated the terminology in paragraph (b)(7) to "restrictive interventions" from "intrusive techniques" and changed the term "face-to face" to the term "in-person" in paragraphs (b)(3) and (4).

§ 5330.188 Debriefing

Comment

Seven commentators suggested that treatment team members should be required to participate in the debriefing only if they are available because involving treatment team representatives and PRTF staff in the debriefing after the use of a manual restraint creates scheduling and administrative challenges, significantly reducing the likelihood of meeting the requirement. Two commentators recommended that the department require a mental health professional instead of a representative from the child's, youth's or young adult's treatment team to participate in the in-person debriefing after the use of a manual restraint. IRRC also asked the department to clarify the necessity and reasonableness of the 24-hour timeframe for an in-person debriefing after the use of a manual restraint and the requirement for a treatment team representative to attend the debriefing.

Response

The department is unable to remove the term “administrative staff” from subsection (d) (renumbered as subsection (e)) because it is a Federal requirement to have a debriefing conducted within 24 hours after the use of restraint or seclusion in accordance with 42 CFR 483.370(b) (relating to postintervention debriefings). However, for further clarity and consistency with the Federal regulation, the department revised the language to “appropriate supervisory and administrative staff.” Similarly, the department did not change the 24-hour deadline for completing debriefings because it is a Federal requirement under 42 CFR 483.370(b). Lastly, the department did not remove the language "treatment team" in subsection (b)(2) and replace it with "mental health professional" because maintaining “treatment team” allows PRTFs flexibility for how to meet the requirement that a debriefing with the child, youth or young adult occur within 24 hours after the use of a manual restraint.

Comment

Four commentators expressed concern that requiring a parent, legal guardian or caregiver in addition to the treatment team to participate in the debriefing would add to the administrative burden, making it difficult for PRTFs to schedule debriefings within the required timeframe.

Response

Based on the comments received, the department revised the requirement in subsection (b)(2) to read "a representative” of the child, youth or young adult, instead of “representatives." The department has determined that this change should reduce the administrative burden. While the department acknowledges that involving a parent, legal guardian or caregiver in the debriefing adds an administrative layer for the provider, it is essential for a child, youth or young adult to be offered this level of support after the use of a manual restraint. The department

clarified in new subsection (c) in the final-form rulemaking that a parent, legal guardian or caregiver must be informed of the debriefing and may participate in-person or through secure, real-time, two-way audio and video, if available.

Comment

Four commentators asked the department to clarify who qualifies as “administrative staff” as used in subsection (d) (renumbered subsection (e)).

Response

This language is consistent with the Federal regulation at 42 CFR 483.370(b). The term “administrative staff” in the final-form rulemaking refers to what PRTFs commonly refer to as staff whose primary duties include the day-to-day operations of a PRTF, which includes the supervision of PRTF staff and ensuring the health, safety and well-being of children, youth or young adults in a PRTF.

Comment

One commentator suggested adding the phrase "that requires more than first aid” to the requirement in subsection (e) (renumbered as subsection (f)).

Response

The department did not add the suggested language “that requires more than first aid” to subsection (e) (renumbered as subsection (f)) of the final-form rulemaking because the requirement would be inconsistent with Federal requirements specified in 42 CFR 483.372(d), which requires documentation of all injuries.

Additional Revisions

For consistency and clarity, the department revised subsection (d) (renumbered subsection (e)) that the debriefing must include “any changes to the child’s, youth’s or young

adult's restrictive procedure plan," which is specified in paragraph (5). The department added this provision because a child's, youth's or young adult's restrictive procedure plan can assist in identifying interventions to mitigate further manual restraint.

For clarity, the department revised subsection (b)(3) and moved it to subsection (c), which requires that "a child's, youth's or young adult's parent, legal guardian or caregiver shall be informed of the date, time and reason for the in-person debriefing specified in subsection (b) and may participate in-person or through secure, real-time, two-way audio or audio video, if available." This revision clarifies how compliance with this requirement can be met. The department also corrected the language in subsection (f) (renumbered (g)) from "discussions" to "debriefings," updated the revised cross-references and added the language "restrictive procedure plan."

§ 5330.189 Time Out

Comment

One commentator asked the department to include language that clarifies the ability of a child, youth or young adult to take a self-directed time-out that does not require direct supervision.

Response

The department agreed with the commentator and removed the term "directly" from subsection (c).

§ 5330.190 Attestation

Comment

One commentator inquired whether there are any exceptions to the closure requirement specified in subsection (e), such as a PRTF staff who performed an improper restraint being

placed on administrative leave or terminated. They also asked if the closure would apply to the entire facility or only to the unit where the restraint occurred. Additionally, the commentator questioned how the department would notify the BH-MCOs of the necessary closure and the timeframe for transferring a child, youth or young adult.

Response

The department has determined that no changes are necessary to this section in the final-form rulemaking. The closure as a result of noncompliance with 42 CFR Part 483, Subpart G discussed in subsection (e) will depend on how the PRTF is licensed. Concerning notification of closure and the timeline for transferring children, youth or young adults, providers shall follow the policies and procedures of the BH-MCOs covering the services affected by the closure. The department will collaborate with BH-MCOs to ensure a smooth transfer of children, youth or young adults when there is a closure.

§ 5330.211 Emergency Contact Information

Comment

Three commentators requested the department clarify subsection (c), which requires that emergency contact information accompany the child, youth or young adult when not at the PRTF.

Response

The department reviewed the requirement in subsection (c) and determined that the requirement caused an administrative burden for a PRTF. Therefore, the department removed subsection (c) in the final-form rulemaking.

§ 5330.212 Child, Youth or Young Adult Record

Comment

Four commentators observed that providers request the information required in subsection (b)(1) but do not always receive it. Additionally, a commentator informed the department that the requirements in (b)(7)(i)-(iv) (renumbered as (b)(6)(i)-(iv)) need further clarification. Another commentator asked for clarification on what is meant by the term "outcome" in subsection (b)(7)(iii).

Response

The department agreed that subsection (b)(7)(i)-(iv) need further clarification. In the final-form rulemaking, the department moved the requirements specified in subparagraph (i)-(iv) to § 5330.145(g) (renumbered § 5330.144(h)). The department determined that moving these requirements provides clarification on what needs to be documented when treatment services are provided, including the efforts to provide those services. Furthermore, the department revised subsection (b)(7) to clarify that records provide "required documentation in accordance with § 5330.144 (h) (relating to treatment services)." However, the department did not change the requirements in subsection (b)(1) for identifying information because a PRTF should be able to obtain the necessary information.

The description of the outcome under § 5330.144(h)(3) is to provide a summary of who was involved in the session, what was discussed in the session, plans for the next session and the length of session.

Comment

One commentator recommended that the department define what is meant by a "secure location," as specified in subsection (a).

Response

For clarity, the department agreed that the term "secure location" should be removed from subsection (a) in the final-form rulemaking. Furthermore, the department revised subsection (a) to provide that "all child, youth or young adult records, written and electronic, shall be secured in accordance with all applicable Federal and State privacy and confidentiality statutes and regulations." This change aligns with current practices followed by PRTFs.

Additional Revisions

For clarity and consistency, the department further revised subsection (b). The department added the cross-reference "in accordance with § 1330.32 (relating to conditions of payment)" to paragraph (b)(2) for additional clarity. The department also revised paragraph (b)(3) to be consistent with the other revisions in the final-form rulemaking. Specifically, paragraph (3) was changed to "medical and behavioral health records, including examinations, evaluations, assessments, screenings and treatment updates." The department also removed the requirement in paragraph (4) because the requirement was moved to paragraph (b)(3) and to eliminate redundancy. The department also moved the requirement previously in paragraph (b)(15) to paragraph (b)(4), which now states "documentation of psychotropic medication reviews, including the clinical rationale for the psychotropic medication."

The department determined that the requirement in paragraph (b)(5) needed further clarification and revised the language from a "treatment plan and updates to the treatment plan" to "required documentation in accordance with § 5330.142 (relating to treatment planning)." The department also revised paragraph (b)(10) (renumbered as paragraph (b)(9)) because it was no longer consistent with other revisions under the final-form rulemaking. Under the revised

paragraph (b)(9), the record shall include required documents in accordance with § 5330.146 (relating to discharge)."

For consistency and clarity, the department added cross-references to restrictive procedures to subsection (b) to clarify the need for these documents to be stored in a child's, youth's or young adult's record. Specifically, the department added "signed acknowledgement of the restrictive procedure policy in accordance with § 5330.181 (relating to use of manual restraints)" under paragraph (11) in the final-form rulemaking. Similarly, the department added "the restrictive procedure plan in accordance with § 5330.184 (relating to restrictive procedure plan)" under paragraph (12) in the final-form rulemaking. Finally, the department added "documentation of the debriefing after the use of a manual restraint in accordance with § 5330.188 (relating to debriefing)" under paragraph (13) of the final-form rulemaking.

The department also revised paragraph (14) because the department determined that it was limited in scope. Under the final-form rulemaking, the provision was renumbered paragraph (16) and clarified to require "documentation concerning all reportable and recordable incidents in accordance with §§ 5330.14 and 5330.15 (relating to reportable incidents; and recordable incidents)." Additionally, the department revised subsection (b) to add new paragraphs (19) and (20) to include documentation relating to therapeutic leave and meals to be stored in a child's, youth's or young adult's record. Specifically, the department added "signed acknowledgment of a therapeutic leave plan, if applicable, in accordance with § 5330.20 (relating to therapeutic leave)" under new paragraph (19) and "documentation of meals declined by the child, youth or young, if applicable, in accordance with § 5330.131 (relating to daily meals)" under a new paragraph (20).

§ 5330.213 PRTF Record

Comment

One commentator asked the department to explain the purpose of updating the written agreement to coordinate services annually. IRRC also highlighted the concern from a commentator regarding the need to update the written agreement annually to coordinate services if nothing has changed and noted the concern regarding the fiscal impact and reasonableness of this requirement.

Response

The department agreed with the comments about updating written agreements annually and has expanded this requirement to "every 5 years" in § 5330.12(b) (relating to coordination of services) and deleted the "updated annually" language from paragraph (b)(5) (renumbered (b)(4)) of the final-form rulemaking.

Comment

Another commentator inquired whether PRTFs will need to maintain a hard copy of the schedules and timesheets specified in subsection (c)(2).

Response

The department will not require a PRTF to maintain a hard copy of timesheets and work schedules; an electronic version is acceptable.

Comment

One commentator noted that requiring a PRTF to maintain records for at least 4 years is shorter than the current standard.

Response

The department agreed that requiring a PRTF to maintain records and staff personnel records for at least 4 years is shorter than current standards and has changed the language to specify that a PRTF needs to keep records and staff personnel records for at least 5 years in subsections (b) and (c) to be consistent with current standards.

Additional Revision

The department removed the requirement in paragraph (b)(2), which required the maintenance of "a detailed service description in accordance with § 5330.11 (relating to service description) and all updates to the service description" because the PRTF will provide these service descriptions to the department in accordance with § 5330.11. The department renumbered the section accordingly.

§ 5330.221 Quality Assurance Requirements

Comment

Four commentators explained that the requirement outlined in subsection (a)(2)(iii) would necessitate additional staffing hours, leading to increased annual costs. One commentator informed the department that the requirement in subsection (a)(2)(v) appears to be duplicative of another section of the regulation. Another requested clarification from the department regarding the requirements in subsection (a)(2)(i)-(iii). One commentator pointed out that some accreditation bodies require a robust quality assurance process similar to what is specified in this section. IRRC also reiterated the feedback from commentators that the requirement that the annual report includes an assessment of services outcomes and treatment goals would necessitate additional staffing hours, which will result in higher annual expenses and noted commentators' concerns regarding the fiscal impact and reasonableness of this requirement.

Response

Based on the comments received, the department removed these proposed requirements from the final-form rulemaking and revised this section by adding quality assurance requirements modeled after those currently required in similar departmental regulations, such as § 5200.44 (relating to quality assurance program). In addition, the department added that the PRTF shall review child, youth or young adult records on an annual basis to ensure compliance with the PRTFs policies and procedures, and Federal and State statutes, regulations and standards, which is specified in subparagraph (a)(2)(iii) and that the quality assurance plan shall include methods for promoting and overseeing implementation of trauma-informed care principles, policies and practices in paragraph (a)(1). The department also added requirements in subsections (b) and (c) that the findings of the annual review shall be available to the public upon request and that the PRTF is required to provide written notification upon admission that the findings of the annual review may be requested at any time by a child, youth, young adult, parent, legal guardian or caregiver.

Comment

One commentator asked whether a licensing certificate would meet the requirements of subparagraph (a)(2)(iv).

Response

As noted above, the department deleted subparagraph (a)(2)(iv) and its requirement for evaluation of compliance.

Comment

Another commentator inquired if the annual report requirement in subsection (c) is based on the license date, calendar year or fiscal year.

Response

Although the proposed annual report language has been deleted in the final-form rulemaking, the revised language does require that the finding of the annual review may be requested any time by a child, youth, young adult, parent, legal guardian or caregiver. The annual review is on a calendar year basis.

§ 5330.231 Waivers

The department removed the term "unconditionally" in subsection (b) in § 5330.231 (relating to waivers) because waivers are time-limited and have conditions that must be met. The department also renumbered this section for further clarity.

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on October 2, 2024, the department submitted a copy of this proposed rulemaking, published at 54 Pa.B. 7156 (November 2, 2024), to IRRC and to the chairperson of the Health and Human Services Committee of the Senate and to the chairperson of the Human Services Committee of House of Representatives.

Under section 5(c) of the Regulatory Review Act, the department is required to submit to IRRC and the Senate and House Committees copies of comments received during the public comment period, as well as other documents when requested. In preparing this final-form rulemaking, the department has considered all comments from IRRC, the Senate and House committees and the public.

Under section 5.1 (j.1) and (j.2) of the Regulatory Review Act (71 P.S. § 745.5a(j.1) and (j.2)), this regulation was [*deemed*] approved by the Committees on _____. Under section

5.1(e) of the Regulatory Review Act, IRRC met on _____ and approved the final-form rulemaking.

Findings

The department finds:

(a) Public notice of proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§ 1201 and 1202), referred to as the Commonwealth Documents Law, and regulations promulgated thereunder at 1 Pa. Code §§ 7.1 and 7.2 (relating to notice of proposed rulemaking required; and adoption of regulations).

(b) A public comment period was provided as required by law and all comments were considered in drafting this final-form rulemaking.

(c) The amendments made to the final-form rulemaking do not enlarge the original purpose of the proposed rulemaking published at 54 Pa.B. 7156 (November 2, 2024).

(d) The adoption of this regulation in the manner provided by this final-form rulemaking are necessary and appropriate for the administration and enforcement of the Human Services Code and the Mental Health and Intellectual Disability Act of 1966.

Order

The department acting under sections 201(2), 911, and 1021 of the Human Services Code (62 P.S. §§201(2), 911, and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)) orders that:

(a) The regulations of the department at 55 Pa. Code Chapters 1330, 3800 and 5330 are amended/adopted to read as set forth in Annex A of this final-form rulemaking.

(b) The department shall submit this final-form rulemaking and Annex A to the Office of General Counsel and the Office of Attorney General for approval as to legality and form as required by law.

(c) The department shall submit this final-form regulation to IRRC and the Health and Human Services Committee of the Senate and the Human Services Committee of the House of Representatives as required by law.

(d) The department shall certify and deposit this final-form rulemaking and Annex A with the Legislative Reference Bureau as required by law.

(e) This order shall take effect as follows:

(1) With the exception of the amendment to § 3800.3 (relating to exemptions), the final-form rulemaking shall be effective upon publication in the *Pennsylvania Bulletin*. The amendment to § 3800.3 will be effective 24 months after publication of the final-form rulemaking.

(2) RTFs currently licensed and certified by the department seeking to obtain a new license under Chapter 5330 shall obtain new licensure as a PRTF within 24 months after publication of the final-form rulemaking. The department will issue licenses in accordance with each RTF's license renewal date.

(3) New facilities seeking licensure to provide behavioral health residential treatment to children, youth or young adults shall obtain a license under Chapter 5330 prior to operating a PRTF.

(4) The MA program will continue to pay for medically necessary behavioral health treatment and room and board for eligible children, youth or young adults provided by an

accredited RTF certified by the department for 24 months after publication of the final-form rulemaking.

Valerie A. Arkoosh, M.D., M.P.H.

Secretary

Annex A

TITLE 55. HUMAN SERVICES

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1330. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

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GENERAL PROVISIONS

§ 1330.1. Policy.

The MA program provides payment for behavioral health treatment when the services are medically necessary and provided to children, youth or young adults with a behavioral health diagnosis by a licensed PRTF enrolled in the MA program.

§ 1330.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly demonstrates a different meaning:

Caregiver—An individual with the primary responsibility for the care and supervision of a child, youth or young adult.

Child—An individual under 14 years of age.

Cost center—A group of services or staff, or both, or another unit or type of activity into which functions of a PRTF are divided for purposes of expense assignment and allocations.

Cost report—A data collection tool issued by the Department to collect expense and utilization information from a PRTF that may include supplemental schedules or addenda as requested by the Department.

Day of care—Room, board and behavioral health services calculated on a 24-hour day basis using a midnight census hour.

Department—The Department of Human Services of the Commonwealth.

Elopement—When a child, youth or young adult leaves the premises of a PRTF or a location **for 1 hour or more** without **PRTF** staff approval.

Fiscal year—The period of time beginning July 1 and ending June 30 of the following year.

Hospital-reserved bed day—A day when a child, youth or young adult who is expected to return to the PRTF is approved for and admitted to an acute care general hospital or a psychiatric or rehabilitation hospital.

***ISPT—interagency service planning team*—A group who meets to plan and coordinate services for the child, youth or young adult with behavioral health needs.**

MA—Medical Assistance.

PRTF—psychiatric residential treatment facility—A **licensed** residential facility that provides services to treat the behavioral health needs of children, youth or young adults under the direction of a psychiatrist.

Parent—The biological or adoptive father or mother of a child, youth or young adult.

Related party—An individual or organization that is associated or affiliated with or has control of or is controlled by a PRTF. Control includes the power to influence or direct the actions or policies of another. The term does not include a child, youth or young adult.

Secure PRTF—A PRTF from which egress is prohibited.

Staff—Individuals employed or contracted by a PRTF on a full-time or part-time basis **who are responsible for care, treatment or supervision of children, youth or young adults receiving care in the PRTF. [Staff include] The term includes** temporary staff, volunteers and interns.

***Therapeutic leave* - A period during which a child, youth or young adult is absent from the premises of a PRTF without supervision of PRTF staff that is directly related to the child's, youth's or young adult's treatment plan.**

Treatment plan—An individualized and detailed written plan of treatment services specifically tailored to address a child's, youth's or young adult's needs.

Treatment team—**[A group of individuals who are led by a treatment team leader and includes the PRTF staff directly involved in the child's, youth's or young adult's treatment, and the child, youth or young adult. The treatment team may also include the child's, youth's or young adult's parent, legal guardian or caregiver; and any individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver] The PRTF staff directly involved in the child's, youth's or young adult's treatment and who are led by a treatment team leader. The treatment team also includes the child, youth or young adult and the child's, youth's or young adult's parent, legal**

guardian or caregiver and may include individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver.

Treatment team leader—A board-certified or board-eligible psychiatrist who has the overall responsibility of directing the child's, youth's or young adult's treatment.

[*Visit*—When a child, youth or young adult is under the approved temporary supervision of an individual at the individual's residence or in the community and not under the supervision of PRTF staff.]

Young adult—An individual 18 years of age or older but under 21 years of age or an individual who is 22 years of age but was admitted to the PRTF prior to turning 21 years of age.

Youth—An individual 14 years of age or older but under 18 years of age.

SCOPE OF BENEFITS

§ 1330.11. Scope of benefits.

Children, youth and young adults who are MA recipients with a behavioral health diagnosis may receive medically necessary services in a PRTF.

PROVIDER PARTICIPATION

§ 1330.21. Participation requirements for a PRTF.

To participate in the MA program, a PRTF shall:

(1) **[Comply with the special provisions applying to psychiatric hospitals set forth in 42 CFR 482.60 (relating to special provisions applying to psychiatric hospitals).**

(2)] Comply with the participation requirements in Chapter 1101 (relating to general provisions).

[(3)] **(2)** Be licensed as a PRTF in accordance with Chapters 20 and 5330 (relating to licensure or approval of facilities and agencies; and psychiatric residential treatment facility).

[(4)] **(3)** Enter into a written provider agreement with the Department to provide PRTF services.

[(5)] **(4)** Be enrolled in the MA program by the Department.

§ 1330.22. Ongoing responsibilities of a PRTF.

(a) A PRTF shall comply with all of the following requirements:

(1) The record keeping and onsite access requirements in § 1101.51(e) (relating to ongoing responsibilities of providers).

(2) The record keeping requirements for child, youth or young adult records in § 5330.212 (relating to child, youth or young adult record).

(3) The record keeping requirements for PRTF records in § 5330.213 (relating to PRTF record).

(b) A PRTF shall retain complete, accurate, legible and auditable clinical, medical and fiscal records.

§ 1330.23. Change of ownership.

(a) If a PRTF changes ownership and the new owner wants to continue to participate in the MA program, the PRTF shall submit an application, on the form provided by the Department, and meet the requirements in § 1330.21 (relating to participation requirements for a PRTF).

(b) When a PRTF changes ownership, the Department will approve participation in the MA program by the new owner if the Department determines the new owner to be eligible to participate in the

MA program under § 1330.21. The new **[ownership]** **owner** shall meet Federal and State laws and regulations prior to the Department approving participation in the MA program.

(c) When a PRTF changes ownership, the PRTF shall submit an attestation that complies with § 5330.190 (relating to attestation).

PAYMENT

§ 1330.31. General payment.

(a) Except as provided in subsection (b), the MA program will pay for medically necessary services provided by a PRTF to a child, youth or young adult who is an MA recipient subject to the conditions and limitations in this chapter and Chapter 1101 (relating to general provisions).

(b) The MA program will pay for medically necessary services provided to a child, youth or young adult who is an MA recipient by a residential treatment facility licensed under Chapter 3800 (relating to child residential and day treatment facilities) and certified by the Department as of [*insert the effective date of the final-form rulemaking*] for **[12]** **24** months after [*insert the effective date of the final-form rulemaking*].

(c) If a PRTF is rendering services to a young adult before the young adult turns 21 years of age, the Department will continue to pay for services if they are medically necessary and the young adult is under 22 years of age.

(d) The MA program will not pay for services provided by a PRTF that exclusively serves children, youth or young adults who are alleged delinquent or adjudicated delinquent.

§ 1330.32. Conditions for payment.

(a) MA will pay a PRTF if all of the following conditions are met:

(1) A psychiatric evaluation of the child, youth or young adult that is a result of a comprehensive in-person diagnostic examination has been completed **no more than 30**

days from the child's, youth's or young adult's admission to the PRTF. The psychiatric evaluation shall:

(i) Include a behavioral health diagnosis.

(ii) Indicate that a PRTF is recommended and medically necessary.

(iii) Address all of the following:

(A) If ambulatory care provided in the community meets the service needs of the child, youth or young adult.

(B) If treatment of the child's, youth's or young adult's behavioral health needs requires services in a PRTF under the direction of a psychiatrist.

(C) If services in a PRTF are needed to improve the child's, youth's or young adult's behavioral health needs or prevent further regression.

(2) An ISPT meeting was held no more than 30 days from a child's, youth's or young adult's admission or reauthorization for continued stay in the PRTF. The ISPT shall be comprised of the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver, service providers, county representatives and may be comprised of other individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver.

[(2)](3) The psychiatric evaluation **[is] and documentation of the ISPT meeting are** reviewed by an independent team [**that includes a psychiatrist who meets all of the following requirements:] that meets the requirements in 42 CFR 441.153 (relating to team certifying need for services).**

[(i) Has competence in the diagnosis and treatment of mental illness, preferably in child psychiatry.

(ii) Has knowledge of the child's, youth's or young adult's treatment needs.]

[(3)]__**(4)**__ The independent team is independent of the psychiatrist who completed the psychiatric evaluation and the PRTF that is being recommended.

[(4)]__**(5)**__ The independent team certifies all of the following:

(i) Ambulatory care provided in the community does not meet the service needs of the child, youth or young adult.

(ii) Treatment of the child's, youth's or young adult's behavioral health needs requires services in a PRTF under the direction of a psychiatrist.

(iii) Services in a PRTF are needed to improve the child's, youth's or young adult's behavioral health needs or prevent further regression.

(b) The child's, **[youth]** __**youth's**__ or young adult's treatment team leader shall review the need for continued PRTF level of care __**at least**__ every 30 days and certify that the child, youth or young adult continues to meet the requirements in subsection (a)**[(4)]**__**(5)**__.

__**(c) MA will pay a secure PRTF if the following conditions are met:**__

__**(1) The requirements of subsections (a) and (b) are met.**__

__**(2) Admission of the child, youth or young adult has been approved by the Department prior to admission to a secure PRTF.**__

§ 1330.33. Limitations on payment.

(a) MA will pay for hospital-reserved bed days for a PRTF that is currently participating in MA as follows:

(1) Payment will **[only]** be made to a PRTF to reserve a bed __**only**__ when a child, youth or young adult is hospitalized __**for a continuous 24-hour period or**__ if the child, youth or young adult is admitted to a licensed hospital or hospital unit accredited as a hospital, the

hospitalization occurs during the child's, youth's or young adult's PRTF stay and the child, youth or young adult is expected to return to the PRTF upon discharge from the hospital.

(2) Payment for hospital-reserved bed days is limited to 15 cumulative days per **[calendar year]** **hospitalization** for each child, youth or young adult, regardless of whether the child, youth or young adult was in continuous or intermittent treatment at one or more PRTFs **[during the calendar year**].

(3) Payment for hospital-reserved bed days begins on the date of a child's, youth's or young adult's admission to the hospital and will be paid at the rate of 1/3 of the PRTF's approved per diem payment rate.

(b) **[MA will pay for up to 2 days of elopement from a PRTF per calendar year for each child, youth or young adult.]** **MA will pay for up to 2 days per calendar year if a child, youth or young adult is absent from a PRTF because of an elopement.**

(c) **[MA will pay for a day of care if the child's, youth's or young adult's bed is reserved while the child, youth or young adult is on a visit.]** **MA will pay for up to 48 days per calendar year if a child, youth or young adult is absent from a PRTF because of therapeutic leave.**

(d) A therapeutic leave day specified in subsection (c) is calculated as follows:

(1) A continuous absence from a PRTF for at least 12 hours to 24 hours is one therapeutic leave day.

(2) A continuous absence for each additional 24-hour period will be an additional therapeutic leave day.

[(d)] **(e)** MA will not pay a PRTF for **[the following:]** **a day of care during which a child, youth or young adult is absent from the PRTF for any of the following reasons:**

(1) **[A day of care during which a child, youth or young adult was absent from the PRTF for one of the following reasons:]** **Leaving the PRTF against medical advice.**

[(i) Elopement, unless the absence meets the criteria in subsection (b).

(ii) Leaving the PRTF against medical advice.

(iii) Hospitalization, unless the hospitalization meets the criteria in subsection (a).

(iv) Visits, unless the visit meets the criteria in subsection (c).]

(2) Admissions and days of care that do not meet the requirements of this chapter.

(3) The day of discharge or transfer to another facility.

§ 1330.34. Allowable costs.

[The Department uses Medicare principles as established by the Social Security Act (42 U.S.C. §§ 301—1397mm) and Federal regulations and instructions as a basis for determining what cost items are allowable for the purposes of MA reimbursement.]

(a) The Department will use Federal Medicaid principles as established by Subchapter XIX of Chapter 7 the Social Security Act (42 U.S.C. §§ 1396 -- 1396w-9) (relating to grants to states for medical assistance payments), regulations, policies and instructions as a basis for determining which cost items are allowable for the purposes of MA reimbursement.

(b) The Department will use Federal Medicare principles as established by Subchapter XVIII of Chapter 7 the Social Security Act (42 U.S.C. §§ 1395x – 1395mmm) (relating to health insurance for aged and disabled), regulations, policies and instructions when the department determines that subsection (a) does not address the allowability of a specific cost item.

§ 1330.35. Income and offsets to allowable costs.

In an annual cost report, the PRTF shall report income from the following as sources to offset allowable costs in the determination of operating costs:

(1) Payments received from a youth or young adult or a child's, youth's or young adult's parent, legal guardian or caregiver.

(2) Gifts, donations, endowments, bequests and contributions restricted by the donor for allowable costs.

(3) Refunds and cash discounts.

(4) Grants designated for allowable costs.

(5) Income from the National School Lunch Program.

(6) Income from space rental, vending machines and similar items.

(7) Fundraising efforts restricted for allowable costs.

(8) Interest earned on items specified in paragraphs (1)—(7).

§ 1330.36. Cost allocation for multiple programs.

(a) If a provider operates a PRTF as well as other types of programs, the provider shall document how various costs are allocated between the multiple programs.

(b) The account of the cost allocation must include all of the following:

(1) Salary costs for individuals responsible for more than one program.

(2) Staff fringe benefits for individuals responsible for more than one program.

(3) Rental costs that apply to more than one program.

(4) Motor vehicles that are used by more than one program.

(5) Other related expenses shared by more than one program.

§ 1330.37. Related-party transactions.

(a) A PRTF shall include in its allowable costs, services and supplies furnished to the PRTF by a related party at an amount equal to the cost of such services and supplies to the related party.

(b) The cost of services and supplies procured by a PRTF through a related-party transaction may not exceed the cost of comparable services and supplies if purchased elsewhere.

(c) The related party's costs include reasonable costs incurred in the furnishing of services and supplies to the PRTF.

§ 1330.38. Nonallowable costs.

(a) The following costs are excluded from the operating costs described in § 1330.34 (relating to allowable costs) and are not included in a PRTF's per diem rate:

(1) Costs for legal services relating to litigation against the State, including administrative appeals, if the litigation is ultimately decided in favor of the State.

(2) Administrative costs of more than 13% of allowable MA costs.

(3) Costs for which Federal financial participation is prohibited by statute.

(4) Costs for services not provided by a PRTF to a child, youth or young adult residing in the PRTF.

(5) Education costs associated with a child's, youth's or young adult's individual educational plan, individual family service plan or treatment plan which are **[to be paid for by]** **the responsibility of** the child's, youth's or young adult's school district.

(6) Costs related to a PRTF staff's medical education, residency programs or education field placements.

(7) Costs for a service if payment is available from another public agency, insurance **[or]**, health program or any other source.

(8) Expenses not related to providing services to MA recipients.

(9) Costs associated with the following:

(i) Advertising, **[excluding employment opportunities]** **unless the cost is allowable in accordance with § 1330.34 (relating to allowable costs).**

(ii) Charitable contributions.

(iii) Staff recognition, such as gifts, awards or dinners.

(iv) Staff social functions, such as picnics or athletic teams.

(v) Nonstandard fringe benefits.

(vi) Fundraising **[and marketing]**.

(vii) Life insurance for officers and directors of the governing board, including life insurance premiums necessary to obtain mortgages and other loans.

(viii) Membership fees for social, fraternal and other organizations involved in activities unrelated to the program or an organization defined as a lobbying group under 65 Pa.C.S. Chapter 13A (relating to lobbying disclosure).

(ix) Meals for visitors.

(x) Political activities.

(xi) Related-party rental, leases or other payments that exceed the provision outlined in § 1330.37 (relating to related-party transactions).

(xii) Reorganization costs.

(xiii) Federal, State, or local income and excess profit taxes.

(xiv) Taxes for which exemptions are available to a PRTF.

(xv) Bad debts and contractual adjustments.

[(xvi) Barber and beautician services.

(xvii)] **(xvi)** Children's, youth's or young adults' allowances.

[(xviii)] **(xvii)** Clothing and shoes for children, youth or young adults receiving services in the PRTF.

[(xix)] **(xviii)** Living expenses for live-in staff, including lodging, meals and personal laundry.

[(xx)] **(xix)** Meals for staff, except for meals provided **[during training activities documented in a child's, youth's or young adult's treatment plan]** **while caring for a child, youth or young adult**.

[(xxi)] **(xx)** Penalties, fines or late charges assessed by any source, whether or not related to a PRTF.

[(xxii) **Personal hygiene items for children, youth or young adults receiving service in the PRTF.**

(xxiii)] **(xxi)** Personal travel for staff, including personal use of a PRTF vehicle.

[(xxiv) **Transportation and living costs associated with onsite visits by parents, legal guardians or caregivers.**

(xxv)] **(xxii)** Salaries for PRTF staff no longer employed by the PRTF.

[(xxvi)] **(xxiii)** Free care or discounted services.

[(xxvii)] **(xxiv)** Personal radio, television, Internet and telephone service.

[(xxviii)] **(xxv)** Direct and indirect costs related to nonallowable cost centers, including all of the following:

(A) Gift, flower and coffee shops.

(B) Homes for administrators or clergy.

(C) Convent areas.

(D) Nurses' quarters.

[(xxix)] **(xxvi)** Pennsylvania capital stock and franchise tax.

[(xxx)] **(xxvii)** Collection expenses associated with bad debts.

[(xxxi)] **(xxviii)** Travel expenses for members of the governing body unrelated to the PRTF's program.

[(xxxii)] **(xxix)** Vocational rehabilitation services.

[(xxxiii)] **(xxx)** Parties and social activities not related to providing care to children, youth or young adults receiving services in the PRTF.

[(xxxiv)] **(xxxi)** Recreation costs not related to providing care to children, youth or young adults receiving services in the PRTF.

[(xxxv)] **(xxxii)** Charity, in-kind and courtesy allowances.

[(xxxvi)] **(xxxiii)** Extraordinary costs related to, or precipitated by, bankruptcy.

(b) The following services are not included in the per diem rate and may not be included as a cost for the PRTF:

(1) Health care, including dental, vision and hearing care, which is not related to the child's, youth's or young adult's behavioral health needs.

(2) Prescription drugs.

(3) Ambulance services.

(4) Methadone maintenance.

(5) Diagnostic procedures or laboratory tests.

(6) Inpatient hospitalization.

(7) Emergency room visits.

(8) Diagnostic or therapeutic procedures for experimental, research or educational purposes.

(9) Experimental or investigative procedures or clinical trial research and services that are not in accordance with customary standards of medical practice or are not commonly used.

(c) The Department will not contribute to a return on equity for proprietary programs.

(d) Costs that are not recognized as allowable costs in a fiscal year may not be carried forward or backward to other fiscal years for inclusion in allowable costs.

§ 1330.39. Annual cost reporting and independent audit.

(a) Residential treatment facilities that are licensed under Chapter 3800 (relating to child residential and day treatment facilities) and certified by the Department as of [*insert the publication date of the final-form rulemaking*] shall provide a projected cost report to the Department within **[3]** **6** months of [*insert the publication date of the final-form rulemakin*g].

(b) A PRTF shall submit to the Department an annual cost report and an independent audit performed by an independent **certified** public accountant **or public accountant**.

(c) If costs have been allocated between programs and supporting services, disclosure shall be made in the independent audit and in accordance with generally accepted accounting principles.

(d) A PRTF shall disclose in the independent audit the existence of any **[affiliate]** **related party** and the **[affiliate's]** **related party's** relationship to the PRTF, including the nature of any financial transaction between the **[affiliate]** **related party** and the PRTF.

(e) A provider that operates PRTFs in different locations but uses a consolidated financial report shall designate cost centers for each location in the independent audit. Information accompanying the independent audit shall include the basis used to allocate income and expenses to each location.

(f) A PRTF shall submit an annual cost report on a form specified by and in accordance with the instructions provided by the Department.

(g) The annual cost report submitted to the Department shall be prepared on an accrual basis.

(h) A PRTF shall identify allowable services, administration, ancillary and related organization costs based on financial and statistical records maintained by the PRTF. The cost information contained in the annual cost report shall be current and accurate.

(i) The annual cost report must cover a fiscal period of 12 consecutive months, from July 1 to June 30, except as noted in subsection (k).

(j) The annual cost report for the preceding fiscal year ending June 30 must be submitted to the Department by **[September 30]** **October 31** of that year.

(k) When a PRTF begins operating after the start of the fiscal year, the cost report must cover the period from the date of approval for participation in the MA program by the Department to June 30.

(l) The Department may adjust costs reported in the annual cost report as follows:

(1) Costs may be adjusted based upon the findings of current or closed audits, cost settlements, approved service descriptions or any information relevant to the costs being adjusted.

(2) The Department will **[inform]** **notify** the PRTF in writing if the annual cost report is adjusted.

(3) If the Department does not **[inform]** **notify** a PRTF of adjustments to the annual cost report in writing within 180 days of receiving the annual cost report, the annual cost report submitted by a PRTF will be accepted by the Department as submitted.

§ 1330.40. Rate setting.

(a) Per diem rates will be established as follows:

(1) A cost report submitted by a PRTF in accordance with § 1330.39 (relating to annual cost reporting and independent audit), as adjusted by the Department, if necessary, will be used for the calculation of the PRTF's per diem rate.

(2) A per diem rate for a PRTF will be established by dividing the total projected operating costs by the number of days of care reported in the annual cost report subject to a minimum of 85% of the maximum number of days based on the number of beds specified on the PRTF's certificate of compliance.

(3) The total actual days of care provided include all days of service provided plus hospital-reserved bed days as specified by § 1330.33 (relating to limitations on payment). Reserved beds counted as actual days of service may not be filled.

(4) The total projected operating cost will be calculated as follows:

(i) For a new PRTF, the total MA allowable costs from the budgeted annual cost report, including adjustments for income and nonallowable, limited and excluded costs, as determined by the Department, are used to determine projected operating costs.

(ii) For an existing PRTF, an annual cost report filed **[September 30]** **by October 31** as specified in § 1330.39, including adjustments for income and nonallowable, limited and excluded costs, as determined by the Department, is used to determine projected operating costs.

(iii) Cost depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness is added to the total operating cost to obtain the total projected operating cost.

(5) Once established, a per diem rate will remain in place**[,]** unless the per diem rate is adjusted.

(b) The costs incurred in providing behavioral health treatment and room and board are included in the per diem payment for services in a PRTF and may not be billed separately or in addition to the per diem payment rate by the PRTF or any other entity with which the PRTF may have an - agreement to provide these services.

(c) If there is more than one accounting method for handling a cost item, the method initially elected by the PRTF shall be followed consistently in subsequent annual cost reports, unless the PRTF submits prior written justification and receives approval from the Department for using a different accounting method.

§ 1330.41. Third-party liability.

(a) A PRTF shall utilize available third-party resources**[, including Medicare Part B,]** for services a child, youth or young adult receives while in the PRTF.

(b) If a PRTF receives reimbursement from a third party subsequent to payment from the Department, the PRTF shall repay the Department by submitting a replacement of **the** prior claim according to the Department's instructions.

(c) If a child, youth or young adult or the legal guardian of a child, youth or young adult requests a copy of the record of payment or amounts due, the PRTF shall submit a copy of the invoice and the request to the Department.

(d) Except as specified in subsection (e), if a child, youth or young adult has third-party resource benefits, the MA program will pay the lesser of the following:

(1) A PRTF's per diem payment rate multiplied by the number of covered days, minus any payment from available third-party resources**[, including any Medicare Part B payment]**.

(2) The amount of the insurance plan's deductible and coinsurance minus any other payment from an available third-party resource**[, including any Medicare Part B payment]**.

(e) If payment from a child's, youth's or young adult's available third-party resources equals or exceeds a PRTF's per diem rate multiplied by the number of compensable days, the Department will not make payment to the PRTF.

§ 1330.42. Billing requirements.

(a) A PRTF shall submit **[invoices]** **claims** to the Department in accordance with the Department's instructions.

(b) Original and resubmitted claims, including replacement claims, must be received for final adjudication within 365 days following the last date of service on the **[invoice]** **claim**.

(c) If the service spans 2 fiscal years, a separate **[invoice]** **claim** must be prepared for each fiscal year.

(d) If the service spans two different per diem rates, a separate **[invoice]** **claim** must be prepared for each period covered by the different rates.

§ 1330.43. Financial records.

(a) A PRTF shall maintain adequate financial and statistical records for the determination of costs payable under the MA program for a period of 5 years after the date of the last payment.

(b) A PRTF shall maintain all of the following records:

(1) General financial ledgers, journals and books.

(2) Original evidence of cost, such as purchase requisitions, purchase orders, vouchers, vendor invoices, requisitions for supplies, inventories, timecards, payrolls and bases for apportioning costs, that are auditable and relate to the determination of reasonable costs.

(3) Records relating to allocated administrative costs.

(4) Records relating to each annual cost report.

(5) Cash disbursement journals.

(6) Cash receipts journals.

(7) Payroll journals or computer printouts.

(8) Fixed asset ledgers or equivalent records.

(9) Inventory control records.

(10) Charts of accounts that parallel or crosswalk to the annual cost report format issued by the Department.

(11) Statement listing all sources of PRTF's revenue, including Federal, State, local and private sources.

(12) Accounting records.

(13) Documentation of staff compensation by PRTF positions.

UTILIZATION REVIEW

§ 1330.51. Scope of claims review procedures.

Claims submitted for payment under the MA program are subject to the utilization review procedures in Chapter 1101 (relating to general provisions).

ADMINISTRATIVE SANCTIONS

§ 1330.61. Sanctions, denied payments and overpayments.

(a) If the Department determines that a PRTF has billed for services inconsistent with the requirements of this chapter or Chapter 5330 (relating to psychiatric residential treatment facility) or provided services outside the scope of customary standards of medical practice or otherwise violated the standards set forth in a provider agreement, the PRTF will be subject to the sanctions in Chapter 1101 (relating to general provisions) up to and including termination from the MA program.

(b) If the Department determines that services or items provided by a PRTF were not provided according to standards of practice for the discipline providing the service, were not medically necessary, were inappropriate or were otherwise noncompensable, the Department will deny payment for the services and items and related services and items and recover payment already made for the services and items and related services and items.

(c) If the Department determines as a result of an audit or through other means that a PRTF received excess funds in the form of an overpayment from the Department, the funds must be returned to the Department within 6 months from the date the PRTF is notified.

PROVIDER RIGHT OF APPEAL

§ 1330.71. Provider right of appeal.

Appeals related to this chapter shall be made in accordance with Chapter 41 (relating to medical assistance provider appeal procedures).

PART V. CHILDREN, YOUTH AND FAMILIES MANUAL

Subpart E. RESIDENTIAL AGENCIES, FACILITIES AND SERVICES

ARTICLE I. LICENSING/APPROVAL

CHAPTER 3800. CHILD RESIDENTIAL AND DAY TREATMENT FACILITIES

GENERAL PROVISIONS

§ 3800.3. Exemptions.

This chapter does not apply to the following:

* * * * *

(11) Private homes of persons providing care to a relative, except homes in which children live with their own children but no other relative, unless the home is a transitional living residence that is exempt from this chapter under paragraph (2).

(12) Psychiatric residential treatment facilities licensed under Chapter 5330 (relating to psychiatric residential treatment facility).

PART VII. MENTAL HEALTH MANUAL

Subpart E. RESIDENTIAL AGENCIES/FACILITIES/SERVICES

CHAPTER 5330. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

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GENERAL PROVISIONS

§ 5330.1. Purpose.

The purpose of this chapter is to establish minimum requirements and service standards that shall be met for a facility to obtain a license as a PRTF.

§ 5330.2. Scope.

This chapter applies to PRTFs that operate in this Commonwealth and serve children, youth or young adults with a behavioral health diagnosis. This chapter does not apply to providers that offer services for substance use disorder or provide services for a primary diagnosis of substance use disorder, which must be licensed by the Department of Drug and Alcohol Programs under 28 Pa. Code Part V (relating to Department of Drug and Alcohol Programs).

§ 5330.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise:

AED—An automatic external defibrillator.

APP—advanced practice professional—An individual who is licensed as a certified registered nurse practitioner or physician assistant.

Aversive conditioning—The application of startling, painful or noxious stimuli.

CMS—The Centers for Medicare & Medicaid Services.

Caregiver—An individual with the primary responsibility for the care and supervision of a child, youth or young adult.

Chemical restraint—The administration of a drug that has the temporary effect of restricting a child's, youth's or young adult's freedom of movement that is used to manage the child's, youth's or young adult's behavior and reduces risk to the safety of the child, youth, young adult or others and is not the standard service for the child's, youth's or young adult's behavioral health needs.

Child—An individual under 14 years of age.

Contraband—Property that poses a threat to a child's, youth’s, young adult's or other's safety.

Department—The Department of Human Services of the Commonwealth.

Educational host district—The school district where a PRTF is physically located.

Elopement—When a child, youth or young adult leaves the premises of a PRTF or a location **for 1 hour or more** without PRTF staff approval.

Emergency safety situation—**[A sudden, unexpected occurrence or set of circumstances demanding immediate action]** **An unanticipated child, youth or young adult behavior that places a child, youth, young adult or others at serious threat of violence or injury if no intervention occurs and that calls for the use of a restrictive procedure**.

***Excessive medication* – Prescription and over the counter medication that is beyond what is medically necessary to treat a child's, youth's or young adult's documented medical condition, including amount and duration of the medication.**

Exclusion—The removal of a child, youth or young adult from the child's, youth's or young adult's immediate environment and restricting the child, youth or young adult alone to a room or area that is not locked.

***First aid* -- Assessing a condition, cleaning a wound, applying topical medications or applying simple bandages.**

Grievance—A written or verbal concern expressed by a child, youth, young adult, parent, legal guardian or caregiver about a PRTF.

Intimate sexual contact—Vaginal and anal penetration, oral sex or direct **[skin-to-skin]** touching of sexual organs or the touching of **[intimate]** **private** body parts.

LPN—licensed practical nurse—The term includes an individual licensed under the laws of this Commonwealth to practice practical nursing or an individual who holds a privilege to practice as a practical nurse under the Nurse Licensure Compact Act (35 P.S. §§ 10291—10295).

Manual restraint—A physical hands-on technique that restricts the movement or function of a child, youth or young adult, or a portion of the child's, youth's or young adult's body. The term does not include the use of hands-on assistance needed to enable a child, youth or young adult to achieve a goal or objective identified in a treatment plan.

Mechanical restraint—The use of a device attached or adjacent to a child's, youth's or young adult's body that restricts freedom of movement or normal access to the child's, youth's or young adult's body which cannot easily be removed by the child, youth or young adult.

PRTF—psychiatric residential treatment facility—A **licensed** residential facility that provides services to treat the behavioral health needs of children, youth or young adults under the direction of a psychiatrist.

Parent—The biological or adoptive father or mother of a child, youth or young adult.

RN—registered nurse—The term includes an individual licensed under the laws of this Commonwealth to practice professional nursing or an individual who holds a privilege to practice as a registered nurse under the Nurse Licensure Compact Act.

Reportable illness—A life-threatening illness, **[involuntary emergency]** psychiatric admission or an illness that appears on the Department of Health's List of Reportable Diseases.

Reportable injury—An injury for which a child, youth or young adult requires medical treatment more intensive than first aid. **[The term first aid includes assessing a condition, cleaning a wound, applying topical medications and applying simple bandages.]**

Seclusion—Restricting a child, youth or young adult in a locked room, at any time**[, including sleeping hours]**. A locked room includes a room with a door locking device, such as a key lock, spring lock, bolt lock or foot pressure lock or a room where the door is physically held closed and the child, youth or

young adult is prevented from leaving the room. The term includes locking a child, youth or young adult in a bedroom during sleeping hours.

Secure PRTF—A PRTF from which egress is prohibited.

Serious injury—Bodily injury which creates a substantial risk of death, or which causes serious permanent disfigurement or protracted loss or impairment of function of any bodily member or organ.

Staff—Individuals employed **or contracted** by a PRTF on a full-time or part-time **basis who are responsible for care, treatment or supervision of children, youth or young adults receiving care in the PRTF**. The term includes **[contracted staff,]** temporary staff, volunteers and interns.

Supervisory staff—PRTF staff that meet the qualifications of a medical director, clinical director, program director, mental health professional or mental health worker supervisor.

***Therapeutic leave* - A period during which a child, youth or young adult is absent from the premises of a PRTF without supervision of PRTF staff that is directly related to the child's, youth's or young adult's treatment plan.**

Time out - A voluntary behavioral approach that enables a child, youth or young adult to leave an immediate environment for a period of time to de-escalate and regain self-control.

Trauma-informed care—A strengths-based approach to service delivery and organizational structure that:

(i) Realizes the widespread impact of trauma, including historical trauma, and understands potential paths to recovery.

(ii) Recognizes the signs and symptoms of trauma in children, youth, young adults, parents, legal guardians, caregivers, staff and others involved with the PRTF.

(iii) Responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively prevent re-traumatization.

Treatment plan—An individualized and detailed written plan of treatment services specifically tailored to address a child's, youth's or young adult's needs.

Treatment team—**[A group of individuals who are led by a treatment team leader and includes the PRTF staff directly involved in the child's, youth's or young adult's treatment, and the child, youth or young adult. The treatment team may also include the child's, youth's or young adult's parent, legal guardian or caregiver; and any individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver]** **The PRTF staff directly involved in the child's, youth's or young adult's treatment and who is led by a treatment team leader. The treatment team also includes the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver and may include individuals chosen by the child, youth or young adult or the parent, legal guardian or caregiver**.

Treatment team leader—A board-certified or board-eligible psychiatrist who has the overall responsibility of directing the child's, youth's or young adult's treatment.

[*Visit*—When a child, youth or young adult is under the approved temporary supervision of an individual off the facility premises at the individual's residence or in the community and not under the supervision of PRTF staff.]

***Visual body search* – Viewing of a child's, youth's or young adult's body after the child, youth or young adult has removed clothing to expose underwear or private body parts for the purposes of checking for contraband.**

Young adult—An individual 18 years of age or older but under 21 years of age, or an individual who is under 22 years of age but was admitted to the PRTF prior to turning 21 years of age.

Youth—An individual 14 years of age or older but under 18 years of age.

§ 5330.4. [Licensure and certificate] Certificate of compliance.

(a) A PRTF shall obtain a **[license] certificate of compliance** from the Department prior to beginning operations.

(b) A residential treatment facility licensed under Chapter 3800 (relating to child residential and day treatment facilities) that provides the services of a PRTF as of [insert the effective date of the final-form rulemaking] shall comply with this chapter by [insert date that is **[12] 24** months after the effective date of the final-form rulemaking].

(c) To **[be licensed] receive a certificate of compliance** as a PRTF, a facility shall:

(1) File an application for a certificate of compliance with the Department in accordance with the Department's application procedure.

(2) Comply with the requirements of this chapter.

(3) Comply with the requirements of Chapter 20 (relating to licensure or approval of facilities and agencies).

(4) Comply with the requirements of Articles IX or X of the Human Services Code (62 P.S. §§ 901—1088) as applicable.

(5) Comply with the requirements of 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individuals under 21 years of age in psychiatric facilities or programs).

(6) Be accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation or another accrediting body approved by the Department.

(7) Obtain a certificate of compliance from the Department prior to beginning operations.

(d) The Department will issue a new certificate of compliance for each physical **[location]** **structure** that qualifies for a certificate of compliance.

(e) A PRTF shall post in a conspicuous and public place the current certificate of compliance and have a copy of this chapter readily available to be viewed.

§ 5330.5. Maximum capacity.

(a) The maximum capacity specified on the certificate of compliance will be based on the available bedroom square footage and the number of toilets and sinks in the PRTF.

(b) The maximum capacity specified on the certificate of compliance may not be exceeded.

§ 5330.6. Fire safety approval.

(a) A PRTF shall obtain a valid fire safety approval from the appropriate local building authority under the Pennsylvania Construction Code Act (35 P.S. §§ 7210.101—7210.1103) prior to applying for an initial certificate of compliance.

(b) If a fire safety approval is withdrawn or restricted, the PRTF shall provide notification to the Department verbally within 24 hours and in writing within 48 hours of service of notice of the withdrawal or restriction. The notification shall include a plan to remedy the issue that led to the withdrawal or restriction of the fire safety approval or a plan for relocating the children, youth or young adults residing in the PRTF.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the PRTF shall submit a new fire safety approval or written certification from the appropriate fire safety authority that a new fire safety approval is not required. The PRTF shall submit this documentation to the Department within 15 days of the completion of the renovation or alteration.

(d) The Department will report fire safety concerns observed during an inspection to the fire safety authority that issued the fire safety approval.

§ 5330.7. Exemptions.

(a) This chapter does not apply to community residences for persons with mental illness that provide care to both children, youth or young adults and adults in the same facility or community residential host homes for persons with mental illness that are licensed under Chapter 5310 (relating to community residential rehabilitation services for the mentally ill).

(b) This chapter does not apply to residential facilities that serve children, youth or young adults that are licensed under Chapter 3800 (relating to child residential and day treatment facilities).

GENERAL REQUIREMENTS

§ 5330.11. Service description.

(a) As part of the initial certificate of compliance application, a facility shall submit to the Department for review and approval a written service description that includes all of the following:

(1) The PRTF's mission and vision for supporting and maximizing the behavioral health of a child, youth or young adult.

(2) **[Address]** **<u>The PRTF's address,</u>** phone number, website and accreditation agency **[of the PRTF]**.

(3) An overview of the PRTF to include a description of specialized services and modalities the PRTF offers.

(4) The average length of treatment.

(5) Identification of the target population served by the PRTF, including age range, gender and total number of children, youth or young adults that will be served.

(6) The bed capacity of the PRTF.

(7) Description of the criteria used for exclusion.

(8) Goals, objectives and expected outcomes of the PRTF.

(9) Description of the overall theoretical design and clinical approaches to services.

(10) Description of how the PRTF implements and utilizes trauma-informed care practices.

(11) Description of the level system as specified in § **[5330.148]** **5330.147** (relating to level system), if applicable.

(12) Description of the **[**expectations**]** **processes** that will be used to encourage active involvement in the treatment process by the parent, legal guardian or caregiver.

(13) Identification of the specific **[restrictive procedures]** **curriculum or procedure models** utilized by **[a]** **the** PRTF **for staff training on restrictive procedures**.

(14) Description of educational providers that will be utilized by a child, youth or young adult while at the PRTF.

(15) Identification of the school district within which the PRTF is located.

(16) Description of the discharge planning process of the PRTF.

(17) An organizational chart of the PRTF according to position titles.

(b) A PRTF's updated service description must be approved by the Department prior to a change in services specified in subsection (a).

§ 5330.12. Coordination of services.

(a) A PRTF shall have written agreements **[to coordinate services with other service providers, including the following]** **describing the accessibility to and availability of the following providers and programs**:

(1) A psychiatric inpatient hospital.

(2) A local community hospital.

(3) Peer support providers **if the PRTF serves youth or young adults**.

(4) Mental health and intellectual or developmental disability case management programs.

(5) **[Drug and alcohol] Substance use disorder** programs.

(6) Educational providers.

(7) Crisis intervention programs.

(b) A PRTF shall update the written agreements **[with the other service providers annually] at least every 5 years** or when the PRTF becomes aware that the agreements are no longer accurate.

(c) A PRTF shall have an affiliation or a written transfer agreement with at least one hospital that participates in the Medical Assistance Program. The affiliation or transfer agreement must reasonably ensure all of the following:

(1) A child, youth or young adult will be transferred from a PRTF to a hospital **[and admitted in a timely manner] immediately** when a transfer is medically necessary for medical care or acute psychiatric care.

(2) Medical and other information needed for the child's, youth's or young adult's care will be exchanged between the PRTF and the hospital in accordance with Federal and State medical privacy laws and regulations, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting.

(3) Services are available to each child, youth or young adult at all times.

§ 5330.13. Abuse.

(a) A PRTF shall have a written policy and procedure **[on the identification of abuse, reporting abuse, plan of supervision for any PRTF staff implicated in abuse and plan for the protection of the child, youth or young adult who was subject to abuse]** **governing:**

(1) Abuse identification, reporting and investigation.

(2) Implementation of a plan of supervision for any PRTF staff implicated in the alleged abuse.

(3) Implementation of a plan for the protection of the child, youth or young adult who was subject to the alleged abuse.

(b) A PRTF shall comply with 23 Pa.C.S. §§ 6301—6388 (relating to Child Protective Services Law) and Chapter 3490 (relating to protective services).

(c) A PRTF shall comply with the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704)**, if the PRTF provides treatment to young adults**.

§ 5330.14. Reportable incidents.

(a) A PRTF shall develop a written policy and procedure on the reporting, investigation and management of reportable incidents.

(b) A PRTF shall **[call]** **notify** the Department **[and complete an incident report through the Department's information management system]** within 12 hours after any of the following reportable incidents are known to the PRTF:

(1) **[Fire]** **Any event** requiring the children, youth or young adults of a PRTF to shelter in place or relocate.

(2) Death of a child, youth or young adult.

(3) **[Serious injury to a child, youth or young adult]** **Elopement of a child, youth or young adult**.

(4) Disruption to water, heat, power or cooling at a PRTF.

(c) A PRTF shall complete an incident report through the Department's information management system within **[12]** **24** hours after any of the following reportable incidents are known to a PRTF:

(1) An incident specified in subsection (b).

(2) Use of a prohibited restrictive procedure specified in § 5330.183 (relating to prohibited restrictive procedures).

[(2)] (3) An incident where a child, youth or young adult requires hospitalization or outpatient treatment at a hospital or other medical facility.

[(3)] (4) Physical act by a child, youth or young adult to attempt suicide.

[(4) Child's, youth's or young adult's elopement from a PRTF.]

(5) **[Incidents of physical assault involving a child, youth, young adult or PRTF staff]** **Serious injury to a child, youth or young adult**.

(6) Violation of a child's, youth's or young adult's civil rights.

(7) Intimate **consensual or nonconsensual** sexual contact involving a child, youth or young adult.

(8) An outbreak of a serious communicable disease as defined by the Department of Health.

(9) Suspected abuse or abuse of a child, youth or young adult.

(10) An event that results in notification of emergency services, such as the fire department, law enforcement or emergency medical services.

(11) Activation of a PRTF emergency preparedness plan.

(12) Misuse of a child's, youth's or young adult's funds.

(13) A medication error as specified in § 5330.165 (relating to medication error).

(d) A PRTF shall **[call]** **notify** the parent, legal guardian or caregiver **[and inform the parent, legal guardian or caregiver]** of the reportable incidents identified in subsections (b) and (c) no later than 12 hours after the reportable incident is known to the PRTF.

(e) A PRTF shall report the following reportable incidents to the State-designated protection and advocacy system **in accordance with 42 CFR 483.374(b) (relating to facility reporting)** no later than close of business the next business day after the reportable incident is known to a PRTF:

(1) Death of a child, youth or young adult.

(2) Physical act by a child, youth or young adult to attempt suicide.

(3) Serious injury to a child, youth or young adult.

(f) If a PRTF reports a reportable incident to the State-designated protection and advocacy system, it shall include all of the following information:

(1) Name of the child, youth or young adult involved in the reportable incident.

(2) Description of the reportable incident.

(3) Name, street address and telephone number of the PRTF.

(g) A PRTF shall document in the child's, youth's or young adult's record the date and time a report was made to the State-designated protection and advocacy system and the name and title of the individual from the State-designated protection and advocacy system that received the report.

(h) A PRTF shall report the death of a child, youth or young adult to the appropriate CMS regional office no later than close of business the next business day after the child's, youth's or young adult's death is known to the PRTF and document in the child's, youth's or young adult's record

that the child's, youth's or young adult's death was reported to the appropriate CMS regional office.

(i) A PRTF shall document in the child's, youth's or young adult's record the date and time the Department was **[called]** **notified** about a reportable incident identified in subsection (b) **[and the name and title of the individual from the Department who was notified of the reportable incident]**.

(j) A PRTF shall document in the child's, youth's or young adult's record the date and time the parent, legal guardian or caregiver was **[called]** **notified** about a reportable incident identified in subsections (b) and (c) and the name of the parent, legal guardian or caregiver who was notified of the reportable incident.

(k) A copy of all incident reports in subsections (b) and (c) shall be maintained in the child's, youth's or young adult's record.

§ 5330.15. Recordable incidents.

(a) A PRTF shall maintain a record of the following recordable incidents:

(1) **[Medical seizure]** **Seizure** that requires medical attention.

(2) Suicidal gesture or verbal threat of suicide or harm to self or others.

(3) Property damage of more than $500.

(4) **[Search]** **Visual body search** of a child, youth or young adult **[or the child's, youth's or young adult's property]**.

(5) A reportable injury or reportable illness while the child, youth or young adult is on **[a visit]** **therapeutic leave**.

(6) Any incident of physically injuring or intentionally striking a child, youth or young adult.

(b) A PRTF shall notify a child's, youth's or young adult's parent, legal guardian or caregiver of a recordable incident specified in subsection **[(a)[(1)—(5)]** **(a)(1)—(6)** no later than 12 hours after a recordable incident **[occurs]** **is known to a PRTF**. The notification shall be documented in the child's, youth's or young adult's record.

§ 5330.16. Child, youth or young adult funds.

(a) A PRTF shall have a written policy and procedure on the management and disbursement of a child's, youth's or young adult's funds.

(b) Money earned or received by a child, youth or young adult is the child's, youth's or young adult's personal property.

(c) If a PRTF maintains funds for a child, youth or young adult, the PRTF shall maintain a separate accounting system for the child's, youth's or young adult's funds, including the dates and amounts of deposits and withdrawals. Combining a child's, youth's or young adult's funds with PRTF funds is prohibited.

(d) If a PRTF maintains funds for a child, youth or young adult, the child, youth or young adult shall be provided with an accounting of their funds at least once a month and upon request.

(e) A PRTF may not use or borrow a child's, youth's or young adult's funds.

(f) A PRTF shall release **[the]** **a** youth's or young adult's funds to the youth or young adult upon discharge and upon request.

(g) A PRTF shall release a child's funds to the child's parent, legal guardian or caregiver upon discharge and upon request.

§ 5330.17. Consent to treatment.

(a) Consent to treatment **[must]** **shall** be obtained in accordance with Federal and State laws, regulations and Department policies regarding consent to treatment**, including the act of**

February 13, 1970 (P.L. 19, No. 10), (35 P.S. §§ 10101–10105), regarding minors' consent to medical care.

(b) Prior to the initiation of **treatment** services provided by a PRTF, the PRTF shall obtain consent from either **[a] the** youth or young adult, or the child's, youth's or young adult's parent**[, legal guardian or caregiver] or legal guardian** for the child, youth or young adult to receive services.

(c) Consent for emergency physical health treatment is not required for life-threatening conditions when an attempt to obtain consent would result in a delay of services and the delay would increase the risk of harm to the child's, youth's or young adult's life or health.

(d) Consent and attempts to obtain consent shall be documented in the child's, youth's or young adult's record. Documentation of consent, refusal to consent and attempts to obtain consent shall include all of the following:

(1) Name of the person contacted to provide consent.

(2) Relationship of the person contacted to provide consent for the treatment to the child, youth or young adult.

(3) Name and title of the PRTF staff person who sought consent.

§ 5330.18. Confidentiality of records.

(a) A PRTF shall comply with all of the following statutes and regulations relating to confidentiality of records, to the extent applicable:

(1) Chapter 63 of 23 Pa.C.S. (relating to Child Protective Services Law).

(2) Part III of 23 Pa.C.S. (relating to Adoption Act).

(3) The Mental Health Procedures Act (50 P.S. §§ 7101—7503).

(4) Section 602(d) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4602(d)).

(5) The Confidentiality of HIV-Related Information Act (35 P.S. §§ 7601—7612).

(6) Sections 5100.31—5100.39 of 55 Pa. Code (relating to confidentiality of mental health records).

(7) Sections 3490.91—3490.95 of 55 Pa. Code (relating to confidentiality).

(8) Section 444 of the General Education Provisions Act (20 U.S.C. § 1232g).

(9) Part 99 of 34 CFR (relating to family educational rights and privacy).

(10) The Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191**, 110 Stat. 1936**).

(11) **Part 2 of 42 CFR (relating to confidentiality of substance use disorder patient records).**

(12) Other applicable **confidentiality** statutes and regulations.

(b) **[Information relating to a child, youth or young adult may only be shared if a signed authorization of release is obtained from the youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver.**

(c) Information relating to the parent, legal guardian or caregiver of a child, youth or young adult may not be shared without an authorization of release of information from the child's, youth's or young adult's parent, legal guardian or caregiver.

(d)] A PRTF shall have a written policy and procedure on protecting the confidentiality and privacy of a child's, youth's or young adult's information that includes all of the following:

(1) The process to obtain permission to release a photograph of a child, youth or young adult.

(2) The use of photographs of children, youth or young adults.

(3) **[How the PRTF will ensure that children's, youth's or young adults and PRTF staff's social media activity does not contain identifying information about a child, youth or young adult served by the PRTF]** **Social media use**.

§ 5330.19. Emergency preparedness.

A PRTF shall comply with the requirements of 42 CFR 441.184 (relating to emergency preparedness).

§ 5330.20. [Visits] Therapeutic leave.

(a) A PRTF shall have a written policy and procedure on **[visits]** **therapeutic leave**.

(b) A PRTF may not deny a child, youth or young adult **[a visit]** **therapeutic leave** as a means of **[punishment or coercion]** **coercion, discipline, convenience or retaliation**.

(c) A PRTF shall develop a **[visit]** **therapeutic leave** plan for a child, youth or young **adult [when the child, youth or young adult is not under the supervision of PRTF staff]** that includes **[both of]** the following:

(1) Identified coping skills for the child, youth or young adult.

(2) Telephone numbers for local crisis intervention services and for the PRTF.

(3) A communication section for the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver to communicate strengths relating to the therapeutic leave or concerns about the therapeutic leave.

(4) Medications taken by the child, youth or young adult, including dosage of the medication for the duration of the therapeutic leave and instructions on how to administer the medication.

(d) A PRTF shall give the **[visit]** **therapeutic leave** plan for a child, youth or young adult to the **child, youth or young adult and** the individual who will be supervising the child, youth or young adult during the **[visit]** **therapeutic leave**.

(e) Prior to a **[visit]** **therapeutic leave** that occurs at the parent's, legal guardian's or caregiver's residence or in the community, a PRTF shall require that the child's, youth's or young adult's parent, legal guardian or caregiver sign an acknowledgement that the parent, legal guardian or caregiver will receive, secure, administer and return **[prescribed]** medication not taken by the child, youth or young adult during the **[visit]** **therapeutic leave**.

(f) The **[visit]** **therapeutic leave** plan and signed acknowledgment shall be included in the child's, youth's or young adult's record.

(g) **[A PRTF shall contact the child's, youth's or young adult's parent, legal guardian or caregiver at least once every 24 hours if a visit lasts more than 24 hours to check on the safety, health and well-being of the child, youth or young adult]** **A PRTF shall review and respond to any concerns communicated in the therapeutic leave plan upon the child's, youth's or young adult's return to the PRTF**.

(h) A therapeutic leave shall be part of the child's, youth's or young adult's treatment plan in accordance with § 5330.142(e)(7) (relating to treatment planning).

[§ 5330.21. Awake hours and sleeping hours.

A PRTF shall have a written policy and procedure that designates the PRTF's awake hours and sleeping hours.]

RIGHTS

§ 5330.31. Rights.

(a) A PRTF shall have a written policy and procedure on the rights of children, youth or young adults.

(b) A child, youth or young adult has the right to all of the following:

(1) To be informed of the policies and procedures of the PRTF.

(2) To appropriate medical, behavioral health**, vision, hearing** and dental treatment.

(3) To receive services in the PRTF in the least restrictive setting necessary to accomplish the treatment objectives.

(4) To participate in the development and review of the child's, youth's or young adult's treatment plan.

(5) To clean and seasonal clothing that is age and gender appropriate.

(6) To be free from excessive medication.

(7) To be free from abuse, mistreatment, threats, harassment, corporal punishment and unusual treatment.

(8) To not be subjected to unusual or extreme methods of discipline which may cause psychological or physical harm to the child, youth or young adult.

(9) To be protected from unreasonable search and seizure. A PRTF may conduct searches of a child, youth or young adult or the child's, youth's or young adult's personal property in accordance with § 5330.34 (relating to searches).

(10) To communicate with PRTF staff in a language that the child, youth or young adult understands, including American Sign Language, and when necessary, through interpreters **[or],** translators **or communication devices**.

(11) To be treated with dignity and respect.

(12) To be assisted by an advocate of the child's, youth's or young adult's choice in the assertion of rights and to communicate with a lawyer in private.

(13) All civil rights unless prohibited by court order.

(14) To practice the child's, youth's or young adult's religion of choice or abstain from religious practices.

(15) To communicate with a clergy person in private.

(16) To file a grievance without retaliation and to receive a prompt response to the grievance.

(17) To communicate privately with an individual unless the communication is prohibited by court order **[or the child's, youth's or young adult's treatment team has determined that communication with an individual would negatively impact the child's, youth's or young adult's treatment, safety or well-being]**.

(18) To visit with the child's, youth's or young adult's parent, legal guardian or caregiver at reasonable hours at least once each week, at a time and location convenient for the parent, legal guardian or caregiver, the child, youth or young adult and the PRTF, unless the parent, legal guardian or caregiver is prohibited from visiting by court order **[or the child's, youth's or young adult's treatment team has determined that the visit with the parent, legal guardian or caregiver would negatively impact the child's, youth's or young adult's treatment, safety or well-being]**.

(19) To receive visitors of the child's, youth's or young adult's choice at reasonable hours unless the visitor is prohibited from visiting by court order or the child's, youth's or young adult's treatment team has determined that the visitor would negatively impact the child's, youth's or young adult's treatment, safety, or well-being.

(20) To receive and send unopened letters and to have outgoing letters stamped and mailed unless prohibited by court order, and to be allowed to read and write letters in private. Incoming and outgoing mail may be inspected for contraband when there is reasonable suspicion that the contents of the mail may negatively impact the child's, youth's or young adult's treatment, safety or well-being. The inspection shall be done in the presence of the child, youth or young adult.

(21) To have access to a telephone designated for use by children, youth or young adults **during times established by the PRTF**.

(22) To keep and use personal property, unless it is determined that a specific item is contraband in accordance with the PRTF's policy and procedure. The reasons for imposing a limitation on personal property and its scope shall be clearly defined, documented and explained to the child, youth or young adult.

(23) To be paid in compliance with the **29 CFR 525.4 (relating to patient workers) for all work performed that is of consequential economic benefit to the PRTF except**: **[Fair Labor Standards Act of 1938 (29 U.S.C. §§ 201—219) and the Child Labor Act (43 P.S. §§ 40.1—40.14) for any work the child, youth or young adult does for the PRTF.]**

(i) Personal housekeeping tasks related directly to the child's, youth's or young adult's personal space or possessions.

(ii) Shared responsibilities for regular household chores among children, youth or young adults.

(24) To peacefully assemble and to join with other children, youth or young adults to organize a body of or participate in **the** government of the PRTF, when it has been determined feasible **[by the PRTF]**.

(25) To be **[discharged] recommended for discharge** from the PRTF as soon as the child, youth or young adult no longer needs services.

(c) A child's, youth's or young adult's rights may not be used as a reward or sanction.

(d) A child's, youth's or young adult's parent, legal guardian or caregiver has all of the following rights:

(1) To communicate with PRTF staff in a language that the parent, legal guardian or caregiver understands, including American Sign Language, and when necessary, through interpreters **[or]**, translators **or communication devices**.

(2) To have ongoing contact with their child, youth or young adult unless prohibited by court order **[or determined by the child's, youth's or young adult's treatment team that the contact would negatively impact the child's, youth's or young adult's treatment, safety or well-being]**.

(3) To actively participate in the development, implementation and monitoring of their child's, youth's or young adult's treatment unless prohibited by court order **[or determined by the child's, youth's or young adult's treatment team that the active participation would negatively impact the child's, youth's or young adult's treatment, safety or well-being]**.

(e) A PRTF shall obtain a written acknowledgement **or document the efforts to obtain a written acknowledgement** from a youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver that the policy **[on]** **and procedure for** the rights of children, youth and young adults was received and reviewed **[within]** **prior to the child's, youth's or young adult's admission but no later than** 7 days **[of]** **after** the child's, youth's or young adult's admission to the PRTF. The signed acknowledgement **or documentation of efforts to obtain a written acknowledgment** shall be maintained in the child's, youth's or young adult's record.

(f) A copy of a child's, youth's or young adult's rights specified in subsection (b) shall be posted in a conspicuous and public location in the PRTF.

§ 5330.32. Grievance procedures.

(a) A child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver has the right to file a grievance with a PRTF.

(b) A PRTF shall have a written policy and procedure on grievances that assures the investigation and resolution of grievances and includes **[both of]** the following:

(1) A process to **file and** document written and verbal grievances.

(2) A process that assures that written and verbal grievances are submitted in a secure manner and without fear of retaliation.

(3) A process to review the grievance and inform the child, youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver if the child's, youth's or young adult's parent, legal guardian or caregiver submitted the grievance of the outcome of the grievance as soon as possible, but no later than 7 days after submission of the grievance.

(c) A copy of the PRTF grievance policy and procedure shall be posted in a conspicuous and public place in the PRTF.

(d) A copy of the grievance policy and procedure shall be provided to the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver on the day of admission to the PRTF.

(e) A PRTF shall obtain a written acknowledgement **or document the efforts to obtain a written acknowledgement** from a youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver that the grievance policy **and procedure** was received and reviewed **[within] prior to the child's, youth's or young adult's admission but no later than** 7 days **[of] after** the child's, youth's or young adult's admission to the PRTF. The signed

acknowledgement **or documentation of efforts to obtain a written acknowledgment** shall be filed in the child's, youth's or young adult's record.

§ 5330.33. Nondiscrimination.

A PRTF may not discriminate based on race, color, creed, disability, religious affiliation, ancestry, gender, gender identity or expression, sexual orientation, national origin or age and shall comply with applicable Federal and State laws and regulations.

§ 5330.34. Searches.

(a) A PRTF shall have a written policy and procedure on searches of a child, youth or young adult or the child's, youth's or young adult's personal property.

(b) A PRTF may conduct searches of a child, youth or young adult, or the child's, youth's or young adult's property and bedroom when a search is necessary to protect the child, youth, young adult or others.

(c) **[Unclothed] Visual** body searches of a child, youth or young adult are **[prohibited] permitted as follows:**

(1) The visual body search is ordered by a physician.

(2) The visual body search is conducted by two PRTF staff of the same gender that the child, youth or young adult identifies.

STAFFING

§ 5330.41. Supervision of staff.

(a) A PRTF shall have a written policy and procedure on the supervision of PRTF staff that includes all of the following:

(1) **[A medical director shall provide the following supervision to an RN, clinical director, or APP:]** **Each PRTF staff person shall be supervised by a qualified PRTF staff person for at least 2 hours each month. Of the 2 hours of supervision, 1 hour shall be in person.**

[(i) One hour of face-to-face supervision every month.

(ii) Thirty minutes of direct observation of the provision of services every 6 months.]

(2) **[A clinical director or medical director shall provide the following supervision to a mental health professional:]** **In addition to the requirement specified in paragraph (1), each PRTF staff person shall have one hour of observation of the provision of services every 6 months by a qualified PRTF staff person. Each occurrence of observation of services shall be for at least 30 minutes.**

[(i) Two hours of supervision each month. Of the 2 hours of supervision, 1 hour shall be face-to-face.

(ii) One hour of direct observation of the provision of services every 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.

(3) A clinical director, medical director, or mental health professional shall provide the following supervision to a mental health worker supervisor:

(i) Two hours of supervision each month. Of the 2 hours of supervision, 1 hour shall be face-to-face.

(ii) One hour of direct observation of the provision of services every 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.

(4)] (3) [A clinical director, medical director, mental health professional, or mental health worker supervisor shall provide the following supervision to a mental health worker:] Annual performance review of each PRTF staff person.

[(i) Two hours of supervision each month. Of the 2 hours of supervision, 1 hour shall be face-to-face.

(ii) One hour of direct observation of the provision of services every 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.

(5) If a PRTF utilizes a mental health worker supervisor, the mental health worker supervisor shall supervise the mental health worker.

(6) An RN shall provide the following supervision to an LPN:

(i) One hour of face-to-face supervision every month.

(ii) Thirty minutes of direct observation of the provision of services every 6 months.]

(b) A PRTF shall maintain documentation **[about each supervision session] of the completion of the requirements in subsection (a)** in the supervised PRTF staff person's personnel file that includes the following:

(1) The date and type of supervision session or date of **[direct]** observation.

(2) The location of the supervision session or location of **[direct]** observation.

(3) The start and end time of the supervision session or **[direct]** observation.

(4) Summary of the purpose and content of the supervision session or **[direct]** observation.

(5) Signature and date of signature for both the supervisee and the supervisor.

(c) **[Face-to-face] With the exception of in-person supervision, observation and** supervision may be **[delivered] conducted** through secure, real-time, two-way audio and video transmission that

meets technology and privacy standards required by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191**, 110 Stat. 1936**).

(d) The medical director and the treatment team leader are not required to be supervised in accordance with the requirements of this section.

§ 5330.42. Staff requirements.

(a) Staff working in a PRTF shall be **[21] 18** years of age or older.

(b) **PRTF staff counted in the supervision ratios required by subsections (d) and (e) shall be 21 years of age or older**.

(c) At least two PRTF staff persons who are trained in the use of manual restraints shall be present and available at the PRTF at all times.

[(c)] (d) During the PRTF's **designated** awake hours, the following requirements must be met:

(1) At least one mental health worker or a PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every six children, youth or young adults.

(2) PRTF staff providing supervision **to children, youth or young adults** shall always be within auditory **[and] or** visual range of children, youth or young adults **being supervised**.

(3) **[A mental health professional shall be present at the PRTF] A PRTF staff person who meets the qualifications of a clinical director or mental health professional shall be present.**

(4) An RN or an LPN shall be present.

[(d)] (e) During **the PRTF's designated** sleeping hours, the following requirements must be met:

(1) At least one mental health worker or a PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every 12 children, youth or young adults.

(2) PRTF staff providing supervision to children, youth or young adults shall **[remain]** **always be** within auditory **[range]** **or visual range** of the children, youth or young adults being supervised.

(3) PRTF staff supervising children, youth or young adults shall conduct and document visual observations of each child, youth or young adult **they are supervising** at least every 15 minutes.

(4) PRTF staff providing supervision to a child, youth or young adult shall remain awake at all times.

(5) An RN or an LPN shall be present at the PRTF or on call.

[(e)] (f) [PRTF staff shall be supervised as follows:] There shall be at least one PRTF supervisory staff person physically present at the PRTF at all times.

[(1) When there are less than 12 children, youth or young adults physically present at a PRTF, at least one PRTF supervisory staff person shall be physically present at the PRTF or on call to consult with PRTF staff.

(2) When 12 or more children, youth or young adults are physically present at a PRTF, at least one PRTF supervisory staff person shall be physically present at the PRTF for every 12 children, youth or young adults.]

§ 5330.43. Medical director.

(a) A PRTF shall have a medical director.

(b) The medical director shall be responsible for **[both of]** the following:

(1) Overseeing the delivery of psychiatric services and programming to children, youth or young adults in a PRTF.

(2) Coordination and supervision of PRTF staff on clinical and medical matters, including the prescribing and monitoring of psychotropic medication.

(c) The medical director shall be licensed in this Commonwealth as a physician practicing psychiatry and be a board-certified or board-eligible psychiatrist.

(d) The medical director may also serve as a treatment team leader.

§ 5330.44. Treatment team leader.

(a) **[A PRTF shall identify a treatment team leader for each child, youth or young adult]** **Each child, youth or young adult shall have a treatment team leader**.

(b) The treatment team leader shall be responsible for all of the following:

(1) Direction of each child's, youth's or young adult's treatment team.

(2) Leading monthly treatment plan meetings for each child, youth or young adult.

(3) **[Development]** **Overseeing the development** and implementation of **[the]****each** child's, youth's or young adult's individualized treatment plan.

(4) Overseeing the update of each child's, youth's or young adult's treatment plan by the treatment team at least every 30 days.

(5) Development of a discharge plan for each child, youth or young adult **with input from the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver**.

(6) **[Completing a comprehensive psychiatric evaluation that includes an examination of the medical, psychological, social, behavioral and developmental aspects of the child, youth or young adult and reflects the need for a PRTF level of care. The**

comprehensive psychiatric evaluation shall be completed within 7 days of a child's, youth's or young adult's admission to the PRTF.

(7)] Determining if a PRTF level of care remains medically necessary for the child, youth or young adult every 30 days.

(c) The treatment team leader shall meet the qualifications of a medical director specified in § 5330.43(c) (relating to medical director).

§ 5330.45. Clinical director.

(a) A PRTF shall have a clinical director.

(b) The clinical director shall be responsible for all of the following:

(1) Oversight of treatment assessments, services, therapeutic activities and program schedules.

(2) Review and response to emergency safety situations that occur at a PRTF.

(3) Oversight of the training curricula to ensure the requirements of §§ 5330.51 and 5330.52 (relating to initial staff training; and annual staff training) are met.

(c) The clinical director shall have at least 2 years of experience in the delivery of behavioral health services to children, youth or young adults with a mental illness or behavioral health disorder and meet one of the following:

(1) Be licensed in this Commonwealth as a physician.

(2) Be licensed in this Commonwealth as a psychologist.

(3) Be licensed in this Commonwealth as a marriage and family therapist.

(4) Be licensed in this Commonwealth as a professional counselor.

(5) Be licensed in this Commonwealth as a clinical social worker.

[(6) Be licensed in this Commonwealth as a social worker and have completed a clinical practicum.]

(d) A medical director may also serve as a clinical director.

§ 5330.46. Program director.

(a) A PRTF shall have a program director.

(b) The program director shall be responsible for all of the following:

(1) Administration and management of a PRTF.

(2) Implementation of the PRTF's policies and procedures.

(3) Compliance with this chapter.

(4) Overseeing the general safety and protection of children, youth and young adults.

(5) Developing and maintaining a program schedule of daily activities, which includes designated awake and sleeping times.

(c) The program director shall have one of the following:

(1) At least 1 year of experience in human service administration or direct care of children, youth or young adults with behavioral health needs and a graduate degree in psychology, sociology, social work, counseling, education, human services, public administration, business administration or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator

agencies to verify a [foreign] degree or its equivalency **from a college or university outside the United States.**.

(2) At least 2 years of experience in human service administration or direct care of children, youth or young adults with behavioral health needs and a bachelor's degree in psychology, sociology, social work, counseling, education, human services, public administration, business administration or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college or university outside the United State**s.

(3) At least 3 years of experience in human service administration or direct care of children, youth or young adults with behavioral health needs and an associate's degree in psychology, sociology, social work, counseling, education, human services, public administration**[, business administration]** or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college**

or university outside the United States. One of the 3 years of experience must be in a supervisory or managerial role.

(4) At least 5 years of experience in direct care of children, youth or young adults with behavioral health needs and a high school diploma or the equivalent of a high school diploma. Two of the 5 years of experience must be in a supervisory or managerial role.

§ 5330.47. Registered nurse.

(a) A PRTF shall have an RN **[who is either onsite or available at all times when not onsite]**.

(b) **[The] An** RN shall be responsible for all of the following:

(1) Overseeing the nursing care for children, youth or young adults in a PRTF.

(2) Assessing the health conditions of children, youth or young adults and determining appropriate nursing care needs.

(3) Participating in monthly treatment plan meetings.

[(c) The RN shall have at least 1 year of experience in treating children, youth or young adults with behavioral health needs.]

§ 5330.48. Mental health professional.

(a) A PRTF shall have a mental health professional.

(b) Children, youth or young adults in a PRTF shall be assigned to a mental health professional.

(c) The mental health professional shall be responsible for all of the following:

(1) Developing **[of]** the child's, youth's or young adult's individualized treatment plan **with input from the child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver**.

(2) Participating in monthly treatment plan meetings for all assigned children, youth or young adults.

(3) Implementing treatment services and therapeutic activities for a child, youth or young adult in accordance with the child's, youth's or young adult's treatment plan.

(4) Providing individual, group or family therapy in accordance with the child's, youth's or young adult's treatment plan.

(5) Coordinating with the treatment team under the direction of the treatment team leader to address the goals, objectives, needs and strengths of assigned children, youth or young adults.

(d) The mental health professional's assigned caseload may not exceed **[eight]** **ten** children, youth or young adults.

(e) The mental health professional shall meet one of the following:

(1) Be licensed in this Commonwealth as a physician, psychologist, marriage and family therapist, professional counselor or clinical social worker.

(2) Be licensed in this Commonwealth as a social worker **[or behavior specialist], behavior specialist, associate marriage and family therapist or associate professional counselor** and have a graduate degree that required a clinical **[or mental health direct service]** practicum from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or have an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college or university outside the United States**.

(3) Have at least 1 year of experience in providing mental health direct services to children, youth or young adults and a graduate degree with at least **[nine]** **12** credits specific to clinical practice in psychology, sociology, social work or counseling from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college or university outside the United States**.

(4) Completed a clinical **[or mental health direct service]** practicum and have a graduate degree with a least **[nine]** **12** credits specific to clinical practice in psychology, sociology, social work, education, counseling or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or have an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college or university outside the United States**.

§ 5330.49. Mental health worker.

(a) A PRTF shall have a mental health worker.

(b) The mental health worker shall be responsible for all of the following:

(1) Implementing therapeutic interventions.

(2) Providing direct and active supervision to children, youth or young adults.

(3) Supporting the strengths and needs of children, youth or young adults.

(4) Sharing pertinent information with the child's, youth's or young adult's treatment team. This may include general observations, progress with service goals and areas of concern.

(5) Facilitating psychoeducational groups.

(c) The mental health worker shall have **[a high school diploma or the equivalent of a high school diploma and at least 1 year of experience working with children, youth or young adults.]** **one of the following:**

(1) At least 12 credits specific to a behavioral health field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or have an equivalent degree from a college or university in another country that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a degree or its equivalency from a college or university outside the United States.

(2) A high school diploma or the equivalent of a high school diploma, and at least 6 months of experience working in a behavioral health or related field.

(d) A PRTF may provide the 6 months of experience specified in subsection (c)(2) so long as the training is separate and distinct from the requirements specified in §§ 5330.51 and 5330.52 (relating to initial staff training; and annual staff training).

(e) If a PRTF provides the experience specified in subsection (c)(2), the PRTF must have a written plan of supervision on how the experience will be obtained.

(f) If a mental health worker is completing the 6 months of experience specified in subsection (c)(2), the mental health worker may not be counted in the staff ratio requirements specified in § 5330.42 (relating to staff requirements).

§ 5330.50. Additional staff positions.

The following PRTF staff positions, if utilized, shall meet all of the following requirements:

(1) If within the scope of the APP's practice, an APP may do the following:

(i) Evaluate the physical **[or]** **and** psychological condition of a child, youth or young adult who takes a prescribed medication.

(ii) **[Review, update, sign and date the child's, youth's or young adult's treatment plan]** **Participate in monthly treatment plan meetings for children, youth or young adults.**

(iii) Perform initial or routine specific screenings and assessments to assess the physical or psychological condition of a child, youth or young adult.

(2) The APP shall **[be licensed in this Commonwealth and]** have at least 1 year of experience working with children, youth or young adults**, and hold a mental health certification within 2 years from the date of hire by the PRTF**.

(3) If within the scope of the LPN's practice, an LPN may do the following:

(i) Accept verbal orders for a manual restraint.

(ii) **Accept verbal orders for medication.**

(iii) Participate in the planning, implementation and evaluation of nursing care provided to a child, youth or young adult.

(4) **[The LPN shall be onsite at a PRTF whenever an RN is not onsite at the PRTF.**

(5) The LPN shall have at least 1 year of experience working with children, youth or young adults.

(6)] A mental health worker supervisor may provide the following:

(i) Supervision of a mental health worker.

(ii) Direct and active supervision to children, youth or young adults.

[(7)] (5) The mental health worker supervisor shall have one of the following:

(i) At least **[1 year] 6 months** of experience in the delivery of behavioral health services to children, youth or young adults and a bachelor's degree in psychology, sociology, social work, counseling, education, human services, public administration**[, business administration]** or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college or university outside the United States**.

(ii) At least **[2 years] 1 year** of experience in the delivery of behavioral health services to children, youth or young adults and an associate's degree in psychology, sociology, social work, counseling, education, human services, public administration**[, business administration]** or a related field from a college

or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a **[foreign]** college or university **in another country** that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a **[foreign]** degree or its equivalency **from a college or university outside the United States**.

(iii) At least **[3] 2** years of experience in the delivery of behavioral health services to children, youth or young adults and a high school diploma or the equivalent of a high school diploma.

§ 5330.51. Initial staff training.

(a) A PRTF shall have a written policy and procedure on the monitoring of initial PRTF staff training.

(b) PRTF staff shall complete an orientation that includes the individual's specific duties and responsibilities and information on the PRTF's policies and procedures.

(c) **[Except as required under subsection (d),]** PRTF staff **who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month** shall complete at least 30 hours of training in the following areas **prior to working directly with children, youth or young adults and** within 120 days of their date of hire:

(1) The requirements of this chapter.

(2) The requirements of 23 Pa.C.S. §§ 6301—6388 (relating to Child Protective Services Law) and Chapter 3490 (relating to protective services).

(3) The requirements of the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704)**, if the PRTF provides treatment to young adults**.

(4) Fire safety by a fire safety expert. The following apply:

(i) Training may be through a video recording if the video recording is prepared by a fire safety expert and is administered onsite by a PRTF staff person who is trained by a fire safety expert.

(ii) If the facility serves 20 or fewer children, youth or young adults, the training may be conducted by a PRTF staff person trained by a fire safety expert.

(5) First aid, opioid overdose reversal medication, Heimlich techniques, cardiopulmonary resuscitation **(CPR)**, use of an AED, universal precautions and blood-borne pathogen training facilitated by an individual qualified as a trainer by a hospital or other recognized health care organization.

(6) The use of manual restraints that is consistent with 42 CFR 483.376 (relating to education and training) and provided by an individual who meets the qualifications in 42 CFR 483.376(c).

(7) Verbal de-escalation, crisis prevention and suicide prevention.

(8) Professional ethics and conduct, professional boundaries and confidentiality.

(9) Cultural competency and equity training that increases awareness of cultural norms and provides skills and knowledge regarding the value of diversity.

(10) **[Trauma-informed care principles and practical applications]** **The impact of trauma on a child, youth or young adult and how trauma-informed care promotes resiliency and recovery of a child, youth or young adult**.

(11) Mental health diagnoses, conditions, needs and effective service interventions for children, youth or young adults.

(12) Principles of child development.

(13) Recognizing and responding to emergency safety situations.

(14) Cross-system collaboration that includes system of care values or child and adolescent service system program principles.

(d) **[The medical director, treatment team leader, clinical director, program director, RN, mental health professional, mental health worker, and if utilized, an APP, an LPN, and a mental health worker supervisor shall complete the training required under subsection (c) prior to working directly with children, youth or young adults.**

(e)] A PRTF shall keep documentation of completion of initial training requirements, which includes all of the following:

(1) Name of the PRTF staff trained.

(2) Training date.

(3) Training source.

(4) Name and qualifications of the trainer.

(5) Length of training.

(6) Copy of materials distributed to PRTF staff.

(7) Copy of materials that were used during the training.

§ 5330.52. Annual staff training.

(a) A PRTF shall have a written policy and procedure on the monitoring of annual PRTF staff training.

(b) PRTF staff **who are involved in providing behavioral health treatment to children, youth or young adults for 30 or more hours in any month** shall have at least **[30] 40** hours of annual training in the **following areas [specified in § 5330.51(c) (relating to initial staff training).**

(c) In addition to the requirements in subsection (b), the medical director, treatment team leader, clinical director, program director, RN, mental health professional, mental health worker, and, if utilized, an APP, an LPN, and a mental health worker supervisor shall complete an additional 10 hours of annual training in the following areas]:

(1) **The areas specified in § 5330.51(c) (relating to initial staff training).**

(2) Best practices, including evidence-based practices to address the unique characteristics of the children, youth or young adults served.

[(2)] (3) Types, uses and side effects of psychotropic medications prescribed to children, youth or young adults.

[(3)] (4) Effective and transferable discharge and reintegration planning.

[(4)] (5) Documentation skills and requirements.

[(5)] (6) Mental health conditions, emotional disturbances or behavior disorders in children, youth or young adults as they relate to their biopsychosocial needs.

[(d)] (c) A PRTF shall keep documentation of completion of annual training requirements, which includes all of the following:

(1) Name of the PRTF staff trained.

(2) Training date.

(3) Training source.

(4) Name and qualifications of the trainer.

(5) Length of training.

(6) Copy of materials distributed to PRTF staff.

(7) Copy of materials that were used during the training.

§ 5330.53. Criminal history checks and child abuse certifications.

(a) Criminal history checks and child abuse history certifications must be completed for all PRTF staff in accordance with 23 Pa.C.S. §§ 6301—6388 (relating to Child Protective Services Law) and Chapter 3490 (relating to protective services).

(b) A PRTF shall have a written policy and procedure to ensure that PRTF staff having contact with children, youth or young adults comply with 23 Pa.C.S. §§ 6301—6388 and Chapter 3490, including mandated reporting and training requirements.

PHYSICAL SITE

§ 5330.61. Applicable construction safety laws.

A PRTF shall comply with the requirements of 34 Pa. Code Part XIV (relating to uniform construction code).

§ 5330.62. Physical accommodations and equipment.

A PRTF shall provide or arrange for physical site accommodations and equipment needed to meet the health and safety needs of a child, youth or young adult served, including special accommodations as a result of a child's, youth's or young adult's disability.

§ 5330.63. Poisons.

(a) Poisonous materials, including cleaning and other toxic materials, must be kept locked and inaccessible to a child, youth or young adult.

(b) Poisonous materials, including cleaning and other toxic materials, must be clearly labeled and stored in a container that meets the requirements for safe storage of that material.

(c) Poisonous materials, including cleaning and other toxic materials, must be kept separate from food, food preparation surfaces and dining surfaces.

§ 5330.64. Heat sources.

Heat sources, such as hot water pipes, fixed space heaters, hot water heaters and radiators exceeding 120°F that are accessible to a child, youth or young adult, must be equipped with protective guards or insulation to prevent a child, youth or young adult from making physical contact with the heat source.

§ 5330.65. Sanitation.

(a) Sanitary conditions must be maintained.

(b) A PRTF shall take steps to prevent and address infestation of insects or rodents.

(c) Trash must be removed from the property at least once a week.

(d) Trash inside and outside of a PRTF must be kept in covered trash receptacles that prevent insect and rodent penetration.

§ 5330.66. Ventilation.

(a) Living areas, recreation areas, dining areas, bathrooms, bedrooms and kitchens must be ventilated by at least one operable window or mechanical ventilation.

(b) Windows, including windows in doors, must be securely screened when open.

§ 5330.67. Lighting.

Rooms, bedrooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps and fire escapes must be properly lighted to avoid accidents.

§ 5330.68. Surfaces.

Indoor and outdoor floors, walls, ceilings, windows, doors and other surfaces must be free of damage or hazards.

§ 5330.69. Water.

(a) A PRTF shall have hot and cold water.

(b) Hot water temperature in areas accessible to a child, youth or young adult may not exceed 120°F.

(c) A PRTF that is not connected to a public water or sewer system shall meet all Federal and State statutes, regulations and standards regarding private water and sewage systems.

(d) A PRTF that is not connected to a public water system shall have a coliform water test performed at least every 3 months by the Department of Environmental Protection.

§ 5330.70. Air temperature.

(a) The indoor temperature shall be at least 65°F during awake hours when a child, youth or young adult is present in a PRTF.

(b) The indoor temperature may not be less than 62°F during sleeping hours.

(c) When the indoor temperature exceeds 85°F, a PRTF shall use mechanical ventilation, such as fans or air conditioning.

§ 5330.71. Communication system.

(a) A PRTF shall have a working telephone that is accessible to PRTF staff at all times.

(b) A PRTF shall have communication equipment**[, such as a hand-held two-way radio,]** to allow PRTF staff to contact other PRTF staff for assistance in an emergency safety situation.

§ 5330.72. Emergency telephone numbers.

The PRTF's physical address and telephone numbers for the nearest hospital, police department, fire department, ambulance and poison control center must be posted on or by all working telephones accessible to PRTF staff.

§ 5330.73. Handrails and railings.

(a) Ramps, interior stairways and outside steps exceeding two steps must have a well-secured handrail.

(b) Porches **[that have]** over an 18-inch drop must have a well-secured railing.

§ 5330.74. Landings and stairs.

(a) Stairs must have a landing which is at least as wide as the doorway beyond each interior and exterior door that opens directly into a stairway.

(b) Interior stairs must have nonskid surfaces.

§ 5330.75. Furniture.

(a) Furniture must be free of hazards.

(b) A PRTF shall have enough furniture to accommodate seating for the largest group of children, youth or young adults that may routinely congregate so that no child, youth or young adult is required to stand or sit on the floor.

§ 5330.76. Equipment.

(a) Equipment must be kept clean and maintained in good repair.

(b) Equipment that poses a hazard to children, youth or young adults must be stored in an area that is inaccessible to children, youth or young adults.

(c) A PRTF shall have a written policy and procedure to ensure that hazardous equipment is used in a safe and appropriate manner.

§ 5330.77. First aid supplies.

(a) A PRTF shall have a first aid kit available to PRTF staff on every floor of the PRTF **where a child, youth or young adult may be present**.

(b) **[PRTF staff shall confirm that a first aid kit is present if an activity is being conducted outside on the grounds of the PRTF or away from the PRTF.]**

(c)] A first aid kit shall contain all of the following items:

(1) A first aid manual.

(2) Nonporous disposable gloves.

(3) Antiseptic.

(4) Assorted adhesive bandages.

(5) Gauze pads.

(6) Thermometer.

(7) Tape.

(8) Tweezers.

(9) Scissors.

[(10) Opioid overdose reversal medication.]

[(d)] **(c)** A first aid kit may not be accessible to children, youth or young adults.

[(e)] **(d)** A PRTF shall have an AED that is **[accessible]** **available** to PRTF staff.

(e) A PRTF shall have Naloxone or other medications that can be used to reverse a substance overdose available to PRTF staff.

(f) **[An AED may not be accessible to children, youth or young adults.]**

A PRTF shall replenish the first aid kit at least once a month.

(g) A PRTF shall maintain the AED in accordance with the manufacturer's operational guidelines.

(h) A PRTF shall document its compliance with the requirements specified in subsections (f)—(g).

§ 5330.78. Elevators.

An elevator must have a valid certificate of operation from the Department of Labor and Industry.

§ 5330.79. Activity space.

A PRTF shall have indoor space for activities such as recreation, studying and group activities and outdoor space for activities such as recreation and group activities.

§ 5330.80. Exterior conditions.

(a) The exterior of structures and grounds or yard of a PRTF must be free of hazards.

(b) Outside walkways must be free of ice, snow and any type of obstruction.

§ 5330.81. Firearms and weapons.

A PRTF shall have a written policy regarding possession of firearms, weapons and ammunition on the premise of a PRTF. A PRTF is not required to permit firearms, weapons and ammunition **on the premises**. The policy shall be in accordance with Federal and State law.

§ 5330.82. Bedrooms.

(a) A single bedroom must have at least 70 square feet of floor space per child, youth or young adult measured wall to wall, including space occupied by furniture.

(b) A shared bedroom must have at least 60 square feet of floor space per child, youth or young adult measured wall to wall, including space occupied by furniture.

(c) No more than four children, youth or young adults may share a bedroom.

(d) The ceiling height in a bedroom must be at least 7 1/2 feet.

(e) A bedroom must have a window with a source of natural light.

(f) A child, youth or young adult shall be provided with all of the following:

(1) A bed with a solid foundation and fire-retardant mattress in good condition.

(2) A pillow and bedding, in good condition, appropriate for the temperature in the PRTF.

(3) A storage area for clothing.

(g) Cots or portable beds are not permitted.

(h) Bunk beds **[must allow enough space between each bed and the ceiling to allow a child, youth or young adult to sit up in bed]** **are prohibited in a PRTF**.

(i) **[Bunk beds must be equipped with securely attached ladders capable of supporting a child, youth or young adult.**

(j) The top bunk of bunk beds must be equipped with a secure safety rail on each open side and open end of the bunk.

(k)] A bedroom may not be used as a means of egress or as a means to access another part of a PRTF.

§ 5330.83. Bathrooms.

(a) A PRTF shall have at least one functional toilet for every six children, youth or young adults.

(b) A PRTF shall have at least one functional sink for every six children, youth or young adults.

(c) A PRTF shall have at least one functional bathtub or shower for every six children, youth or young adults.

(d) A PRTF shall have slip-resistant surfaces in bathtubs and showers.

(e) Privacy must be provided for toilets, showers and bathtubs by partitions or doors.

(f) A PRTF shall have at least one wall mirror for every six children, youth or young adults.

(g) All of the following toiletry items must be provided for each child, youth or young adult:

(1) Towels and washcloths.

(2) Toothpaste.

(3) Toothbrush.

(4) Comb or hairbrush.

(5) Shampoo.

(6) Soap.

(7) Feminine hygiene products, if needed.

(8) Toilet paper.

(9) Deodorant, if needed.

(10) Body lotion, if needed.

(h) Bar soap is not permitted unless there is a separate bar clearly labeled for each child, youth or young adult.

§ 5330.84. Kitchen area.

(a) A PRTF shall have a kitchen area with an operable refrigerator, sink, cooking equipment and cabinets for storage.

(b) Utensils for eating, drinking, serving food and preparing food must be washed and rinsed after each use.

(c) Food must be protected from contamination while being stored, prepared, transported and served.

(d) Uneaten food from a child's, youth's or young adult's dish may not be served again or used in the preparation of future meals.

(e) Food must be kept at the following temperatures:

(1) Cold food must be kept at or below 40°F.

(2) Hot food must be kept at or above 140°F.

(3) Frozen food must be kept at or below 0°F.

§ 5330.85. Laundry.

Bed linens, towels, washcloths and clothing must be laundered at least once a week.

§ 5330.86. Swimming.

(a) The perimeter of swimming pools must be surrounded by a fence that meets local codes and a gate that is locked when the pool is not in use.

(b) Swimming pools must be inaccessible to children, youth or young adults when not in use.

(c) A certified lifeguard shall supervise children, youth or young adults at all times while swimming. A certified lifeguard may not be counted towards the supervision ratio specified in § 5330.42 (relating to staff requirements).

FIRE SAFETY

§ 5330.91. Compliance with fire safety statutes, regulations and ordinances.

A PRTF shall comply with applicable Federal and State laws, regulations and local ordinances regarding fire safety.

§ 5330.92. Unobstructed egress.

(a) Stairways, hallways, doorways, passageways and egress routes from rooms and from a PRTF must be unlocked and unobstructed unless the fire safety approval specified in § 5330.6 (relating to fire safety approval) permits locking of certain means of egress. If a fire safety approval is not required in accordance with § 5330.6, means of egress may not be locked.

(b) Doors used for egress routes from rooms **[and from a PRTF]** may not be equipped with key-locking devices, electronic card-operated systems or other PRTF staff-controlled devices that prevent immediate egress by a child, youth or young adult [**from the PRTF**].

(c) Doors with delayed egress **from a PRTF** must **[be equipped with a mechanism that unlocks after no more than a 15-second delay and must]** meet the requirements of section 1008.1.9.7 of the International Building Code, regarding delayed egress locks.

(d) Doors without delayed egress from a PRTF may not be equipped with key-locking devices, electronic card-operated systems or other PRTF staff-controlled devices that prevent immediate egress by a child, youth or young adult from the PRTF.

§ 5330.93. Exits.

(a) If more than four children, youth or young adults sleep above the ground floor of a PRTF, there must be at least two interior or exterior exits from each floor.

(b) If a fire escape is used as a means of egress, it must be permanently installed.

§ 5330.94. Evacuation procedures.

(a) A PRTF shall have written emergency evacuation procedures that include PRTF staff responsibilities, means of transportation and designated meeting areas.

(b) A PRTF shall have emergency evacuation procedures that contain a detailed diagram of exit paths, exit doors and fire extinguishers for each floor posted in a conspicuous and public place on each floor of the PRTF.

(c) An elevator may not be used during a fire drill or an emergency evacuation procedure.

§ 5330.95. Notification of local first responders.

(a) A PRTF shall notify local first responders in writing of all of the following:

(1) Maximum number of children, youth, young adults and PRTF staff that could be present at the PRTF.

(2) Physical address of physical structures.

(3) Specific location of bedrooms.

(4) Assistance needed to evacuate children, youth or young adults in an emergency.

(b) Notification to local first responders must be reviewed and updated annually or within 5 days of when there is a change in the physical address of a physical structure, location of bedrooms or assistance needed to evacuate.

§ 5330.96. Flammable and combustible materials.

Flammable and combustible materials must be used safely, stored away from heat sources and inaccessible to children, youth or young adults.

§ 5330.97. Furnaces.

(a) Furnaces must be inspected and cleaned annually by a professional furnace cleaning company or properly trained PRTF maintenance staff.

(b) A PRTF shall maintain documentation of the annual inspection and cleaning of a furnace.

§ 5330.98. Portable space heaters.

Portable space heaters or heaters that are not permanently mounted or installed are not permitted.

§ 5330.99. Wood and coal burning stoves.

The use of wood and coal burning stoves is not permitted.

§ 5330.100. Fireplaces.

(a) Fireplaces must be securely screened or equipped with protective guards while in use.

(b) PRTF staff shall be present with a child, youth or young adult while a fireplace is in use.

(c) A fireplace chimney and flue must be cleaned and inspected annually by a professional cleaning company or properly trained PRTF maintenance staff.

(d) A PRTF shall maintain documentation of the cleaning and inspection of the fireplace chimney and flue.

(e) Inoperable fireplaces must be inaccessible.

§ 5330.101. Detectors and alarms.

(a) A PRTF shall have an operable smoke detector located within 15 feet of each bedroom door.

(b) A PRTF shall have at least one operable smoke detector on each floor, including a basement and an attic.

(c) **A carbon monoxide alarm must be installed in a PRTF no more than 15 feet from any fossil fuel-burning device or appliance.**

(d) Smoke detectors**, carbon monoxide alarms** and fire alarms must be a type approved by the Department of Labor and Industry or listed by Underwriters Laboratories.

[(d)] (e) If a PRTF serves four or more children, youth or young adults or if the PRTF has three or more floors, including a basement and an attic, there must be at least one smoke detector on each floor that is interconnected and audible throughout the PRTF or a fire alarm system that is audible throughout the PRTF.

[(e)] (f) Smoke detectors**, carbon monoxide alarms** and fire alarms must be equipped with a visual aid so that an individual with a hearing impairment can be alerted in the event of a fire **or the detection of a dangerous level of carbon monoxide in the air**.

[(f)] (g) If a smoke detector**, carbon monoxide alarm** or fire alarm becomes inoperable, repair or replacement shall be completed within 24 hours of the time the detector or alarm was found to be inoperable.

[(g) An approved carbon monoxide alarm must be installed in a PRTF no more than 15 feet from any fossil fuel-burning device or appliance.]

(h) **[Carbon monoxide detectors and alarm systems] Smoke detectors, carbon monoxide alarms and fire alarms** must be tested and replaced in accordance with the manufacturer's guidelines.

(i) A PRTF shall have a written procedure for fire safety and carbon monoxide monitoring if a smoke detector, fire alarm or carbon monoxide detector becomes inoperative.

(j) A PRTF shall make accommodations to alert children, youth or young adults with a sight or hearing impairment of an emergency situation.

§ 5330.102. Fire extinguishers.

(a) Fire extinguishers must be inspected and approved annually by a fire safety expert who is not an employee of the PRTF. The date of the inspection must be documented on the fire extinguisher.

(b) Fire extinguishers must be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

(c) There must be at least one approved fire extinguisher with a minimum 2-A rating for each floor, including a basement and an attic.

(d) If an indoor floor area including a basement or an attic is more than 3,000 square feet, there must be an additional approved fire extinguisher with a minimum 2-A rating for each additional 3,000 square feet of indoor floor space.

(e) An approved fire extinguisher with a minimum 2A-10BC rating must be in a kitchen. The kitchen fire extinguisher meets the requirements for one approved fire extinguisher for each floor as required in subsection (c).

(f) Fire extinguishers must be accessible to all PRTF staff. A fire extinguisher must be secured if access to the extinguisher by a child, youth or young adult may cause a safety risk to the child, youth or young adult. If fire extinguishers are secured, PRTF staff shall have the means to immediately gain access to the fire extinguisher in the event of a fire emergency.

§ 5330.103. Fire drills.

(a) An unannounced fire drill must be held at least once a month.

(b) Fire drills must be held during normal staffing conditions and not when additional PRTF staff are present.

(c) The evacuation routes must allow children, youth or young adults to evacuate the entire physical structure into a public thoroughfare or to a fire-safe area designated in writing within the past year by a fire safety expert. The public thoroughfare or to a fire-safe area must be within 2 1/2 minutes or within the period specified in writing within the past year by a fire safety expert. The fire safety expert may not be an employee of the PRTF.

(d) A fire drill must be held during sleeping hours at least once every 6 months.

(e) Alternate exit routes must be used during fire drills at least once every 3 months.

(f) Fire drills must be held on different days of the week, at different times and during different staffing shifts.

(g) A fire alarm or smoke detector must be activated during each fire drill.

(h) A PRTF shall have a written fire drill record that contains all of the following:

(1) Address and name of the physical structure where the fire drill occurred.

(2) Date the fire drill occurred.

(3) Time the fire drill occurred.

(4) Amount of time for all individuals to evacuate the PRTF.

(5) The exit route that was utilized during the fire drill.

(6) The number of children, youth or young adults in the location at the time of the fire drill.

(7) Documentation of any issues encountered during the fire drill.

(8) Documentation of whether fire alarms or smoke detectors were operable.

HEALTH

§ 5330.111. Health and behavioral health services.

(a) A PRTF shall identify acute and chronic conditions of a child, youth or young adult and shall arrange for or provide appropriate medical treatment.

(b) Medically necessary physical and behavioral health treatment, diagnostic services, follow-up examinations and services, such as medical, nursing, pharmaceutical, dental, dietary, hearing, vision, blood lead level, psychiatric and psychological services that are planned or prescribed for the child, youth or young adult, shall be arranged for or provided.

§ 5330.112. Initial medical assessment.

(a) **[A PRTF shall have a written policy and procedure on inclusion of the assessment of health or safety risks in the initial medical assessment of children, youth or young adults]** **A child, youth or young adult shall have an initial medical assessment completed by a physician, APP or RN within 24 hours of admission to a PRTF**.

(b) An initial medical assessment must include all of the following:

(1) Vital signs, such as blood pressure, pulse, temperature and breathing rate.

(2) Allergies.

(3) Medication history.

(4) Immunization history.

(5) Substance use history.

(6) Prior or current injuries or illnesses.

(7) Prior hospitalizations.

(8) Medical diagnoses.

(9) Parents' medical history, if known.

(10) Vision screening **history**.

(11) Hearing screening **history**.

(12) Dental examination **history**.

(13) Laboratory tests history, including prior tests of blood lead level or for sickle cell, if applicable.

(14) Review history of prohibited manual restraints, because of a child's, youth's or young adult's medical condition, if applicable.

(c) **[A child, youth or young adult shall have an initial medical assessment completed by a physician, APP, or RN within 24 hours of admission to a PRTF.**

(d)] An initial medical assessment must be signed and dated by the physician, APP or RN who completed the initial medical assessment.

[(e)] (d) If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within **[3] 7** days from the date the initial medical assessment was completed.

[(f)] (e) A copy of the initial medical assessment shall be kept in a child's, youth's or young adult's record.

§ 5330.113. Health and safety plan.

(a) If an initial medical assessment specified in § 5330.112 (relating to initial medical assessment) **or the child's, youth's or young adult's most recent psychiatric evaluation** identifies a health or safety risk to a child, youth, young adult or others, a written health and safety plan to protect the child, youth, young adult or others must be developed and implemented within 24 hours after the initial medical assessment is completed.

(b) The health and safety plan to protect the child, youth, young adult or others must be communicated to and made available to PRTF staff and must be filed in the child's, youth's or young adult's record.

(c) A written health and safety plan must be developed and implemented within 24 hours of the PRTF medical staff or treatment staff being notified of a health or safety risk to the child, youth or young adult.

(d) Written health and safety plans must be updated based on the health and safety risks of the child, youth or young adult.

§ 5330.114. Medical examination.

(a) If a child, youth or young adult did not have a medical examination, or there is no documentation of a medical examination 12 months prior to admission to a PRTF that meets the requirements of the State Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Periodicity Schedule, a medical examination by a physician or APP shall be completed within 15 days of the child's, youth's or young adult's admission to a PRTF.

(b) An initial medical examination must include all of the following:

(1) Review of the assessments specified in § 5330.112 (relating to initial medical assessment).

(2) Review of the health history and medical information pertinent to the child, youth or young adult to inform medical care, diagnosis and services needed in an emergency safety situation.

(3) Review of required immunizations, screening tests and laboratory tests, including the ordering of any immunizations, screening tests and laboratory tests that are indicated.

(4) Communicable disease detection, if recommended by a physician or APP based on the child's, youth's or young adult's health condition and with appropriate consent from the youth or young adult or the child's, youth's or young adult's parent**[, legal guardian or caregiver]** **or legal guardian**.

(5) Recommendations for follow-up physical or behavioral health treatment, examinations or services.

(c) A child, youth or young adult shall have a medical examination completed annually by a physician or APP that meets the requirements of the State EPSDT Program Periodicity Schedule.

(d) A medical examination must be signed and dated by the physician or APP who completed the medical examination.

(e) Written verification of completion of the medical examination must be kept in the child's, youth's or young adult's record specifying all of the following:

(1) Date of the examination.

(2) Results of the examination.

(3) Name, address and contact information of the examining physician or APP.

(4) Follow-up recommendations.

§ 5330.115. Dental care.

(a) A child, youth or young adult shall have a dental examination performed by a licensed dentist and teeth cleaning performed by a licensed dentist or dental **[technician] hygienist** at least semiannually.

(b) **[A]** **Except as provided in subsection (c), a** child, youth or young adult shall receive a dental examination and teeth cleaning within 30 days after admission to a PRTF.

(c) If the child, youth or young adult had a **semiannual** dental examination and teeth cleaning prior to admission to the PRTF that meets the requirements of subsection (a), an initial examination and teeth cleaning within 30 days after admission is not required.

(d) Follow-up dental work indicated by the examination, such as treatment of cavities and application of protective sealants, must be provided as recommended by the licensed dentist.

(e) A written record of completion of each dental examination and teeth cleaning, including the preadmission dental examination and teeth cleaning permitted in subsection (c), specifying the date of the examination and teeth cleaning, the licensed dentist's name and address, results of the examination, follow-up recommendations made and the dates and provision of follow-up services and treatment, must be kept in the child's, youth's or young adult's record.

§ 5330.116. Vision care.

(a) A child, youth or young adult shall receive vision screening and treatment to include diagnosis and services, including eyeglasses, for defects in vision.

(b) **[A] Except as provided in subsection (c), a** child, youth or young adult shall receive a vision screening within 30 days after admission to a PRTF in accordance with the periodicity schedule recommended by the American Academy of Pediatrics.

(c) If the child, youth or young adult had a vision screening prior to admission to the PRTF that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b), an initial examination within 30 days after admission is not required. The next screening shall be required within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment, such as provision of eyeglasses, must be provided as recommended by the treating practitioner.

(e) A written record of completion of each vision screening, including the preadmission screening permitted in subsection (c), specifying the date of the screening, the treating practitioner's name and address, results of the screening, follow-up recommendations made, and the dates and provision of follow-up services and treatment, must be kept in the child's, youth's or young adult's record.

§ 5330.117. Hearing care.

(a) A child, youth or young adult shall receive a hearing screening and treatment to include diagnosis and services, including hearing aids, for defects in hearing.

(b) **[Each]** **Except as provided in subsection (c), each** child, youth or young adult shall receive a hearing screening within 30 days after admission in accordance with the periodicity schedule recommended by the American Academy of Pediatrics.

(c) If the child, youth or young adult had a hearing screening prior to admission to the PRTF that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b), an initial examination within 30 days after admission is not required. The next screening shall be required within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment, such as provision of hearing aids, must be provided as recommended by the treating practitioner.

(e) A written record of completion of each hearing screening, including the preadmission screening permitted in subsection (c), specifying the date of the screening, the treating practitioner's name and address, the results of the screening, follow-up recommendations made and the dates and provision of follow-up services and treatment, must be kept in the child's, youth's or young adult's record.

§ 5330.118. Use of drugs, alcohol, tobacco and e-cigarettes.

(a) A PRTF shall have a written policy and procedure on the use of **[drugs, alcohol, tobacco and e-cigarettes.]** **the following:**

(1) Illegal drugs.

(2) Alcohol.

(3) Tobacco.

(4) E-cigarettes.

(5) Staff use of prescription and non-prescription medications

(b) Use or possession of **illegal** drugs, alcohol, tobacco and e-cigarette products by a child, youth or young adult is prohibited.

(c) Use or possession of **illegal** drugs, alcohol, tobacco and e-cigarettes products by a PRTF staff person is prohibited in the PRTF and during transportation of a child, youth or young adult.

(d) If **[PRTF staff are permitted to]** **the** use of tobacco and e-cigarette products is permitted on the grounds of the PRTF, the following apply:

(1) The PRTF shall designate **outside** areas of the PRTF **[grounds]** where it is permissible to use tobacco or e-cigarettes.

(2) The PRTF shall have a written fire safety procedure in the areas where it is permissible to use tobacco and e-cigarettes. Procedures must include extinguishing procedures and requirements that use of tobacco and e-cigarette products shall occur **at** a safe distance from flammable or combustible materials and physical structures.

(3) Use of tobacco and e-cigarette products must be out of the sight of a child, youth or young adult.

§ 5330.119. Emergency plan.

(a) A PRTF shall have a written medical emergency plan for children, youth, young adults and PRTF staff. The plan must include all of the following:

(1) A hospital or health care provider that will provide services in an emergency.

(2) A transportation method to be used during an emergency.

(3) An emergency staffing plan.

(4) Medical and behavioral health needs or situations for which emergency medical care and services are warranted.

(b) A child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver shall be given a copy of the medical emergency plan upon the child's, youth's or young adult's admission to the PRTF.

(c) A child's, youth's or young adult's parent, legal guardian or caregiver shall be notified within 12 hours from the time the medical emergency plan is implemented for their child, youth or young adult.

STAFF HEALTH

§ 5330.121. Staff assessment.

(a) PRTF staff who have direct contact with children, youth or young adults or who work in food preparation shall have a health assessment completed within 12 months prior to being hired by the PRTF and shall have a health assessment completed within 24 months of their last health assessment thereafter.

(b) A physician or APP shall complete the health assessment.

(c) The health assessment must include all of the following:

(1) A physical examination.

(2) Tuberculosis screening consistent with § 5330.122 (relating to tuberculosis screening).

(3) Examination for communicable diseases.

(4) Examination of medical problems which might threaten the health of a child, youth or young adult or prevent a PRTF staff person from providing adequate care to children, youth or young adults.

(d) The physician or APP who completed the assessment shall complete a report of the assessment that includes all of the following:

(1) The signature and professional title of the physician or APP who completed the assessment.

(2) Results of the examination for communicable disease.

(3) The physician's or APP's assessment of the PRTF staff person's suitability to provide care to a child, youth or young adult.

(e) A copy of the report of the current health assessment must be included in the PRTF staff person's record.

§ 5330.122. Tuberculosis screening.

(a) A PRTF staff person shall have a tuberculosis screening completed at initial employment.

(b) A PRTF staff person shall have a subsequent tuberculosis screening completed if directed by a physician, an APP, the Department of Health or a local health department.

(c) A PRTF staff person who has had a positive tuberculin skin test and a negative chest X-ray is not required to have further tuberculosis testing, unless one of the following occurs:

(1) The PRTF staff person is exposed to an active case of tuberculosis.

(2) The PRTF staff person develops a productive cough that does not respond to medical treatment within 14 days of the onset of the cough.

(d) A copy of a positive tuberculin test shall be included in the PRTF staff person's record along with the results of a chest X-ray and evaluation for chemoprophylaxis.

§ 5330.123. Serious communicable diseases or medical problem.

(a) If a PRTF staff person has a serious communicable disease as defined by the Department of Health, written authorization from a physician or APP is required for the PRTF staff person to be present at the PRTF.

(b) The written authorization from a physician or APP shall include a statement that the PRTF staff person will not pose a serious threat to the health of the children, youth or young adults and specific instructions and precautions to be taken for the protection of the children, youth or young adults while the PRTF staff person has a communicable disease.

(c) A PRTF shall follow the written instructions and precautions specified in the written authorization from a physician or APP.

NUTRITION

§ 5330.131. Daily meals.

(a) A PRTF shall provide at least three meals and one snack a day to children, youth or young adults.

(b) There may be no more than 15 hours between an evening meal and a morning meal.

(c) If a child, youth or young adult misses a meal, a PRTF shall provide the child, youth or young adult with a meal as soon as possible.

(d) If a child, youth or young adult **[refuses]** **declines** to eat a meal, the **[refusal]** **denial** shall be documented in the child's, youth's or young adult's record and reported to the child's, youth's or young adult's treatment team.

(e) If a child, youth or young adult requests a meal after initially **[refusing]** **declining** a meal, a PRTF shall provide the meal to the child, youth or young adult when requested.

§ 5330.132. Quantity of food.

(a) The quantity of food for each meal served must meet the minimum daily requirements as recommended by the United States Department of Agriculture, unless otherwise recommended in writing by a physician or an APP for a specific child, youth or young adult.

(b) Dietary alternatives must be available for a child, youth or young adult who has food allergies, special health needs or religious beliefs regarding dietary restrictions or dietary preferences.

(c) Additional portions of meals must be available for a child, youth or young adult upon request, unless a physician or an APP has directed in writing that additional portions must not be available for the child, youth or young adult.

(d) Water must be available to a child, youth or young adult at all times.

§ 5330.133. Withholding or forcing of food.

(a) A PRTF may not withhold food or drink as a means of punishment or coercion.

(b) A child, youth or young adult may not be forced to consume food or drink.

TREATMENT SERVICES

§ 5330.141. Treatment planning requirements.

(a) A treatment team shall meet the requirements of 42 CFR 441.156 (relating to the team developing an individual plan of care).

(b) A treatment team leader shall ensure that **[only PRTF staff who are trained and experienced in the use of the modalities proposed in the treatment plan participate in its]** **treatment team members participate in the** development, implementation and review **of the child's, youth's or young adult's treatment plan**.

(c) A treatment team leader shall actively involve the child's, youth's or young adult's treatment team in the treatment planning process.

[(d) PRTF staff shall maintain a communication log for each child, youth or young adult that includes daily notes about the child's, youth's or young adult's behaviors and observations about the child, youth or young adult that can be used by the treatment team in the treatment planning process.]

§ 5330.142. Treatment [plan] planning.

(a) The following requirements must be met prior to the development of a child's, youth's or young adult's treatment plan:

(1) A multi-disciplinary assessment and screening must be completed within **[48 hours]** **7 days** of a child's, youth's or young adult's admission to the PRTF **if the multi-disciplinary assessment and screening was not completed within 30 days prior to admission to the PRTF**.

(2) A psychiatric evaluation must be completed that includes an examination of the medical, psychological, social, behavioral and developmental aspects of the child, youth or young adult and reflects the need for a PRTF level of care. The psychiatric evaluation must be completed within 7 days of a child's, youth's or young adult's admission to the PRTF **if the psychiatric evaluation was not completed within 30 days prior to admission to the PRTF**.

(b) The multi-disciplinary assessment **[and], screening and** psychiatric evaluation must address all of the following:

(1) Specific service recommendations that address the reasons the child, youth or young adult was admitted to the PRTF.

(2) The child's, youth's or young adult's trauma history.

(3) The parents', legal guardian's or caregiver's trauma history, if known.

(4) Identification of the child's, youth's or young adult's strengths.

(5) The child's, youth's or young adult's educational history and needs.

(6) Prior evaluations, assessments and screenings.

(7) Prior treatment services and their effectiveness.

(8) The child's, youth's or young adult's legal history, including legal guardianship, medical rights, educational rights or any other legal matters.

(c) A child's, youth's or young adult's treatment team shall utilize the multi-disciplinary assessment, **screening,** psychiatric evaluation and PRTF staff observations to formulate an individualized treatment plan for the child, youth or young adult.

(d) A child's, youth's or young adult's treatment plan shall be developed and implemented no later than 14 days after the child's, youth's or young adult's admission to the PRTF.

(e) A treatment plan must:

(1) Be designed to result in the child's, youth's or young adult's discharge at the earliest possible time from the PRTF.

(2) Identify **goals,** objectives **[and],** interventions and modalities aimed at treating and eliminating behavior that may lead to the use of a manual restraint.

(3) Reflect the need for a PRTF level of care.

(4) State individualized and measurable treatment objectives.

(5) Monitor the progress of each individualized treatment objective.

(6) Identify the child's, youth's or young adult's strengths.

(7) Include the child's, youth's or young adult's plan for **therapeutic leave and** discharge.

(8) Document the child's, **[youth] youth's** or young adult's achievements since the last treatment plan.

(9) Prescribe an integrated program of therapies and experiences designed to meet the child's, youth's or young adult's treatment needs.

(10) Address the impact of the child's, youth's or young adult's medical and trauma history.

(11) Include all medications the child, youth or young adult is prescribed.

(f) **[A PRTF shall document in the child's, youth's or young adult's record the participation of treatment team members in the development of the child's, youth's or young adult's treatment plan.] Treatment team members shall sign and date the treatment plan. If a treatment team member objects to the treatment plan or refuses to sign the treatment plan, the reason must be documented in the child's, youth's or young adult's record.**

(g) **[Treatment team members shall sign and date the treatment plan. Objections to the treatment plan or refusal to sign the treatment plan must be documented in the child's, youth's or young adult's record] A copy of the child's, youth's or young adult's treatment plan and updates to the treatment plan must be offered and provided to the treatment team and placed in the child's, youth's or young adult's record.**

(h) A PRTF shall document in the child's, youth's or young adult's record the participation of treatment team members in the development of the child's, youth's or young adult's treatment plan.

(i) **If a child, youth or young adult declines to participate in the multi-disciplinary assessment, screening, psychiatric evaluation or treatment planning, the refusal must be documented in the child's, youth's or young adult's record, including the reason for the refusal.**

§ 5330.143. Maintenance of treatment plan.

(a) A child's, youth's or young adult's treatment plan must be **[revised]** **reviewed, updated and signed by the members of the child's, youth's or young adult's treatment team** at least every 30 days in accordance with 42 CFR 441.155(c) (relating to individual plan of care).

(b) A child's, youth's or young adult's treatment plan must be revised when changes to service objectives and goals are identified.

(c) A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver at least 14 days prior to the date of a regularly scheduled treatment plan meeting. The PRTF shall document the notification, including the method of notification.

(d) A PRTF shall implement a treatment plan in accordance with the objectives, therapies and activities that have been determined by the treatment team.

[§ 5330.144. Copies of treatment plan.

A copy of the child's, youth's or young adult's treatment plan and revisions to the child's, youth's or young adult's treatment plan must be provided to all of the following:

(1) The child, youth or young adult.

(2) The child's, youth's or young adult's parent, legal guardian or caregiver with authorized release of information.

(3) An individual who participated in the development of or revision to the treatment plan with authorized release of information.]

§ 5330.[145]144. Treatment services.

(a) A PRTF shall ensure the physical and psychological well-being of a child, youth or young adult are being met in accordance with age, presenting behaviors and other vulnerabilities.

(b) **PRTF staff shall document daily observations about the child's, youth's or young adult's behaviors that can be used by the treatment team in the treatment planning process.**

(c) A PRTF shall provide therapy that addresses a child's, youth's or young adult's psychological, social, behavioral, medical, recreational, developmental needs and traumatic experiences.

[(c)] (d) All of the following must be provided in accordance with the child's, youth's or young adult's treatment **[objectives] plan**:

(1) **[Individual therapy with the child's, youth's or young adult's treatment team leader must be provided for at least 1 hour each month.] A meeting with the child's, youth's or young adult's treatment team leader for at least 1 hour each month.**

(2) Individual therapy with the child's, youth's or young adult's mental health professional must be provided for at least **[2 hours each week] 6 hours each month**.

(3) Group therapy must be provided for at least **[3 hours each week] 12 hours each month**. PRTF staff who meet the qualifications of a mental health professional, clinical director or treatment team leader shall facilitate group therapy.

(4) Family therapy as follows:

(i) Family therapy must be provided by PRTF staff who meet the minimum qualifications of a mental health professional, clinical director or treatment team leader.

(ii) Family therapy must be scheduled at a time that is convenient for the child's, youth's or young adult's parents, legal guardians or caregivers.

(iii) Family therapy must be provided for at least **[1 hour each week]** **4 hours each month**.

(5) Psychoeducation group **[therapy]** must be provided **[at least 3 hours each week. PRTF staff that meet the minimum qualifications of a mental health worker shall facilitate psychoeducation groups]** **as directed by the treatment team**.

[(d)] **(e)** If a child, youth or young adult or parent, legal guardian or caregiver **[refuses]** **declines** to receive a treatment service, the refusal to receive the service must be documented in the child's, youth's or young adult's record.

[(e)] **(f)** Individual **[and]** **meetings, individual therapy,** group therapy and psychoeducation groups must be in person **[and may not be provided through two-way audio and video transmission]**.

[(f)] **(g)** Family therapy may be provided in person or through **[secure, real-time, two-way audio and video transmission that meets technology and privacy standards required by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).]** **one of the following:**

(1) **Real-time interactive audio and video communication using technology that conforms to industry-wide standards and is in compliance with Federal and State laws, guidance and requirements.**

(2) **Real-time interactive audio-only telecommunication, provided that the use of audio-only telecommunication technology is in compliance with Federal and State laws, guidance and requirements.**

[(g)] (h) **All** services received by a child, youth or young adult or parent, legal guardian or caregiver, including efforts to conduct services, must be documented in the child's, youth's or young adult's record **and include all of the following:**

(1) **Date and time a service was provided, duration of service and setting where the service is provided.**

(2) **Identification of the service provided to address a goal in the treatment plan.**

(3) **Description of the outcome of the service provided.**

(4) **Signature of the PRTF staff person providing the service**.

§ 5330.[146]145. Education.

(a) Under 22 Pa. Code Chapters 11, 14 and 15 (relating to student attendance; special education services and programs; and protected handicapped students), a child, youth or young adult who is of compulsory school age shall participate in a school program provided by an entity that is licensed by the Department of Education.

(b) A child's, youth's or young adult's educational needs may not be a prerequisite for admission to a PRTF.

(c) Decisions regarding the education of the child, youth or young adult shall be made by the educational host district, on an individualized basis, utilizing the most integrated setting appropriate, with input from the treatment team, home school district, the educational decision maker and court, if applicable.

(d) A child, youth or young adult shall have the right to an appropriate education consistent with State laws, including the opportunity to participate in extracurricular, cultural, vocational and personal enrichment activities that are reasonably available and consistent with the child's, youth's or young adult's age, developmental level and treatment plan.

§ 5330.[147]<u>146</u>. Discharge.

(a) A plan for the child's, youth's or young adult's discharge shall begin on the day of admission to the PRTF and remain an active part of the child's, youth's or young adult's treatment plan.

(b) **[A PRTF shall provide no less than 30 days advance written notice of the pending discharge of a child, youth or young adult to all of the following:**

(1) The child's, youth's or young adult's treatment team.

(2) Identified community providers, with authorized release of information.

(3) The child's, youth's or young adult's educational host district and receiving district, if known, with authorized release of information.]

(c)] Prior to discharging a child, youth or young adult, the treatment team shall meet to complete a **[plan for]** discharge **<u>summary</u>** that must be **<u>centered on the</u>** child, youth or young adult **[centered]** and include all of the following:

(1) The child's, youth's or young adult's strengths and needs.

(2) Specific and transferable short-term and long-term objectives for the child, youth or young adult.

(3) A summary of the treatment provided, including the goals, objectives and services used.

(4) If the child, youth or young adult receives psychotropic medications, the rationale for the psychotropic medications, the dosage taken by the child, youth or young adult and the effectiveness of the psychotropic medications.

(5) The name and contact information of identified community providers **<u>,including the dates and times of scheduled appointments</u>**.

<u>(6) The name, address and contact information of a local crisis intervention services provider.</u>

(c) **A PRTF shall provide a copy of the discharge summary to the child, youth or young adult, or the child's, youth's or young adult's parent, legal guardian or caregiver on the day of discharge from the PRTF.**

(d) **In the event of an unplanned or emergency discharge, the PRTF shall complete the discharge summary and provide a copy to the child, youth young adult, or the child's, youth's or young adult's parent, legal guardian or caregiver no later than 7 days after discharge.**

[(d)] (e) The treatment team meeting specified in subsection **[(c)] (b) and the discharge summary** must be **[documented] included** in the child's, youth's or young adult's record.

[(e)] (f) The **[mental health professional] PRTF**, in coordination with the child's, youth's or young adult's parent, legal guardian or caregiver, shall contact the community providers identified in the **[plan for]** discharge **summary** to schedule an appointment.

[(f)] (g) Documentation of the contact specified in subsection **[(e)] (f)** and date of appointment must be included in the child's, youth's or young adult's record.

[(g)] (h) At least a 30-day supply of prescribed medications must be provided upon discharge to the young adult or the person to whom the child, youth or young adult is being discharged.

§ 5330.[148]147. Level system.

The following requirements must be met if a PRTF utilizes a level system:

(1) A PRTF shall develop a written policy and procedure **[which utilizes trauma-informed care principles]** to provide incentives, structure, limit setting, encouragement and support to a child, youth or young adult.

(2) The level system must **utilize trauma-informed care principles and** be individualized according to a child's, youth's or young adult's age and stage of development.

(3) The level system must be consistent with the child's, youth's or young adult's treatment objectives.

(4) The level system must be age and developmentally appropriate for the child, youth or young adult.

(5) The level system may not be punitive in nature.

TRANSPORTATION

§ 5330.151. Transportation.

(a) PRTF staff who provide transportation for children, youth or young adults shall comply with all applicable Federal and State laws and regulations regarding vehicles and properly transporting children, youth or young adults according to age, size, disability and other needs.

(b) **[A driver of a vehicle may not be counted towards the supervision ratio requirements specified in subsection (d).**

(c) A driver of a vehicle and at least one PRTF staff person shall be present in the vehicle when a child, youth or young adult is being transported.

(d) There shall be at least one PRTF staff person present for every three children, youth or young adults being transported.

(e) A manual restraint may not be utilized on a child, youth or young adult during transport.] **During transport the PRTF staff to child, youth or young adult ratio specified in § 5330.42(d)(1) (relating to staff requirements) apply.**

(c) The requirements for restrictive procedures specified §§ 5330.181 -- 5330.188 apply during transport.

MEDICATION

§ 5330.161. Storage of medication.

(a) Prescription and **[nonprescription]** **over the counter** medication must be kept in an area or container that is locked and not accessible to children, youth or young adults.

(b) Prescription and **[nonprescription]** **over the counter** medication stored in a refrigerator must be kept in a locked container.

(c) Prescription and **[nonprescription]** **over the counter** medication must be stored under proper sanitary, temperature, moisture and light conditions.

(d) A PRTF shall have a written policy and procedure that meets Federal and State laws and regulations regarding the handling of discontinued and expired medication.

§ 5330.162. Labeling of medication.

(a) Prescription medication must be kept in its original container and labeled with a pharmacy label that includes all of the following:

(1) The child's, youth's or young adult's name.

(2) Name of the medication.

(3) Prescription number.

(4) Date the prescription was issued.

(5) Prescribed dosage.

(6) Name of the prescribing physician.

(b) **[Nonprescription]** **Over the counter** medication must be stored in its original container with the original label.

§ 5330.163. Use of [prescription] medication.

(a) Prescription medication must be used only by the child, youth or young adult for whom the medication was prescribed.

(b) **Over the counter medication must be used only to treat a medical condition associated with the medication.**

(c) The use of pro re nata medication to control a child's, youth's or young adult's acute, episodic behavior is prohibited.

(d) Naloxone or other medications that can be used to reverse a substance overdose can be used as indicated without a prescription if needed by a child, youth or young adult.

§ 5330.164. Medication [log] record.

(a) A prescription and **[nonprescription] over the counter** medication **[log] record** must be kept for each child, youth or young adult.

(b) The prescription and **[nonprescription] over the counter** medication **[log] record** must be available to the treatment team upon request.

(c) A child's, youth's or young adult's medication **[log] record** must include all of the following:

(1) Known allergies of the child, youth or young adult.

(2) For each prescription and **[nonprescription] over the counter** medication taken by the child, youth or young adult, all of the following:

(i) Name of the medication**[, including brand name and generic name]**.

(ii) If a prescription medication, name of the prescribing physician or APP.

(iii) If a prescription medication, prescribed dosage of the medication.

(iv) Method of administration.

(v) **[Time] Date and time** medication must be administered.

(vi) Other specific administration instructions, as applicable.

(vii) Possible side effects.

(viii) Contraindicated medications**, if applicable**.

(ix) Name of the qualified PRTF staff specified in § 5330.168 (relating to medication administration) who distributed, administered or observed the child's, youth's or young adult's self-administration of the medication, if applicable.

(x) **[Time] Date and time** medication was administered.

§ 5330.165. Medication error.

(a) A medication error includes **one of** the following, regardless of whether the **medication is a prescription or over the counter medication or if the** error resulted in an adverse reaction:

(1) Failure to administer **[the] a** prescribed medication.

(2) Utilizing the incorrect method to administer the medication.

(3) Administering the incorrect medication.

(4) Administering the correct medication in an incorrect dosage.

(5) Administering the correct medication at the incorrect time.

(b) Documentation of a medication error that includes detailed information about the medication error must be recorded in the child's, youth's or young adult's medication **[log] record**.

§ 5330.166. Medication refusal.

(a) A child, youth or young adult and the child's, youth's or young adult's parent, legal guardian or caregiver has the right to refuse a prescription or **[nonprescription] over the counter** medication in accordance with applicable Federal and State laws and regulations.

(b) If a child, youth or young adult refuses to take a prescription or **[nonprescription]** **over the counter** medication, the refusal must be documented in the child's, youth's or young adult's medication **[log]** **record**.

(c) A PRTF shall **[inform]** **notify** the child's, youth's or young adult's treatment team leader of the refusal to take prescription medication **[as soon as possible, but no later than 1 hour after the refusal]** **prior to the next scheduled dosage, but no later than 12 hours after the medication refusal**.

§ 5330.167. Adverse reaction.

(a) If a child, youth or young adult experiences an adverse reaction to a prescription or **[nonprescription]** **over the counter** medication requiring immediate medical attention, a PRTF shall notify the parent, legal guardian or caregiver and treatment team leader prior to the next scheduled dosage, but no later than **[1 hour]** **12 hours** after the adverse reaction.

(b) If a child, youth or young adult experiences an adverse reaction from a prescription or **[nonprescription]** **over the counter** medication not requiring immediate medical attention, a PRTF shall notify the parent, legal guardian or caregiver and treatment team leader prior to the next scheduled dosage, but no later than **[12]** **24** hours after the adverse reaction.

(c) Documentation of an adverse reaction from a prescription or **[nonprescription]** **over the counter** medication must be included in the child's, youth's or young adult's medication **[log]** **record**.

(d) The treatment team leader shall review the adverse reaction and document a change to a medication in the child's, youth's or young adult's medication **[log]** **record**.

§ 5330.168. Medication administration.

(a) Prescription and **[nonprescription]** **over the counter** medication, including injections, shall **[only]** be administered **only** by the following:

(1) Physician.

(2) Physician assistant.

(3) Certified registered nurse practitioner.

(4) RN.

(5) LPN.

(6) PRTF staff who meet the requirements of § 5330.169 (relating to medication administration training).

(7) A child, youth or young adult who meets the requirements of § 5330.170 (relating to self-administration).

(b) Prescription and **[nonprescription]** **over the counter** medication must be administered in accordance with the instructions for the medication.

§ 5330.169. Medication administration training.

(a) PRTF staff who have completed and passed a Department-approved medication administration course within the past 2 years are permitted to administer oral, inhaled, topical **[, eye and ear drop medications, diabetes medications and epinephrine injections for insect bites or other allergic reactions]** **and injectable medications**.

(b) PRTF staff who have completed and passed a Department-approved medication administration course and have completed and passed a diabetes patient education program within the past 12 months that meets the Standards for Diabetes Patient Education Programs of the Department of Health are permitted to administer insulin injections.

(c) PRTF staff medication administration training must be documented and must include the name of PRTF staff trained, training date, training source, name of qualified trainer and length of training.

§ 5330.170. Self-administration.

The following requirements must be met for a child, youth or young adult to self-administer oral, inhaled, topical**[, eye, and ear drop medications, diabetes medications and epinephrine injections for insect bites or other allergic reactions]** **and injectable medications**:

(1) Documented approval from a prescribing physician stating that a child, youth or young adult has the knowledge, skills and abilities to self-administer the medication.

(2) The child, youth or young adult recognizes the prescription or **[nonprescription]** **over the counter** medication and knows the condition or illness for which the prescription or **[nonprescription]** **over the counter** medication is being taken, the correct dosage and when to take the prescription or **[nonprescription]** **over the counter** medication.

(3) A PRTF staff person who meets the qualifications of § 5330.168(a)(1)—(6) (relating to medication administration) is physically present **to supervise** throughout the self-administration and immediately records the administration in the child's, youth's or young adult's medication **[log]** **record**.

RESTRICTIVE PROCEDURES

§ 5330.181. Use of manual restraints.

(a) A manual restraint is the only restrictive procedure permitted in a PRTF.

(b) A manual restraint may **[only]** be used **only** if **[a child, youth or young adult poses an imminent threat to physically harm themselves or others]** **all of the following are met:**

(1) The child, youth or young adult poses an imminent threat to physically harm themselves or others.

(2) Every attempt has been made to de-escalate the child's, youth's or young adult's behavior.

(3) Less intrusive techniques and resources appropriate to address the child's, youth's or young adult's behavior have been tried and failed.

(c) Children, youth **[or]** **and** young adults have the right to be free from a manual restraint used as a means of coercion, discipline, convenience or retaliation.

(d) A PRTF staff person **[shall only]** **may** use a manual restraint **only** if the PRTF staff person has completed training in the use of manual restraints that is consistent with 42 CFR 483.376 (relating to education and training) and is provided by an individual who meets the qualifications in 42 CFR 483.376(c).

(e) A PRTF shall develop a written policy and procedure for the use of manual restraints that includes all of the following:

(1) The requirements of subsections (a)—(d).

(2) Therapeutic approaches, such as goal planning, which are aimed at de-escalating, redirecting and **[releasing]** **defusing** aggression through healthy channels, counseling and removing a child, youth or young adult from an overstimulating environment.

(3) A performance improvement process **[that must be reviewed every 30 days]** to monitor and reduce the use of manual restraints.

(4) Contact information, including the phone number and mailing address, for the appropriate State protection and advocacy organization.

(f) **[On the day of admission] Prior to admission or within 24 hours of admission**, a PRTF shall do all of the following:

(1) Provide a copy of the **PRTF's** restrictive procedure policy to the child, youth or young adult and the parent, legal guardian or caregiver.

(2) Inform the child, youth or young adult and the parent, legal guardian or caregiver of the PRTF's restrictive procedure **policy in a language that the child, youth or young adult and the parent, legal guardian or caregiver understands, including American Sign Language, and when necessary, through interpreters, translators or communication devices**.

(3) Obtain a signed acknowledgment from a youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver that the **PRTF's** restrictive procedure policy was received and reviewed. The signed acknowledgment must be filed in the child's, youth's or young adult's record.

§ 5330.182. Ordering a manual restraint.

(a) The ordered manual restraint must be the least restrictive manual restraint.

(b) An order for a manual restraint must align with all of the following conditions relating to the child, youth or young adult:

(1) The results of the assessment, screening and evaluation specified in § 5330.142 (relating to treatment **[plan] planning**).

(2) Chronological and developmental age.

(3) Size.

(4) Gender.

(5) Physical condition.

(6) **[Psychiatric] Behavioral health** condition.

(7) Personal trauma history.

(8) Personal abuse history.

(c) A manual restraint may be ordered only **[when a child, youth or young adult poses an imminent threat to physically harm themselves or others, and both of the following have occurred:] if the requirements specified in § 5330.181(b) (relating to use of manual restraints) have been met**.

[(1) Every attempt has been made to de-escalate the child's, youth's or young adult's behavior.

(2) Less intrusive techniques and resources appropriate to address the behavior have been tried and failed.]

(d) A manual restraint may not be ordered as a standing order or on an as-needed basis.

(e) If a child's, youth's or young adult's treatment team leader is available to the PRTF staff and certified in the use of manual restraints, the treatment team leader is the only PRTF staff person who may order a manual restraint.

(f) If the treatment team leader is not available to PRTF staff or if the treatment team leader is available but not certified in the use of manual restraints, PRTF staff who meet the qualifications specified in §§ 5330.43 or 5330.45 (relating to medical director; and clinical director) or an APP may order a manual restraint provided the ordering PRTF staff are certified in the use of manual restraints.

(g) An order for a manual restraint must be received by an RN or LPN while the manual restraint is being used by PRTF staff or after the manual restraint ends.

(h) A child's, youth's or young adult's treatment team leader **shall be [contacted and informed] notified** about the use of a manual restraint within **[48] 24** hours of its use, unless the manual restraint was ordered by the treatment team leader.

(i) An order for a manual restraint and the application of a manual restraint may not exceed 30 minutes.

(j) An order for a manual restraint must include all of the following and be documented in the child's, youth's or young adult's record:

(1) The name of the qualified PRTF staff person who ordered the manual restraint.

(2) The date and time a manual restraint was ordered.

(3) The type of manual restraint that was ordered.

(4) The length of time for which a manual restraint was ordered.

[(5) The start time and end time the manual restraint was applied.]

(k) An order for a manual restraint expires once the manual restraint of the child, youth or young adult ends and a new order must be obtained prior to the initiation of a new manual restraint.

(l) The qualified PRTF staff who ordered a manual restraint shall be available in person or by telephone for consultation with PRTF staff administering and observing the manual restraint throughout the duration of a manual restraint.

(m) The qualified PRTF staff who ordered a manual restraint shall sign the order for a manual restraint as soon as possible, but no later than 3 days from the date the manual restraint was ordered.

§ 5330.183. Prohibited restrictive procedures.

(a) The following restrictive procedures are prohibited:

(1) Seclusion.

(2) Exclusion.

(3) Chemical restraint.

(4) Mechanical restraint.

(5) A manual restraint that places a child, youth or young adult in a prone position or applies pressure or weight on the child's, youth's or young adult's respiratory system.

(6) Aversive conditioning.

(7) A restrictive procedure that limits a child's, youth's or young adult's food, drink or access to a toilet.

(b) Seclusion and exclusion do not include the use of a time-out as defined in this chapter.

(c) Exclusion does not occur if a PRTF staff person remains in the exclusion area with the child, youth or young adult.

§ 5330.184. Restrictive procedure plan.

(a) A restrictive procedure plan must be written within **[24 hours]** **7 days** of a child's, youth's or young adult's admission to a PRTF and prior to the use of a manual restraint.

(b) A restrictive procedure plan must be developed and revised with the participation of the treatment team.

(c) A restrictive procedure plan must be reviewed, approved, signed and dated by treatment team members at least every 30 days.

(d) A restrictive procedure plan must include all of the following:

(1) Known observable signals that occur prior to any behaviors that put a child, youth or young adult at risk for a manual restraint, and the suspected reason for the behavior.

(2) Desired behavioral outcomes, documented in measurable terms.

(3) Interventions to be used to modify or eliminate behaviors that put a child, youth or young adult at risk for a manual restraint.

(4) Physical or behavioral health needs or past trauma that may contraindicate the use of a specific manual restraint.

(e) A restrictive procedure plan must be implemented as written.

(f) Copies of a restrictive procedure plan must be kept in a child's, youth's or young adult's record.

§ 5330.185. Application of a manual restraint.

(a) A PRTF shall have at least two PRTF staff persons **who have successfully completed the required manual restraint training** present during the application of a manual restraint.

(b) At least one PRTF staff person who is medically trained to provide emergency first aid and cardiopulmonary resuscitation shall be present throughout the use of a manual restraint.

(c) At least one PRTF staff person who has **successfully** completed the required manual restraint training and who is not involved in applying a manual restraint shall be physically present throughout the use of a manual restraint to continually assess the physical and psychological well-being of the child, youth or young adult and to oversee that the manual restraint is being applied correctly.

(d) The child's, youth's or young adult's physical and psychological condition must be documented in the child's, youth's or young adult's **[medical]** record at least every 10 minutes during a manual restraint.

(e) **[Both] One** of the following must occur at 10-minute increments during the application of a manual restraint:

(1) The manual restraint is released.

(2) The child, youth or young adult is transitioned to another approved manual restraint technique.

(f) PRTF staff who are directly or indirectly involved in a manual restraint shall reduce or eliminate influences that may impede the child, youth or young adult from de-escalating.

(g) During a manual restraint, a child's, youth's or young adult's basic needs and rights must continue to be met.

(h) A manual restraint must end when the earliest of the following occurs:

(1) The order for a manual restraint expires.

(2) The manual restraint has been applied for 30 minutes.

(3) When the child, youth or young adult no longer poses an imminent danger of physical harm to self or others.

(i) If a manual restraint continues beyond the time limit of the order for the use of the manual restraint, an RN or LPN must immediately contact the PRTF staff who ordered the manual restraint to receive further instructions.

(j) [Within 30 minutes of initiation of a manual restraint or immediately after a manual restraint is removed] Immediately after a manual restraint and no later than 1 hour from the initiation of a manual restraint, a treatment team leader, physician, APP, or RN, who is certified in the use of manual restraints, shall conduct **[a face-to-face] an in-person** assessment of all of the following:

(1) The child's, youth's or young adult's physical and psychological condition **and if there is a need for medical or psychological treatment or intensive emotional support**.

(2) The child's, youth's or young adult's behavior.

(3) Appropriateness of the **[intervention measures] implementation of the manual restraint**.

(4) Complications caused by the use of the manual restraint._.

[(j)] (k) The **[face-to-face] in-person** assessment specified in subsection **[(i) must be in person and] (j)** may not occur through secure, real-time, two-way audio and video transmission.

[(k)] (l) A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver of the manual restraint within **[1 hour] 24 hours** after the manual restraint has ended.

§ 5330.186. Injuries from a manual restraint.

(a) A PRTF shall immediately obtain medical treatment from qualified medical personnel for a child, youth or young adult injured as a result of a manual restraint.

(b) Injuries that occur as a result of a manual restraint, including injuries to PRTF staff, must be documented in the child's, youth's or young adult's record.

§ 5330.187. Documentation of a manual restraint.

(a) The PRTF staff shall document the use of a manual restraint in the child's, youth's or young adult's record **[by the end of the shift in which] within 24 hours after** the manual restraint was concluded.

(b) Documentation of the use of a manual restraint must include all of the following:

(1) The requirements of § 5330.182(j) (relating to ordering a manual restraint).

(2) The requirements of § 5330.185(d) (relating to application of a manual restraint).

(3) The time and results of the **[face-to-face]in-person** assessment specified in § 5330.185**[(i)] (j)**.

(4) The name of the qualified medical personnel that completed the child's, youth's or young adult's **[face-to-face] in-person** physical and psychological assessment during and after the manual restraint.

(5) Description of the emergency safety situation that created the need for the manual restraint.

(6) Description of the attempts made to de-escalate the child's, youth's or young adult's behavior.

(7) Description of the less **[intrusive techniques]** **restrictive interventions** and resources that are appropriate to address the child's, youth's or young adult's behavior that were tried and failed.

(8) The name and title of PRTF staff involved in the ordering, application and observation of the manual restraint.

(9) The date and time the treatment team leader was consulted, if the treatment team leader did not order the manual restraint.

(10) Written **[statements from PRTF staff describing the events prior to, during and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint]** **statement from a PRTF staff person who was directly involved or who observed the manual restraint describing the events prior to, during and following the manual restraint**.

(11) The date, time and method the PRTF used to contact the child's, youth's or young adult's parent, legal guardian or caregiver regarding the use of the manual restraint and the name of the PRTF staff person that contacted the child's, youth's or young adult's parent, legal guardian or caregiver.

(12) The start time and end time of the application of the manual restraint.

[(c) A verbal order for a manual restraint must be verified in writing by the qualified PRTF staff person who ordered the manual restraint and documented in the child's, youth's or young adult's record within 48 hours of the verbal order.]

§ 5330.188. Debriefing.

(a) A PRTF shall have a written policy and procedure on debriefing after the use of a manual restraint.

(b) Within 24 hours after the use of a manual restraint, **[a face-to-face discussion]** **an in-person debriefing** with the child, youth or young adult must occur and include all of the following:

(1) PRTF staff involved in the manual restraint, except when the presence of a particular PRTF staff person may jeopardize the well-being of the child, youth or young adult.

(2) **[Representatives]** **A representative** from the child's, youth's or young adult's treatment team.

[(3) The child's, youth's or young adult's parent, legal guardian or caregiver, if available.]

(c) **A child's, youth's or young adult's parent, legal guardian or caregiver shall be notified of the date, time and reason for the in-person debriefing specified in subsection (b) and may participate in-person or through secure, real-time, two-way audio or audio/video, if available.**

(d) The **[discussion]** **in-person debriefing** specified in subsection (b) must provide the child, youth or young adult; parent, legal guardian or caregiver; and PRTF staff the opportunity to discuss the circumstances resulting in the use of a manual restraint and strategies to be used by PRTF staff, the child, youth, young adult or others that may prevent the future use of a manual restraint.

[(d)] **(e)** Within 24 hours after the use of a manual restraint, the PRTF staff involved in the manual restraint, **and appropriate** supervisory and administrative staff, shall conduct a debriefing that includes, at a minimum, a review and discussion of all of the following:

(1) The circumstances that led to the use of the manual restraint, including a discussion of the precipitating factors.

(2) Alternative techniques that may have prevented the use of a manual restraint.

(3) The procedures, if any, that PRTF staff are to implement to prevent a recurrence of the use of a manual restraint.

(4) The outcome of the manual restraint, including any physical or emotional injuries resulting from the use of the manual restraint.

(5) Any changes to the child's, youth's or young adult's restrictive procedure plan.

[(e)] **(f)** PRTF staff involved in a manual restraint that results in an injury to a child, youth**,** [or] young adult or PRTF staff shall meet with PRTF supervisory staff within 24 hours of the manual restraint and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

[(f)] **(g)** PRTF staff shall document in the child's, youth's or young adult's record the **[discussions]** **debriefings** required by subsections (b), **[(d) and (e)]** **(e) and (f)**, including the names of the PRTF staff who were present, the names of PRTF staff that were excused and any changes to the child's, youth's or young adult's treatment plan **or restrictive procedure plan** as a result of the discussion.

§ 5330.189. Time out.

(a) A child, youth or young adult in a time-out may not be physically prevented from leaving the time-out area.

(b) Time outs may take place in areas away from other children, youth or young adults or in areas where other children, youth or young adults are having activities.

(c) PRTF staff shall **[directly]** supervise the child, youth or young adult while in a time-out.

(d) A time out may not be used in a punitive manner or to exclude or seclude a child, youth or young adult from activities.

§ 5330.190. Attestation.

(a) A PRTF shall attest, in writing, in accordance with 42 CFR 483.374 (relating to facility reporting) that the PRTF is complying with CMS's standards on the use of restrictive procedures and this chapter's requirements on the use of restrictive procedures.

(b) The attestation shall include the signature of the PRTF program director.

(c) A PRTF shall provide an attestation to the Department annually.

(d) A PRTF enrolling in the Medical Assistance Program shall provide the attestation required by subsection (a) when it executes a provider agreement with the Department.

(e) Within 5 days of receiving notification from the Department of Health that it has determined that the PRTF is out of compliance with 42 CFR Part 483, Subpart G (relating to condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21) and must close, the PRTF shall provide the Department with the PRTF's plans for the orderly transfer of children, youth or young adults.

SECURE PRTF

§ 5330.201. Requirements for a secure PRTF.

(a) A PRTF must be designated as a secure PRTF when egress from the PRTF, or a portion of the PRTF, is prohibited through one of the following mechanisms:

(1) Internal locks within the building or exterior locks.

(2) Secure fencing around the perimeter of the PRTF.

(b) A secure PRTF shall have a written fire safety approval that is appropriate for a secure setting from the Department of Labor and Industry, the Department of Health or the appropriate local building authority under the Pennsylvania Construction Code Act (35 P.S. §§ 7210.101—7210.1103) prior to applying for an initial certificate of compliance.

(c) A secure PRTF shall meet all of the following staffing requirements:

(1) During awake hours, at least one mental health worker or PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every four children, youth or young adults.

(2) During sleeping hours, at least one mental health worker or PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every eight children, youth or young adults.

(d) No more than two children, youth or young adults may share a bedroom in a secure PRTF.

(e) A fence that surrounds the secure PRTF may not have razor ribbon or barbed wire attached to it.

(f) A secure PRTF may not have security bars attached to doors and windows.

§ 5330.202. Exceptions for a secure PRTF.

A secure PRTF shall comply with the requirements of this chapter, except for the following:

(1) Section 5330.42(d)(1) (relating to staff requirements).

(2) Section 5330.42(e)(1).

(3) Section 5330.82(c) (relating to bedrooms).

(4) Section 5330.92 (relating to unobstructed egress).

RECORDS

§ 5330.211. Emergency contact information.

(a) Emergency contact information for a child, youth or young adult must be documented in a child's, youth's or young adult's record and accessible to PRTF staff.

(b) Emergency contact information for a child, youth or young adult must include all of the following:

(1) The name, address and telephone number of a parent, legal guardian or caregiver to be contacted in case of an emergency.

(2) The name, address and telephone number of a child's, youth's or young adult's physician and health insurance.

(3) The name, address and telephone number of the parent, legal guardian or caregiver permitted to give consent for medical treatment.

[(c) The emergency contact information for each child, youth or young adult shall accompany the child, youth or young adult when the child, youth or young adult is not at the PRTF.]

§ 5330.212. Child, youth or young adult record.

(a) **[A PRTF shall store child, youth or young adult records in a secure location.]** **All child, youth or young adult records, written and electronic, shall be secured in accordance with all applicable Federal and State privacy and confidentiality statutes and regulations**.

(b) A PRTF shall maintain a record for each child, youth or young adult it serves that includes all of the following:

(1) Identifying information as follows:

(i) The child's, youth's or young adult's name, gender, gender identity, admission date, birth date and social security number.

(ii) The child's, youth's or young adult's race and ethnicity, height, weight, hair color, eye color and identifying marks.

(iii) Dated photograph of the child, youth or young adult taken within the past year.

(iv) The language spoken and understood by the child, youth or young adult and the primary language used by the child's, youth's or young adult's parent, legal guardian or caregiver if other than English or other means of communication used by the child, youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver.

(v) The child's, youth's or young adult's religious affiliation.

(vi) The name, address and telephone number of the person to be contacted in the event of an emergency.

(2) Independent certification of need for PRTF services **in accordance with § 1330.32 (relating to conditions of payment)**.

(3) Medical and behavioral **health** records, including **[medication logs,] examinations, evaluations,** assessments, screenings and treatment updates.

(4) **[A psychiatric evaluation and updates to the psychiatric evaluation] Documentation of psychotropic medication reviews, including the clinical rationale for the psychotropic medication**.

(5) **[A treatment plan and updates to the treatment plan] Required documentation in accordance with § 5330.142 (relating to treatment planning)**.

(6) Documentation of efforts to coordinate care with other services and community supports.

(7) [**Documentation of each service provided, including all of the following:] Required documentation in accordance with § 5330.144(h) (relating to treatment services).**

[(i) Date and time a service is provided, duration of service and setting where the service is provided.

(ii) Identification of the service provided to address a goal in the treatment plan.

(iii) Description of the outcome of the service provided.

(iv) Signature of the PRTF staff providing the service.]

(8) [Documentation of the reason why a service was not provided in accordance with the treatment plan.

(9)] Consent to treatment and authorized release of information forms.

[(10) Plan for discharge in accordance with § 5330.147 (relating to discharge).]

(9) Required documents in accordance with § 5330.146 (relating to discharge).

[(11)] (10) Documentation of the use of manual restraints as required by § 5330.187 (relating to documentation of a manual restraint).

(11) Signed acknowledgement of the restrictive procedure policy in accordance with § 5330.181 (relating to use of manual restraints).

(12) The restrictive procedure plan in accordance with § 5330.184 (relating to restrictive procedure plan).

(13) Documentation of the debriefing after the use of a manual restraint in accordance with § 5330.188 (relating to debriefing).

[(12)] (14) Applicable court orders.

[(13)] (15) Educational records.

[(14) Reportable incidents as specified in § 5330.14 (relating to reportable incidents).]

(16) Documentation concerning all reportable and recordable incidents in accordance with §§ 5330.14 and 5330.15 (relating to reportable incidents; and recordable incidents)

[(15) Documentation of psychotropic medication reviews, including the clinical rationale for the psychotropic medication.]

[(16)] (17) Signed notification of rights and grievance procedures specified in §§ 5330.31 and 5330.32 (relating to rights and grievance procedures).

[(17)] (18) Signed notice of confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191**, 110 Stat. 1936**).

(19) Signed acknowledgement of a therapeutic leave plan, if applicable, in accordance with § 5330.20 (relating to therapeutic leave).

(20) Documentation of meals declined by the child, youth or young adult, if applicable, in accordance with § 5330.131 (relating to daily meals).

(c) A child's, youth's or young adult's record must be:

(1) Legible.

(2) Signed and dated by the PRTF staff writing in the record.

(3) Reviewed for quality by the program director, clinical director or designated quality assurance staff within 6 months of the initial entry. After the initial review, subsequent reviews may be limited to new additions to the record and must occur at least annually.

(d) A child's, youth's or young adult's record must be kept for at least 4 years following the child's, youth's or young adult's discharge from the PRTF or until any audit or litigation is resolved, whichever is later.

§ 5330.213. PRTF record.

(a) A PRTF shall store its records in a secure location.

(b) A PRTF shall maintain records that contain all of the following for at least **[4]** **5** years:

(1) Inspection reports, certifications or licenses issued by Federal, State and local agencies.

(2) **[A detailed service description in accordance with § 5330.11 (relating to service description) and all updates to the service description.**

(3)] A copy of the emergency preparedness plan specified in § 5330.19 (relating to emergency preparedness).

[(4)] **(3)** Human resources policies and procedures.

[(5)] **(4)** Written agreements to coordinate services in accordance with § 5330.12 (relating to coordination of services) **[that must be maintained by a PRTF and updated annually]**.

[(6)] **(5)** Daily schedules for services and activities.

[(7)] **(6)** If the PRTF is not connected to a public water system, the results of water tests performed by the Department of Environmental Protection.

[(8)] **(7)** Quality assurance plans in accordance with § 5330.221 (relating to quality assurance requirements).

(c) A PRTF shall maintain PRTF staff personnel records that include all of the following for at least **[4]** **5** years after the PRTF staff is no longer employed by the agency:

(1) Job descriptions.

(2) Work schedules and time sheets.

(3) Criminal history checks and child abuse certifications required by 23 Pa.C.S. §§ 6301—6388 (relating to Child Protective Services Law) and Chapter 3490 (relating to protective services).

(4) Documentation of PRTF staff credentials and qualifications.

(5) Documentation of required trainings, including completion of continuing education credits required for professionally licensed PRTF staff in accordance with the applicable professional regulations.

(6) Documentation of PRTF staff health assessments.

§ 5330.214. Record retention and disposal.

A PRTF shall secure, maintain and dispose of records, both written and electronic, that contain protected health information in accordance with applicable Federal and State privacy and confidentiality laws and regulations.

QUALITY ASSURANCE

§ 5330.221. Quality assurance requirements.

(a) **[A PRTF shall establish and implement a written quality assurance plan that meets all of the following:**

(1) Identifies the methodology for PRTF and individual record reviews, including all of the following:

(i) Method for establishing the sample size of PRTF and individual records for review.

(ii) Frequency of individual records review to prepare for the annual report.

(iii) Qualifications of PRTF staff who perform the review of records.

(2) Provides an annual report of services provided by the PRTF that includes all of the following:

(i) Review of individual records for compliance with this chapter.

(ii) Review of individual and parent, legal guardian or caregiver satisfaction information.

(iii) Assessment of delivered services outcomes and whether treatment plan goals have been completed.

(iv) Evaluation of compliance with the PRTF's approved service description.

(v) Analysis of manual restraint usage.

(b) A PRTF shall make annual reports available to the public upon request.

(c) A PRTF shall provide written notification that a copy of the annual report may be requested at any time by a child, youth, young adult, parent, legal guardian or caregiver upon the child's, youth's or young adult's admission to the PRTF.]

A PRTF shall have a quality assurance plan designed to ensure that the most appropriate treatment is delivered to the child, youth or young adult receiving services and that treatment is indicated. The quality assurance plan shall include the following:

(1) Methods for promoting and overseeing the implementation of trauma-informed care principles, policies and practices.

(2) A process for the annual review of the following:

(i) Quality, timeliness and appropriateness of the services provided.

(ii) Feedback on satisfaction with services from the child, youth or young adult receiving services and the child's, youth's or young adult's parent, legal guardian or caregiver.

(iii) Child, youth or young adult records to ensure compliance with the PRTF's policies and procedures, and Federal and State statutes, regulations and standards.

(3) Identification of the type of review and the methodology for the review.

(4) Documentation of the findings of the annual review.

(5) How the findings of the annual review will be utilized to improve PRTF services.

(b) A PRTF shall make the findings of the annual review available to the public upon request.

(c) A PRTF shall provide written notification upon the child's, youth's or young adult's admission to the PRTF that findings of the annual review may be requested at any time by a child, youth, young adult, parent, legal guardian or caregiver.

WAIVERS

§ 5330.231. Waivers.

(a) A PRTF may submit a written request to the Department for a waiver of a specific regulation in this chapter.

(b) The Department may grant a waiver **[unconditionally or]** subject to conditions that must be met.

(c) The Department may revoke a waiver if conditions required by the waiver are not met.

(d) A waiver request will be granted only in exceptional circumstances and if all of the following are met:

(1) The waiver does not jeopardize the health and safety of the children, youth or young adults.

(2) The waiver will not adversely affect the quality of services.

(3) The intent of the requirement to be waived will still be met.

(4) Children, youth or young adults will benefit from the waiver of the requirement.

(5) The waiver does not violate a Federal or State statute or regulation or local ordinance.

[(d)] **(e)** The scope, definitions and purpose of this chapter may not be waived.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

October 16, 2026

Mr. David Sumner, Executive Director
Independent Regulatory Review Commission
555 Walnut Street, Suite 804
Harrisburg, Pennsylvania 17101

Dear Executive Director Sumner:

Enclosed is a final-form rulemaking for psychiatric residential treatment facilities (PRTFs) that serve children, youth or young adults in need of residential behavioral health treatment. This regulation was published as a proposed rulemaking at 54 Pa.B. 7156 (November 2, 2024).

The final-form rulemaking codifies the minimum licensing and treatment standards, Medical Assistance (MA) participation requirements and MA payment conditions for PRTFs. The final-form rulemaking incorporates requirements for operating PRTFs that are in line with the Federal requirements for PRTFs.

This final-form regulation, which amends Title 55 of the *Pennsylvania Code* Chapter 3800 (relating to child residential and day treatment facilities) and adds Chapters 1330 and 5330 (relating to psychiatric residential treatment facility), is being submitted for review to your Committee pursuant to the Regulatory Review Act.

The Department of Human Services will provide the Commission with any assistance required to facilitate a thorough review of this proposal.

Sincerely,

Valerie A. Arkoosh, MD, MPH
Secretary

Enclosure

RECEIVED
Independent Regulatory Review Commission
October 16, 2026

From: Burnett, David
To: Curley, Maeve
Subject: Re: DHS Final-form Rulemaking #14-555 (PRTF)
Date: Friday, October 16, 2026 9:06:29 AM
Attachments: image001.jpg

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Sent: Friday, 16 October 2026 08:58:59
To: Burnett, David <dburnett@pasen.gov>
Subject: DHS Final-form Rulemaking #14-555 (PRTF)

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This message came from outside your organization.

Good morning,

DHS is submitting Reg. No. 14-555, Psychiatric Residential Treatment Facilities (final-form) to the Senate Health and Human Services Committee and the House Human Services Committee

Please provide written (email) confirmation that this rulemaking was received.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
macurley@pa.gov
https://www.dhs.pa.gov

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October 16, 2026

From: Freeman, Clarissa
To: Curley, Maeve
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Attachments: image001.jpg

Received.

Clarissa L. Freeman
Deputy Chief Counsel | Senate Democratic Caucus
Executive Director-Health and Human Services Committee
717-783-1220

From: Curley, Maeve <macurley@pa.gov>
Sent: Friday, October 16, 2026 8:59 AM
To: Freeman, Clarissa <clarissa.freeman@pasenate.com>
Subject: DHS Final-form Rulemaking #14-555 (PRTF)
Importance: High

■ EXTERNAL EMAIL ■

Good morning,

DHS is submitting Reg. No. 14-555, Psychiatric Residential Treatment Facilities (Final-Form) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received.

-
Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
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https://www.dhs.pa.gov

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From: Annmarie Robey
To: Curley, Maeve
Subject: Re: [EXTERNAL]: DHS Final-form Rulemaking #14-555 (PRTF)
Date: Friday, October 16, 2026 9:21:50 AM
Attachments: image001.jpg

Good morning:

I received this regulation on behalf of Chair Heffley. Thank you, Annmarie

Annmarie K Robey
Executive Director/Legal Counsel (R)
Pennsylvania House of Representatives
House Human Services Committee
(p): 717-772-9842

From: Curley, Maeve <macurley@pa.gov>
Sent: Friday, October 16, 2026 8:59 AM
To: Annmarie Robey <Arobey@pahousegop.com>
Subject: [EXTERNAL]: DHS Final-form Rulemaking #14-555 (PRTF)

Good morning,

DHS is submitting Reg. No. 14-555, Psychiatric Residential Treatment Facilities (Final-Form) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received.

Best,
Maeve

Maeve Curley
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Regulatory Coordinator
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To: Curley, Maeve
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Date: Friday, October 16, 2026 9:08:39 AM
Attachments: image001.jpg

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Sent: Friday, October 16, 2026 8:59 AM
To: Lindberg, Dylan P. <DLindberg@pahouse.net>
Subject: DHS Final-form Rulemaking #14-555 (PRTF)
Importance: High

Good morning,

DHS is submitting Reg. No. 14-555, Psychiatric Residential Treatment Facilities (Final-Form) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
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macurley@pa.gov
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