RECEIVED
Nov 16 2026
Independent Regulatory Review Commission

PCCYFS
PA COUNCIL OF CHILDREN YOUTH & FAMILY SERVICES
A UNITED VOICE FOR PROVIDERS

November 16, 2026

Independent Regulatory Review Commission
555 Walnut Street, Suite 804
Harrisburg, PA 17101

RE: Final Form Regulation #14-555: Psychiatric Residential Treatment Facilities (IRRC #3417)

Dear Chairman Bedwick, Vice Chairman Mizner, and members of the Independent Regulatory Review Commission:

The Pennsylvania Council of Children, Youth and Family Services (PCCYFS) is the collective voice for private agencies that serve Pennsylvania's most vulnerable children and their families through services such as psychiatric residential treatment facilities (PRTFs), foster care/kinship care, adoption, residential treatment, alternative education, counseling, independent living/transitional living services and others. We are writing to share our concerns with final form *Regulation #14-555: Psychiatric Residential Treatment Facilities*.

DHS has been clear that their goal in drafting these regulations is to create a more clinical and standardized set of baseline regulations for PRTFs and we support the value of offering programs that prioritize patient safety, quality of care, and accountability. Children receiving psychiatric care are a particularly vulnerable population and regulations should therefore reflect their unique developmental needs while also accounting for the realities of service provision in order to effectively deliver on intended outcomes.

We acknowledge that the Department has made some important changes in these final form regulations, including the revision of their implementation timeline, flexibility in on-site nursing, and some credential requirements. However, we remain concerned regarding regulations that seemingly reflect change for the sake of change. Many areas offer no supporting data or justification to warrant a deviation from long-established successful practice nor do they include meaningful integration of recommendations from actual practitioners. We share in DHS' commitment, but the success of these regulations will require that PRTFs remain a strong, sustainable level of care for those young people who need it most. We are concerned that these regulations will result in unintended consequences that are not in the public interest because they will adversely impact the availability of PRTF beds and programming in Pennsylvania.

3425 Simpson Ferry Road, Suite 201, Camp Hill, PA 17011
www.pccyfs.org | 717-651-1725 | hbgoffice@pccyfs.org
PCCYFS is a leading statewide membership organization serving as a united voice for our valued partners through education, data, resources, and advocacy towards achieving a brighter future for children, youth, and families.

Although DHS characterizes these regulations as establishing a baseline, many of the proposed requirements go well beyond existing federal standards and impose obligations that substantially exceed minimum regulatory expectations. Further, PRTF providers are already subject to a broad range of standards to obtain and maintain accreditation, and the proposed regulations exceed those requirements as well. We encourage the Department to re-establish regulatory guidelines that truly reflect their commitment to baseline requirements.

Although we have submitted our fuller comments during the initial comment period, we want to highlight the following themes as continued threats to the well-being of young people within these final form regulations while also presenting reasonable, achievable alternatives for the Department to consider. We respectfully request the Commission to disapprove these regulations until DHS can establish greater consensus:

§5330.144 Treatment Services

PCCYFS strongly disagrees with the provisions outlined in this section mandating therapeutic minimum requirements for a young person and their families.

- There is no established research that affirms that every young person who enters a PRTF will require a minimum hour of psychiatric involvement every month, nor is there any documentation from DHS that PRTF-involved youth have been receiving insufficient therapeutic intervention from PRTF professionals under the current regulatory framework.
- DHS has affirmed that this is not an area mandated by the federal government and does not necessarily require inclusion within the regulations. We further contend that this regulation actually contradicts 42 CFR subpart D, a federal guideline that calls for youth to have *individualized* plans of care developed by a team of professionals. Individualized care means it must be tailored to that individual's unique needs, and federal regulations identify the treatment team to be best-positioned to identify youth needs based on their history. As an oversight entity, DHS has exceeded the scope of their authority in seeking to regulate psychiatric and therapeutic requirements that may not be necessary, appropriate, or individualized for every young person who enters a PRTF.
- This is not a youth-driven requirement and could actually be more damaging to youth than supportive. Therapeutic supports may vary based on past trauma history, actual clinical diagnoses and youth needs.
- Psychiatric resources are already incredibly scarce for providers operating these facilities. PRTFs are struggling to find these psychiatric professionals and, when they are able to secure staff, their limited time should be spent on the young people who would benefit from them the most.

Mandating arbitrary therapy requirements is not improving the PRTF quality of service nor is it in the public's best interest. Rather, incorporating treatment requirements within regulatory language is a governmental overreach that will, in fact, dilute the effectiveness of a PRTF.

Workforce

We are also concerned with the remaining sections related to workforce and DHS' unwillingness to align regulations to true need and the realities of what is feasible and practicable in light of workforce shortages, costs, and true youth needs. DHS has retained several provisions that are impractical and unlikely to be executed well. Instead, young people, families, and service providers will be left scrambling as the needs exceed the availability of quality workers and bed capacity significantly shrinks.

While we appreciate and acknowledge DHS has shifted the implementation period from 12 months to 24 months to address the workforce challenges, this does not address ongoing workforce realities. The regulations are silent on the regulatory risk that occurs when agencies experience staff turnover, and any temporary options for case limitations and maximums. While DHS acknowledges that PRTFs will need more time to staff, there is no additional leeway available to PRTFs once these regulations go into effect, even though hiring and turnover will persist. The Department notes that it received the most significant comments related to workforce but did not incorporate the recommended changes from these commenters.

In addition to the aforementioned minimum treatment requirements, other requirements that will impact workforce include:

- *§ 5330.42 Staff requirements.*
    - The Department has not shown any need or rationale behind the regulation requiring a mental health professional or Clinical Director to be physically present during all waking hours to justify the cost and impact on PRTFs despite receiving significant opposition to this section. This requirement is operationally burdensome and may negatively affect clinician recruitment and retention, particularly for evening, weekend, and holiday coverage. Currently, professionals are permitted to be on-call and this arrangement has been sufficient. Not even hospitals, which offer a higher level of care, require this level of overnight staffing. DHS has not offered justification that this requirement will improve outcomes or reduce length of stay, or that the previous on-call requirement was insufficient.
    - Increasing the awake-hour staffing ratio from 1:8 to 1:6 significantly intensifies staffing demands amid existing workforce shortages. Higher staffing levels maintained by some providers are dependent on available resources and cannot reasonably be expected of facilities at all times. Providers are constantly making adjustments to account for unexpected staffing changes and ultimately providers may be forced to reduce licensed capacity or close beds to remain compliant, further limiting the availability of residential treatment services for children and adolescents in need of care.

- §5330.45 Clinical director.
    - The qualifications for a Clinical Director are extensive and do not account for temporary coverage during vacancies. Those who supervise or temporarily assume these responsibilities may not meet the formal requirements. DHS must provide flexibility to reflect the realities of staff turnover and ensure continuity of operations.

- § 5330.48 Mental health professional.
    - While we appreciate that the Department has increased the caseload from 8 to 10, the regulations remain silent on regulatory risk when an agency experience staff turnover, which can happen frequently. Language must address exceptions for short-term temporary circumstances under which caseloads may need to exceed 10. If the state requires a maximum, PCCYFS proposes that we can temporarily cover an additional 3 cases, if circumstances require.

- § 5330.49 Mental health worker.
    - The new qualifications for mental health workers (high school degree plus either 12 credits specific to a behavioral health field or six months of experience in behavioral health) are expected to narrow the hiring pool and make recruitment more difficult. Additionally, the alternative proposed by DHS, requiring newly hired staff to obtain qualifying experience before counting toward staffing ratios, creates an additional staffing burden that potentially forces providers to hire beyond their immediate staffing needs to maintain regulatory compliance. This will lead to additional financial impact, while offering minimal benefit to the organization. This requirement is particularly concerning given the existing workforce shortages and challenges providers face recruiting and retaining qualified personnel. We believe this regulation could be effectuated with various other work experience opportunities and offer an obvious opportunity to allow immediate employment for those with lived experience. Additionally, there must be additional parameters to allow for workers to count towards the staffing ratio while gaining the required six months of experience if specific supervision and support is made available.

§5330.185 Application of a manual restraint.

- The proposed 30-minute limit of manual restraints is another area that is unjustifiable more restrictive than federal standards and may actually jeopardize youth and staff safety. PRTFs are executing manual restraints based on absolute need, and DHS has not offered any rationale or support that would justify a time limit below the federal requirement. Requiring release followed by renewed restraint may actually lead to additional injury risk, unjustified administrative burden, trauma, and other adverse impacts.

Funding

PCCYFS also strongly disagrees with DHS' conclusion that PRTF providers are receiving per diem rates that meet or exceed the projected rates needed to implement the rule, and that 78% of providers are adequately reimbursed. As an association that works with many PRTF agencies, the vast majority, if not all of them regularly express their inability to adequately cover their expenses. Many of our members account for annual deficits in the millions and requests for rate increases are often met with blanket rate increase denials for entire fiscal years.

Additionally, extending the implementation timeline does not address the financial burden of implementation. Providers are being given two years to prepare for increased staffing, facility, and operational requirements, but no corresponding financial support plan has been established by DHS or the Behavioral Health Managed Care Organizations (BHMCOs). Providers must begin incurring these costs now to meet the mandatory implementation date, creating a significant unfunded financial obligation. Over the course of two years, providers must start hiring additional personnel, initiate any facility modifications, develop new policies and procedures, train employees, implement new systems, with no guaranteed funding to support these operating costs.

We understand that DHS does not oversee BHMCOs. While DHS has the authority to establish regulatory requirements for behavioral health providers, the financial responsibility for implementing those requirements cannot be separated from the managed care system through which providers are reimbursed. DHS must recognize the relationship between increased regulatory obligations, BHMCO reimbursement rates, and the financial sustainability of provider organizations. Establishing new requirements without ensuring that corresponding reimbursement structures adequately account for the associated costs places providers in the position of being mandated to increase expenditures without a reliable mechanism to recover those costs. **DHS cannot view regulatory implementation and provider reimbursement as two separate issues.** If the state requires providers to increase staffing, clinical oversight, and facility expenditures, there needs to be a corresponding discussion about how those costs will be funded through the HealthChoices system.

Consensus

We appreciate and agree that IRRC's previous recommendation for DHS to utilize the Advance Notice of Final Rulemaking (ANFR) to assist in reaching consensus with stakeholders before moving to the final-form regulation would have been a critical component of the regulatory process that has been overlooked. This Commission previously expressed concern regarding the "volume of objections, concerns, and questions about the proposed regulation," and the final form regulations has not addressed much of this opposition. Our engagement with DHS throughout this regulatory process was minimal, and they held a single meeting with providers to offer an update and elicit additional feedback, but we have not had any additional substantive opportunity to achieve consensus on these regulations.

Public Interest

Throughout this regulatory process, PCCYFS has been meeting regularly with our PRTF providers and plan to continue to do so. In all of these conversations, one common theme is abundantly clear: if these regulations move forward in their current form, there will be a substantial loss of capacity in the PRTF level of service. The cumulative impact of these changes will threaten the financial and operational sustainability of PRTF providers, resulting in service reductions, interruptions, and permanent closure of facilities. The need clearly exists: one agency noted that out of 659 referrals in a single year, they were only able to accept 73. This will not only reduce access to an essential level of service but will also place additional pressures on remaining service areas and create gaps in provision that may be difficult to address. These regulations, as currently drafted, are not in the public interest; they will have an adverse impact to Pennsylvania's children and families.

Accordingly, we respectfully request the Commission to disapprove these regulations so that the Department can withdraw or resubmit the regulation with revisions after working towards achieving consensus, as initially recommended by the Commission.

Please do not hesitate to contact us with any questions.

Sincerely,



Samea J. Kim, Esquire
Vice President, Legal & Public Affairs
PA Council of Children, Youth & Family Services