

Criminal Justice Coordinating Council

Benefits and Costs of a D.C.-based Psychiatric Residential Treatment Facility

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Executive Summary

Purpose

The CJCC Principals charged the Juvenile Justice Committee (JJC) with developing recommendations for reducing lengths of stay for committed youth awaiting placement in secure facilities. One of the issues identified by JJC members as contributing to placement delays is the challenge that DYRS has with the placement of youth at out-of-state Psychiatric Residential Treatment Facilities (PRTFs), when those youth have been assessed to need that type and intensity of care. One proposed solution, which would affect all youth-serving agencies in D.C., would be for the city to build and operate its own local PRTF.

The purpose of this report is to provide information to assist policymakers in determining whether to build a PRTF in the District. Specifically, this report aims to identify the financial and non-financial costs and benefits of D.C. continuing to send children and youth to out-of-state PRTF placements, compared to the financial and non-financial costs and benefits of D.C. building and operating a local PRTF.

This report also makes several recommendations to D.C. policymakers about how any local PRTF should be structured and how it should fit in with a range of behavioral health services available to children and youth in the District, should the city choose to move forward with building and operating a local PRTF.

Methods

In August 2023, the Office of Budget and Performance Management (OBPM) released a report in collaboration with DBH titled *Check In: Psychiatric Residential Treatment Facility for Youth*, which outlined the estimated cost of building and operating a PRTF in the District. CJCC presents the projected cost estimates from this report and the current costs to Medicaid of placing youth in out-of-state facilities reported by the Department of Health Care Finance (DHCF).

CJCC conducted qualitative interviews with key informants from four agencies (Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), Department of Behavioral Health (DBH), and the Metropolitan Police Department (MPD)) involved in the placement of youth and/or in the juvenile justice system in D.C.¹ These key informant interviews were focused on issues related to access to services, education, family engagement, agency management and coordination, and reentry planning (see Appendix C for Key Informant Interview Guide).

¹ CJCC attempted to complete key stakeholder interviews with other agencies, including CSSD, OSSE, and DHCF, as well as nonprofit services or advocacy organization for children and youth involved in the juvenile justice system, but was unable to schedule these meetings in time to produce this report.

Results: Financial costs

In a 2023 report, OBPM and DBH projected that it would cost \$50 million in initial capital costs for D.C. to build a PRTF and \$18 million in annual operating costs for 45 youth. These costs would include staffing, facility upkeep, educational, and ancillary medical costs.

In order for a youth to be placed in a residential facility, there are two available streams of funding that placing agencies can utilize—Level of Care (LOC) or Human Care Agreements (HCA). If the youth has a psychiatric evaluation that recommends a PRTF placement, placing agencies can petition DBH or the youth’s health insurance provider to obtain a Level of Care (LOC). An LOC refers to the classification of health care services based on their intensity and complexity. When a placing agency wants to place a youth in a PRTF, it must get the placement approved by DBH or the youth’s health insurance provider. If the PRTF placement is deemed medically necessary, DBH or the insurer will issue an LOC letter that approves the placement for a particular length of time. The youth’s insurance provider (usually D.C. Medicaid) will then fund the placement for the amount of time approved in the LOC.

Alternatively, placing agencies can utilize local funds to place a youth in a residential placement through Human Care Agreements (HCA).² HCAs are contracts between D.C. government’s Office of Contracting and Procurement (OCP) and a service provider for the purchase of social, health, or human services. HCAs allow placing agencies to use local dollars, instead of Medicaid or private insurance, to place youth in out-of-home placements, and do not require the LOC process.

In FY24, there were 107 youth referred to a PRTF in D.C. The District placed 23 youth in out-of-state PRTF placements funded by a Level of Care (LOC) approved through D.C. Medicaid and the Children’s Health Insurance Program (CHIP), costing a total of \$1,062,334. The Office of the State Superintendent for Education (OSSE) is responsible for paying the educational costs of youth placed in residential settings if they have an Individualized Education Plan (IEP). The educational costs paid by OSSE in FY24 for the 23 youths whose PRTF placements were funded by LOC were \$938,653. An additional 50 children and youth were placed in PRTFs through HCAs; the cost of placements under HCAs is currently not available.

Results: Qualitative Costs

While it would very likely cost the city more to operate its own PRTF than it would be for it to place all eligible youth in out-of-state facilities, these financial estimates do not take into consideration the qualitative costs of D.C.’s reliance on out-of-state placement providers. One challenge experienced by placing agencies is that it can be difficult to find PRTFs that will accept youth with violent charges, histories of aggression towards others, or complex behavioral issues, meaning that those youth with the highest risk and need are least able to access recommended services. Indeed, 31 out of the 107 youth referred to PRTF were denied placement and were ultimately placed in less appropriate settings.

² [§ 2–354.06. Human care procurements. | D.C. Law Library](#)

As a result of these placement challenges, youth often experience long wait times at the Youth Services Center (YSC) or in the community, which can directly affect their mental health since they are not receiving the intensity of services they need while awaiting placement. In addition, long wait times themselves are frustrating and can be experienced as rejection by youth. Agencies may also place youth in a Residential Treatment Center/Facility (RTC/RTF) that is geared towards addressing behavioral issues rather than psychiatric issues. Such inappropriate placements in an RTC/RTF can lead to placement disruptions, new charges, or even acute hospitalizations.

Youth may also experience educational challenges related to out-of-state PRTF placements, as there can be a lack of continuity of education services between the placing agency, D.C. Public Schools (DCPS), the Department of Behavioral Health (DBH), and the PRTF. Youth may experience challenges with credit transfers, the timing of their return to school, finding an appropriate school placement, and delays with school transportation when reintegrating into the community.

Furthermore, youth placed out-of-state may experience intense homesickness and loneliness when placed far away from their families, friends, and local environments, which can be severe enough to cause trauma, undermining the treatment goals of the PRTF. Distance also impedes regular family visits and families' meaningful engagement in youth's treatment, and it prevents youth from maintaining their natural support systems while in placement. Youth having ongoing access to family members, mentors, and natural supports could help improve treatment outcomes.

The reliance on out-of-state PRTFs also redirects agency staff time away from case management, care coordination, site visits, and engagement with youth and families and towards administrative and contracting functions. While the coordination that occurs between D.C. government agencies to place youth in a PRTF involves work, this collaboration is not perceived as challenging by those involved, as it occurs routinely through established processes. By contrast, information sharing and coordination between out-of-state facilities and D.C. government agencies can be a challenge.

In addition, reentry planning could be improved if D.C. had a local PRTF, as it would allow for improved communication among stakeholders, an easier referral process, and warm hand-offs to local service and treatment providers. Finally, D.C. having its own PRTF would allow for more deliberate and structured step-down planning, enabling youth to build a supportive community to help them maintain the gains they achieved while in placement as they transition back to the community.

Recommendations if D.C. Builds a Local PRTF

If the District opts to build and operate its own PRTF, based on the findings of key informant interviews with District agency staff, it should consider the following factors:

- ❖ D.C. will need to appropriately staff and fund the facility, ensuring that it has both the staff expertise and financial resources required to effectively implement programming

with fidelity to evidence-based treatment models. The District may have to set a PRTF per diem rate that would pay staff competitive rates to ensure that the facility will accommodate youth who present with challenging behaviors, such as aggression.

- ❖ D.C. should simultaneously invest in broadening its behavioral health continuum of care to ensure that youth have access to appropriate services, regardless of the level of care they need. Indeed, the increased expense of operating a PRTF should not lead to an underinvestment in other community-based and acute behavioral health services, as this would undermine the projected welfare gains of having a local facility. Specifically, youth not having access to intensive community-based services can lead to an exacerbation of their psychiatric symptoms and behavioral issues, causing them to need a residential level of care.
- ❖ D.C. should develop a Memorandum of Understanding (MOU) that specifically defines the population of youth that the facility will serve, the referral process, the acceptance criteria, and the specific reasons for which a youth could not be placed in the local PRTF (e.g., community safety issues, concerns around human trafficking, stay away orders that make placement unfeasible). Furthermore, the city will need to decide what specific services the facility will provide and whether it would only accept District youth or would also accept youth from other jurisdictions.
- ❖ Acceptance to the local PRTF should depend entirely on medical necessity. In other words, the DBH PRTF Review Committee should independently review each youth's case to ensure their placement in a PRTF is appropriate. Placing agencies have expressed concerns that the facility could be used to alleviate placement pressures and become a *de facto* secure group home for youth who are hard to place. One way to ensure that will not happen is for the facility to only accept youth for whom the placement is deemed medically necessary.
- ❖ In order to fully realize the gains from a local PRTF, D.C. should consider assessing the current process for determining medical necessity, with the goals of standardizing that process across Managed Care Organizations (MCOs) and shortening the procedures for conducting assessments and obtaining necessary documentation.
- ❖ D.C. should continue to maintain contracts with out-of-state PRTF providers to ensure that youth who need specialized care or who cannot be placed locally due to safety concerns can still access needed treatment services.

Background

What is a PRTF?

According to the Centers for Medicare and Medicaid Services, a “Psychiatric Residential Treatment Facility (PRTF) is a non-hospital facility that provides intensive inpatient psychiatric treatment to children and youth under the age of 21.” These facilities are designed for youth who require a higher level of care than can be provided in community-based outpatient or acute hospital settings.³ The care provided by these facilities must be under the direction of a physician and must be accredited under federal and state approved accrediting organizations. PRTFs provide structured, therapeutic milieus with multidisciplinary treatment teams where youth receive interventions including individual therapy, group therapy, family therapy, psychiatric assessment, medication management and nursing services. In addition to these clinical services, youth also receive educational services, usually within the facility, although some non-secure PRTFs allow youth to attend a local school rather than receiving educational services on site. Some facilities may also offer specialized services, such as programming designed for youth with intellectual and developmental disabilities and specific clinical interventions.

The length of a PRTF placement varies and depends on several factors including the youth’s clinical needs and the length of treatment deemed medically necessary by the Department of Behavioral Health (DBH) or the youth’s insurance provider. A typical stay at a PRTF tends to last six to nine months, although they can be as short as 30 days or last up to a year. According to the Department of Health Care Finance (DHCF), in FY24 the average length of stay at PRTFs for D.C. Medicaid beneficiaries was 7.2 months (approximately 218 days). PRTF placements are usually funded by a youth’s medical insurance, most often Medicaid, though some private insurers may also provide coverage. Such placements can also be privately funded by families or paid for directly by placement agencies through the establishment of Human Care Agreements (HCA), which are contracts between a service provider and the District government’s Office of Contracting and Procurement (OCP) for the delivery of social, health, human, or education services.

There is currently a lack of research and data regarding the effectiveness of PRTFs. Many studies looking at the effectiveness of residential treatment in general, as well as the efficacy of specific interventions delivered in PRTF settings, have yielded mixed or inconclusive results.⁴ While there is an acknowledgement that PRTF placements are necessary in the continuum of care of behavioral health services, a report by Magellan Health found that when PRTF placement is warranted, the best outcomes are achieved when youth’s families are involved in

³ Centers of Medicare and Medicaid: [What is a PRTF](#)

⁴ Lanier, Paul & Jensen, Todd & Bryant, Katherine & Chung, Gerard & Rose, Roderick & Smith, Quinton & Lackmann, Lisa, 2020. A systematic review of the effectiveness of children’s behavioral health interventions in psychiatric residential treatment facilities, *Children and Youth Services Review*, Elsevier, vol. 113(C).

treatment, when discharge and reentry planning are robust, and when placements are time-limited.⁵

Some evidence suggests that providing youth with serious mental health concerns in the community is more cost-effective than PRTF placements. In a July 2013 report to Congress, the Centers for Medicare and Medicaid Services (CMS) outlined the findings of a five-year demonstration project to test whether children and youth who meet the requirements to be served in a PRTF could successfully, and cost effectively, be served in the community. The major findings of the demonstration project were that children and youth generally maintained or improved their functional status when receiving services in the community and that providing youth with community-based services costs about a third (32 percent) of comparable services provided in PRTFs.^{6, 7, 8}

Concerns have also been raised about the safety of PRTF placements for youth. A 2024 Senate Finance Committee Report identified a host of systemic harms experienced by youth placed in Residential Treatment Facilities from unsafe and unsanitary conditions, to insufficiently trained staff and staff shortages, to instances of physical and sexual abuse. In addition, the report notes concerns around facilities not providing appropriate clinical interventions to youth, as well as issues around the use of restraints and seclusion.^{9, 10}

Reduction in PRTF Capacity Nationally

Due to a lack of standardized data regarding PRTFs, it is difficult to get an accurate estimate of the number of facilities operating nationally. Some data conflate PRTFs and Residential Treatment Centers/Facilities (RTCs/RTFs). While these two types of facilities provide similar services, PRTFs are subject to Medicaid regulations set forth by CMS and a more stringent certification process. Conversely, because the services provided by RTCs are not provided under the direction of a physician, they are not Medicaid reimbursable and as such, are not subject to federal regulations and must only comply with state regulations. In 2015, CMS estimated that there were 384 PRTFs across the country.¹¹

⁵[Perspectives on Residential and Community-Based Treatment for Youth and Families](#), Magellan Health Services Children's Services Task Force

⁶[Report to the President and Congress Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration As Required by the Deficit Reduction Act of 2005 \(P.L. 109-171\) From the Department of Health and Human Services Office of the Secretary prtf-demo-report.pdf](#)

⁷ [National Evaluation of the Medicaid Demonstration Waiver Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities](#)

⁸ [Report to the President and Congress Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration As Required by the Deficit Reduction Act of 2005 \(P.L. 109-171\) From the Department of Health and Human Services Office of the Secretary prtf-demo-report.pdf](#)

⁹ Senate Finance Committee Report ["Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities"](#)

¹⁰Senate Finance Committee Report ["Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities"](#)

¹¹ [Psychiatric Residential Treatment Facilities - General Requirements and Conditions of Participation](#)

In 2025, 32 states have reported a shortage of RTF and PRTF beds for youth.¹² According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there was a 46% reduction in the number of RTF beds for youth from 2010 to 2020 (from 30,952 beds to 16,487 beds), as well as a reduction in the number of youth served by such facilities (from 27,223 clients served in 2010 to 14,502 in 2020).^{13,14} The reduction in the number of available beds is related to a variety of changes in federal policy during this period. First, following a demonstration by CMS that showed that youth with severe emotional and behavioral challenges could be served in the community at a fraction of the cost of a PRTF, there was a concerted effort by the federal government to encourage states to serve youth in the least restrictive environment, which led to declines in residential placements.¹⁵ The U.S. saw further reductions in the number of facilities and beds for youth after the passage of the Family First Prevention Services Act (FFPSA) in 2018, which enabled states to use federal funding to provide preventative services to youth at risk of entering the child welfare system.¹⁶ The Act also placed limits on federal funding for residential programs, setting additional requirements that mandated PRTF providers to routinely demonstrate that a patient is appropriate for residential care to ensure appropriate lengths of stay.

The number of available PRTF beds further declined during the COVID-19 health emergency, as providers had to limit the number of children placed at a facility to accommodate COVID-19 protocols. In addition, many placement providers experienced staff shortages, which further limited the number of youth they could serve at any given time. Because of the decline in the number of available beds nationally, states prioritized the placement of in-state youth in their facilities, making it harder for jurisdictions that depend on out-of-state placement to find beds for youth.

D.C. Agency Referrals and Placements in Out-of-State PRTFs

D.C. is one of several jurisdictions that does not have its own local PRTF. If a state chooses not to have a PRTF, it is still responsible for providing those services to all youth in their jurisdiction who need the service, leading youth to be placed in out-of-state PRTF providers.¹⁷ Given the reduction in PRTF beds nationally, D.C. youth effectively compete for increasingly rare bed space with youth in other states referred to their in-state PRTFs.

There are currently eleven out-of-state PRTF providers that are enrolled in D.C. Medicaid (see Figure 1).

¹² [Use of State Psychiatric Hospitals, NRI State Profiles July 2025](#)

¹³ [Substance Abuse and Mental Health Services Administration \(SAMHSA\) National Mental Health Services Survey 2010](#)

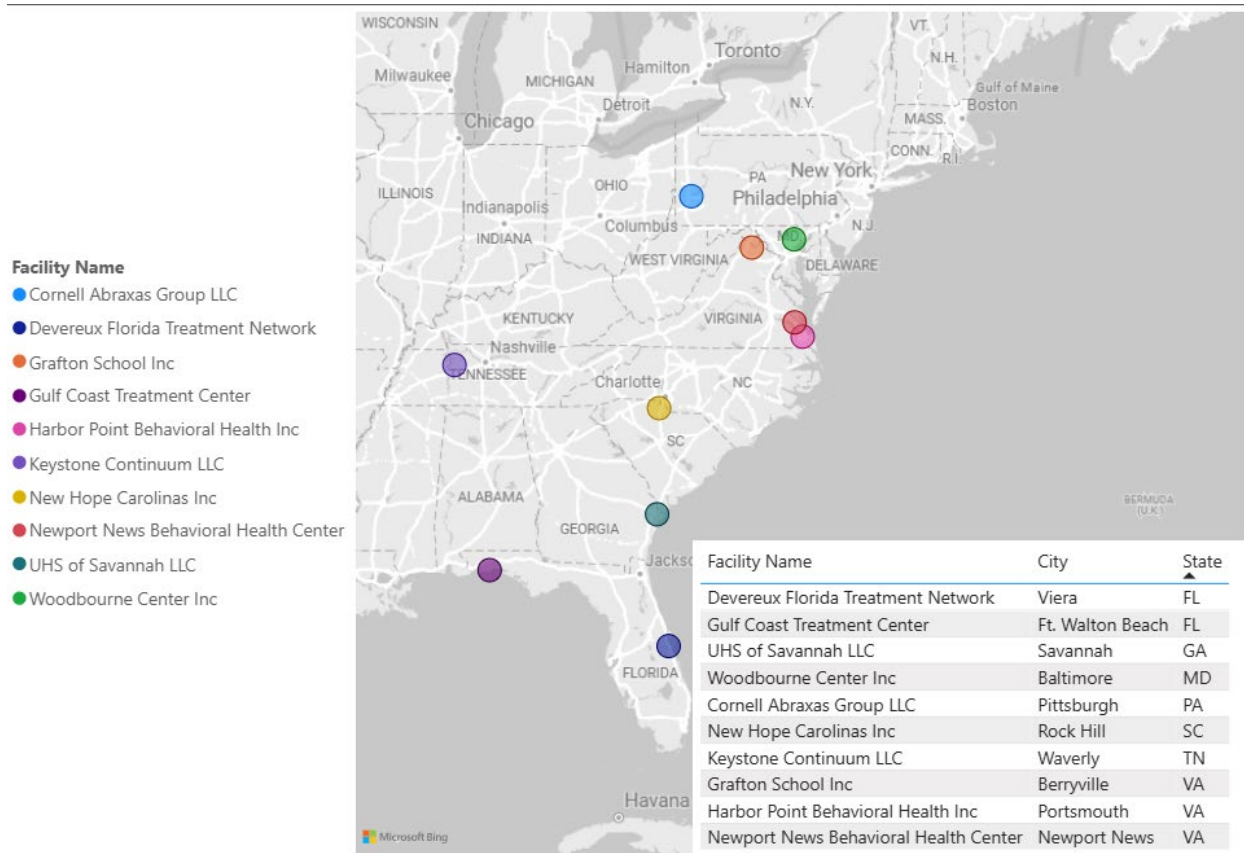
¹⁴ [Substance Abuse and Mental Health Services Administration \(SAMHSA\) National Mental Health Services Survey 2020](#)

¹⁵ [Report to the President and Congress Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration As Required by the Deficit Reduction Act of 2005 \(P.L. 109-171\) From the Department of Health and Human Services Office of the Secretary prtf-demo-report.pdf](#)

¹⁶ [Family First Prevention Services Act \(FFPSA\) | Congress.gov | Library of Congress](#)

¹⁷ [Psychiatric Residential Treatment Facilities - General Requirements and Conditions of Participation](#)

Figure 1: Psychiatric Residential Treatment Facilities Currently Enrolled in D.C. Medicaid



Source: DCHF, www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/35846

The District has several agencies that can place youth in PRTFs, including the Child and Family Services Agency (CSFA), the Court Social Services Division (CSSD), the Department of Youth Rehabilitation Services (DYRS), the Office of the State Superintendent for Education (OSSE), and D.C. Public Schools (DCPS). Three of the four placing agencies were able to report the number of children and youth that they referred for PRTF placement and the total number placed regardless of funding source (Medicaid, Medicaid – CHIP, or local funds) (see Table 1). In Fiscal Year 2024 (FY24), 107 D.C. youth were referred for PRTF placement. Of those, 31 were denied from all available PRTFs, 23 were placed in out-of-state PRTFs funded by D.C. Medicaid, and 50 were placed using local funds.

DYRS was, by far, the largest referring and placing agency for children and youth at PRTFs, with 78 youth referred in FY24 and 57 placed at PRTFs. Of the 57 children and youth placed at PRTFs, 38 were placed using a Human Care Agreement, and funded by local funds, with the remaining youth placed following a Level of Care determination using Medicaid funds. Additionally, there were 21 children and youth committed to DYRS who were referred to a PRTF, but where DYRS was not able to secure a PRTF placement. These 21 youth were ultimately placed at New Beginnings, which does not provide the same intensity and complexity of psychiatric services as would a PRTF.

Table 1: Fiscal Year 2024 PRTF referrals, placements, and denials

| | <i>CSSD</i> | <i>CFSA</i> | <i>DYRS</i> | <i>OSSE*</i> | <i>DCPS</i> | <i>Total**</i> |
|--|-------------|-------------|-------------|--------------|-------------|----------------|
| Number of PRTF referrals | Unknown | 21 | 78 | 8 | Unknown | 107 |
| Number of PRTF placements, regardless of funding source | 0 | 15 | 57 | 1 | 0 | 73 |
| Number of PRTF denials | Unknown | 6 | 21 | 4 | Unknown | 31 |

* There were three children referred by OSSE who improved while awaiting PRTF placement and were therefore found to no longer require that level of care.

** The Total column is the sum of only the known numbers of referrals, placements, denials.

There were eight children and youth referred to PRTFs by OSSE, of whom one was placed in FY24, and four were denied placement. CFSA had 21 referrals in FY24 and 15 placements, which is in line with the 20 to 25 referrals and approximately 15 placements they reported having per year. There were no children and youth placed by CSSD or DCPS in FY24.

Placement costs for the 23 children and youth placed through a Level of Care determination using Medicaid or Medicaid – CHIP funds amounted to \$1,062,334.00 (see Table 2). The remaining 50 placed youth were funded through local funds. The costs paid through local funds by the different placing agencies is not currently available. In FY24, OSSE paid \$938,653 for educational services for children placed at PRTFs. If a child or youth has an Individualized Education Plan (IEP) in place, then OSSE is responsible for paying the per diem education rate of the state in which the PRTF is located. If the young person does not have an IEP, then the placing agency must pay for the education costs while the child or youth is in a PRTF.

Table 2: Actual Medicaid Expenditure and OSSE-funded Educational Services for PRTF placements in Fiscal Year 2024, all agencies (CSSD, CFSA, DYRS, and OSSE)

| Funding source | # of placements | Cost (\$) |
|---|------------------------|------------------|
| Educational Services (OSSE-funded) | 23 | \$938,653 |
| Residential Services* (Medicaid-funded, after going through LOC process) | 23 | \$1,062,334 |

* The cost paid by Medicaid is aggregated together with the cost paid by Medicaid-CHIP. In FY 2024, the total expenditures incurred by Medicaid was \$948,940 with CHIP expenditures totaling \$113,394.

Results: The Financial and Nonfinancial Costs of D.C. Building a Local PRTF and D.C. Continuing without a Local PRTF

Financial Costs D.C. Building and Operating a PRTF: Projected Costs

In August 2023, the Office of Budget and Performance Management (OBPM) released a report in collaboration with DBH titled *Check In: Psychiatric Residential Treatment Facility for Youth*, which outlined the estimated costs of building and operating a PRTF in the District. The projected costs for D.C. building and operating such a facility are provided in Table 3.

Table 3: DBH Projected Costs of Building and Operating a local PRTF

| Cost Type | Estimated Cost |
|--------------------------------|----------------|
| Initial capital cost | \$50,000,000 |
| Annual Operating Costs (total) | \$18,422,380 |
| Staff salaries | \$10,423,000 |
| Facility upkeep | \$640,000 |
| Administrative costs | \$7,539,380 |

The estimate is separated into initial capital costs of construction (\$50,000,000) and annual operating costs (\$18,422,380). The estimates for annual operating costs, including staff salaries, upkeep of the physical plant (maintenance, building operations, utilities etc.), and administrative costs, are based around a projection of 45 youth placed each year. However, this would be an underestimate, if this potential facility were to accept most or even half of the 107 youth referred for PRTF placements in a given year.

Nonfinancial costs of Relying on Out-of-State PRTFs: Child and Family Wellbeing, Public Safety, and Agency Staff Time

Placement Wait Times

In FY24, the average length of stay for committed youth awaiting placement at the Youth Services Center (YSC) was 72 days.¹⁸ Because the District does not have its own PRTF facility, agencies can experience delays in getting youth successfully placed. First, it is often difficult to find placement providers who will accept youth with violent charges or histories of aggression towards others. As a result, the youth with the most high-risk behaviors are often the least able to receive recommended clinical interventions. Additionally, several agencies reported that they perceive there to be bias against youth from D.C. due to prior incidents with previously placed youth or cultural differences between youth from urban areas and the staff who operate out-of-state PRTFs, many of which are in rural areas. Finally, given the reduced number of PRTF

¹⁸ [D.C. Council Subcommittee on Youth Affairs Department of Youth Rehabilitation Services \(DYRS\) 2025 Oversight Hering testimony](#)

beds nationally, states are prioritizing in-state youth when beds are available, making it more challenging to find appropriate placement for D.C. youth.

In addition, because a PRTF placement is based on medical necessity, providers will often request updated assessments of youth to ensure the placement is still clinically appropriate, especially when they have been awaiting placement for long periods of time, whether in the community or at YSC. If a youth's behavior has decompensated or improved, they may be deemed inappropriate for a placement to which they were previously accepted. Furthermore, difficulties in identifying an out-of-state provider who will accept a youth can also cause LOCs to lapse, leading to further placement delays.

Extended wait times themselves can have a negative impact on youth's behavior and psychiatric symptoms because they are not receiving the level of care they need while awaiting placement. Youth may also interpret denials from multiple facilities as rejection, making them feel lonely, isolated, frustrated, and "not wanted." More than one agency that struggles to place children and youth at PRTFs described the wait time as harmful.

Access to Services

D.C.'s reliance on out-of-state PRTFs affects access to mental health services for children and youth assessed to need that level of care. In some cases, the agency may give up on finding a PRTF placement for youth and place them at an RTC or community-based placement instead, preventing youth from accessing the therapeutic milieu they would have most benefited from. Such inappropriate placements can lead to placement disruptions or even hospitalizations. One agency described the potential for a cascading effect, where the inability to find a PRTF bed leads to an inappropriate placement, which can result in further behavioral incidents, which in turn can lead to deeper juvenile justice involvement and damage to remaining supportive relationships, making finding a new placement even more difficult.

Several agencies also noted the challenges that arise when a youth placed in an out-of-state PRTF requires routine medical or dental care. Most MCOs are only responsible for covering the cost of a youth's PRTF placement during the first thirty days of placement, at which point the financial costs are born by Fee-for-Service (FFS) Medicaid. However, if a youth requires medical care that must be administered outside of the PRTF, the outside provider must then coordinate the youth's care with their MCO, causing additional administrative burdens and potential delays in accessing care.

Education

Youth may also experience educational challenges related to out-of-state PRTF placements. There can be a lack of continuity of education services provided at YSC and at the PRTF. The classes offered at the PRTF may not match those the youth was enrolled in at YSC, causing frustration and confusion. While DCPS coordinates with placing agencies to ensure youth are enrolled in classes that most closely mirror DCPS graduation requirements, the PRTF may lack the specific courses a youth needs to graduate.

In addition, challenges can arise when youth are discharged from PRTFs and need to be re-enrolled in school. If youth require placement in a non-public therapeutic school to meet their

IEP needs, their enrollment can be delayed, as most such schools require that youth complete an in-person site visit prior to acceptance. Youth therefore may not be able to start attending school as soon as they return to the community, which can lead to poor outcomes, as youth are transitioning from the highly structured environment of a PRTF to a community placement without the benefit and structure of daily school attendance.

Youth may also experience challenges with transferring the credits they earned while at a PRTF to their DCPS transcript. While DCPS and placing agencies make all efforts to ensure youth receive appropriate credits, at times, they may be unable to transfer those credits, especially if they return to the community in the middle of a semester without having completed the classes they were enrolled in at the PRTF. In addition, as noted above, a youth may have earned an appropriate number of credits but not have participated in the correct courses to meet DCPS graduation requirements.

Family Contact and Engagement and Natural Supports

Youth and families can also be negatively affected by youth's distant placement. Indeed, youth placed out of state may experience intense homesickness and loneliness when placed far away from their families, friends, and local environments. Furthermore, many PRTFs are located in rural areas, making it challenging for District youth to acclimate to an unfamiliar culture. Youth might also experience mental and behavioral decompensation due to the trauma of dislocation and loneliness, which undermines the treatment goals that a PRTF placement is meant to address. In some instances, a child may sabotage their out-of-state placement by acting out or making false allegations against a treatment provider in order to be returned to a facility closer to home, such as New Beginnings. This can lead the facility to be less willing to accept another child or youth from D.C.; and the placing agency may have difficulty finding an alternative placement for youth as a result of the disruption. Indeed, placing agencies noted that youth often find it challenging to transition from YSC, where they can regularly receive family visits, to out-of-state PRTFs, where they have little access to their families and natural support systems.

If the District had its own PRTF, youth's families could visit more regularly in person; for a youth placed in a PRTF, more frequent visitations would likely benefit youth's adjustment to and willingness to meaningfully participate in treatment. A local PRTF could enable family to participate in-person in therapeutic services, treatment team meetings, and IEP meetings, which would be more conducive to building therapeutic relationships with providers as compared to phone or virtual participation. Several agencies noted the importance of meaningfully and collaboratively engaging the whole family system in youth's treatment to help improve outcomes.

Placing agencies also noted that youth benefit from being able to build natural support systems with peers when they are programming in a PRTF. When youth are discharged from their out-of-state PRTFs, they lose access to the supportive community they were able to build while in placement. If D.C. had a local PRTF, youth could maintain these natural supports, potentially improving their outcomes following placement.

Agency Management and Staff Time

District agencies, including DYRS and CFSA, have staff dedicated to facilitating youth placements. These placement specialists, as well as budget and procurement staff, report spending a significant amount of time on administrative work related to placing a youth in a facility in another state. (Please see Appendix D: The PRTF Referral and Placement Process in D.C. for details on what is involved.) Agencies report that negotiating with vendors and collecting the appropriate data and information is more time-consuming than the actual care coordination, whereas if D.C. had its own PRTF, the contract negotiation would occur once and there would be no interstate compact issues. While the need for specialized staff would not change, their administrative workload would be reduced, allowing for a greater focus on engagement with youth and families to discuss placements and services, and on care coordination.

Information Sharing with Out-of-State Facilities

An additional coordination issue identified was the challenge of information sharing between out-of-state facilities and the D.C. justice system, both law enforcement and the courts. When there are substantial issues at an out-of-state facility, up to and including an escape, the regulations around information sharing between a placement provider and D.C. law enforcement may not be clear to all actors. Failing to share important and non-confidential information in a timely manner can lead to dangers to public safety. An illustrative example from May 2025 involved the alleged escape from an out-of-state facility in Pennsylvania by three youth committed to DYRS. Challenges with information sharing from the facility to D.C. law enforcement potentially contributed to delays in identifying a vehicle the youth were in. At least one of the youth was later arrested for involvement in a robbery in which a person was shot, which took place following the escape.¹⁹ Challenges can also arise if a youth picks up new charges while placed in an out-of-state PRTF, as it can be difficult for the placing agency to obtain information from law enforcement and local courts in other jurisdictions, making care coordination more difficult.

Reentry Planning

Agencies reported that reentry planning would likely be improved by having a local PRTF. Children and youth may not lose touch with local support, treatment, and education if D.C. had a local PRTF; and if young people required reconnection to services and supports, the transition could happen at a deliberate pace with planned steps down. For example, residential facilities often allow home passes as youth achieve certain programming milestones and demonstrate progress. However, when youth are placed in out-of-state PRTFs located far away from the District, such day or weekend passes become infeasible. If youth had the ability to remain in D.C. while placed in a PRTF, they could benefit from home passes, helping to ensure that their families are able to manage their behavior in the home prior to discharge. For those youth who will not be returning to home placements upon their discharge from a PRTF, having a local facility would give youth an opportunity to meet and develop rapport with their prospective foster parents prior to discharge. This would enable both the youth and parents to develop rapport, and ensure the placement is a good fit that will meet the child's needs.

¹⁹ [Three juvenile escapees charged after DC crime spree | wusa9.com](https://www.wusa9.com/news/local/three-juvenile-escapees-charged-after-dc-crime-spree/)

In addition, a local facility would allow young people to remain linked to their local treatment and service providers while in placement and to benefit from ongoing supports and interventions. Alternatively, if youth were not previously linked with community-based mental health providers, they would have the opportunity to engage their new treatment teams through warm handoffs prior to their release from the facility. D.C. agencies would also have the opportunity to build community resources around youth through the creation of step-down plans to ease the transition.

Youth could potentially attend their local school depending on the model of PRTF programming that is adopted; or, the same school could serve both YSC and the local PRTF, easing the transition between facilities. In addition, a local PRTF would likely facilitate the transition to a neighborhood, charter, or therapeutic school when a youth is released. Not only would youth potentially have the opportunity to visit schools prior to enrollment when needed, their release could be better timed to the DCPS calendar (e.g., a youth could get released during a break so that they can return to school when other children are coming back from break, rather than youth having to reintegrate school in the middle of a week).

In sum, placing agencies could be more deliberate in their discharge planning, ensuring that youth are placed in an appropriate placement, a well-matched school, and are linked with community-based providers that can meet their complex needs.

Travel

When a youth is placed in an out-of-state PRTF, the placing agency must make arrangements for youth to be transported to the placement. When youth are awaiting placement at YSC, secure transportation can be arranged, however, if youth are awaiting placement in the community, they must be voluntarily transported. This can be challenging for youth undergoing psychiatric crises that warrant a PRTF placement and requires substantial staff time to coordinate logistics. Furthermore, youth must be accompanied by agency staff, which puts a strain on staff time, as many PRTFs are located far enough from the District to require overnight travel.

In addition to these challenges, agencies must coordinate and fund travel for families to visit youth when they are away at placement. Medicaid will cover two family visits to a PRTF within a year, and agencies can fund travel for two family members at a time – two parents or a parent and a sibling. However, parents may not be able to take time away from employment to make a visit; or they may have family responsibilities such as other children or dependents in the home. Additionally, several agencies reported that many families with youth placed at out-of-state PRTFs have never traveled outside of D.C. before nor have they been on an airplane, leading to substantial discomfort. Finally, the child or youth may have had supportive non-family relationships, such as with a mentor, credible messenger, or positive peers. As these relationships are not with family members, there is no funding to support their travel to an out-of-state PRTF; with a local PRTF, these supportive relationships could be maintained throughout a child or youth's treatment.

Finally, having a local PRTF would also decrease travel costs and the staff time needed to do site visits. This would allow for more frequent site visits and permit staff to redirect time away from travel and logistics and towards engaging with youth, observing the facility, and conducting monitoring and oversight.

Recommendations if D.C. Builds a Local PRTF

If the District opts to build and operate its own PRTF, based on the findings of key informant interviews with District agency staff, it should consider the following factors:

Standardizing Assessment of Medical Necessity

Placing agencies noted that there is no standardized, operational definition of medical necessity among different Medicaid MCOs and DBH, which can result in divergent outcomes based not on the youth needs, but rather on the MCO's internal administrative processes. For example, some MCOs require that all community-based services be exhausted prior to approving an LOC, making it more challenging to obtain. This can present barriers to accessing appropriate treatment, leading to negative consequences for youth and families. Standardizing assessment of medical necessity across MCOs administering D.C. Medicaid would be a significant undertaking, but one that could have substantial benefits for youth requiring a PRTF level of care. Shortening Timelines for Assessment of Medical Necessity

The process for determining medical necessity can take a long time, which, as mentioned, can exacerbate psychiatric symptoms and behaviors among children and youth. A substantial amount of coordination needs to be done among District agencies when working to place a youth. Various agencies are responsible for conducting assessments, submitting and approving an LOC, coordinating educational needs and ensuring continuity of care for youth in out-of-state placements. For example, if a youth does not have current evaluations (completed within the last year for psychiatric evaluations and within the last two years for psychoeducational evaluations), placement providers will not accept them until those evaluations are completed or updated. In addition, if a youth's evaluation was completed prior to their adjudication, it will usually not include a placement recommendation, as the evaluator is unable to discuss the instant offense with the youth. Placing agencies have to request that the evaluation be updated to reflect an appropriate placement recommendation, which can take time. Similarly, if a youth has a lapsed IEP due to poor school attendance, this may cause placement delays, as providers need to assess youth's educational needs to ensure that they can be met (e.g., many PRTF providers are unable to accommodate youth having a one-on-one aide). Finally, PRTF placements may be delayed by parents not completing paperwork for Medicaid recertification in a timely manner, causing the youth's Medicaid coverage to lapse. Placing agencies must then work with parents and/or guardians to re-apply for Medicaid, which is a time-consuming and difficult to navigate process.

Challenges with obtaining an LOC compound challenges with securing a placement for a young person at an out-of-state PRTF: delays in securing a placement for a youth can last so long that the LOC lapses. Some agencies may use HCAs when a PRTF bed becomes available, while waiting for the LOC process to be completed again. The use of HCAs in response to the lengthy

timelines for securing LOCs is quite common: in FY24, there were 50 children and youth placed at a PRTF using an HCA, compared to 23 children who were placed using an LOC. The use of HCAs is not necessarily problematic in and of themselves; however, they are symptomatic of the intersecting issues of lengthy timelines to secure an LOC and a PRTF bed at an out-of-state facility.

D.C. should conduct an evaluation of the current process for determining medical necessity with the goal of determining ways to improve coordination and shorten timelines for completing the process.

Acceptance to the local PRTF should depend entirely on medical necessity.

Concerns have been raised about how having a local PRTF may incentivize placing youth in a more restrictive setting prior to exhausting alternative community-based treatment options, leading to an increase in residential placements. Given the challenges around YSC being over capacity, some agencies expressed concerns that a local PRTF could be used to reduce the population of youth awaiting placement. To prevent inappropriate PRTF placements, several agencies noted the importance of developing stringent medical eligibility criteria for youth to ensure that the facility is not used to warehouse youth or to help address overcrowding at YSC. The District will need to develop clear guidelines and legal frameworks that define the specific population that a local PRTF will be designed to serve and to enforce eligibility criteria to ensure that the PRTF doesn't experience mission drift. The referral and placement process would need to be properly managed, and guardrails would need to be built into the process.

Investing in a Complete Behavioral Health Continuum of Care

If the District does opt to build and operate its own PRTF, that should not preclude further investments in strengthening the city's behavioral health continuum of care. Such investments will be crucial to ensure that youth can be served in the least restrictive environment and that the dearth of intensive community-based treatment options is not contributing to youth requiring PRTF placement. Youth having access to more robust interventions in the community could act as a guardrail against youth being placed in a PRTF by providing early intervention services that could prevent youth requiring a higher level of residential care.

A PRTF is one component of a complete behavioral health continuum of care for youth. In the District, youth can access community-based services such as outpatient psychiatry, individual therapy, Community-Based Interventions (CBI), High Fidelity Wrap Around Services, Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT). However, D.C. does not currently have a Partial Hospitalization Program (PHP) nor a Day Program provider. Furthermore, the District has a limited number of inpatient psychiatric hospital beds for youth who require acute hospitalization, as Children's National Hospital and the Psychiatric Institute of Washington (PIW) are the only hospitals in the city that serve this population. Children's National Hospital has 26 inpatient psychiatric beds for youth across two units. Their Child Unit has twelve beds and serves youth under the age of 13, while their adolescent unit has fourteen beds that serve youth aged 13-17.²⁰ PIW has a total of 130 beds and accepts youth aged 10-17, but they do not

²⁰ [Psychiatry and Behavioral Sciences | Children's National Hospital](#)

provide a breakdown of the number of psychiatric beds for youth.²¹ Greater availability and utilization of intensive community-based and acute inpatient psychiatric treatment options would provide more youth with an appropriate level of care in the community, preventing decompensation that can lead to a residential placement.

Making Procurement Choices

If the District decides to build and operate its own PRTF, it will need to identify a treatment provider to operate the facility, which may be challenging given the District's regulatory environment. For example, the District requires providers to navigate a local accreditation process, even for those providers who are already federally accredited. These challenges are reflected in the fact that the city has experienced difficulties in finding a substance use disorder provider to run an inpatient facility for youth. Such challenges may be replicated if D.C. attempts to secure a PRTF contractor to operate the facility.

D.C. will also need to appropriately staff and fund the facility, ensuring that it has both the staff expertise and financial resources required to effectively implement programming with fidelity to evidence-based treatment models. The District may have to set a PRTF per diem rate that would pay staff competitive rates to ensure that facility will accommodate youth who present with challenging behaviors, such as aggression.

D.C. will also have to outline the specific conditions under which a local facility would be able to refuse placement of medically and psychiatrically eligible youth referred to the local PRTF (e.g. due to safety issues or stay away orders that would preclude placement). Placing agencies expressed concerns about the PRTF provider having the ability to deny youth, given the current difficulties in identifying out-of-state PRTF providers to accept District youth. Such issues would need to be addressed and resolved during the contracting process.

Maintaining Relationships with Out-of-State PRTF Providers

While there would be meaningful benefits to the District having its own PRTF, there would likely still be circumstances when young people would need to be placed in out-of-state PRTF. Some agencies report that some youth may need to be separated from their local environment for safety reasons or due to negative peer influences or gang involvement. In addition, youth may present with clinical needs that require specialty care (such as youth with developmental and intellectual disabilities, eating disorder treatment, or experiences with child sexual exploitation) and interventions (e.g., Eye Movement Desensitization and Reprogramming (EMDR) therapy) that a local PRTF placement may not provide. In such cases, youth would still need to be placed in out-of-state facilities that can accommodate their individualized treatment needs.

²¹ [The Psychiatric Institute of Washington | PsychInstitute.com](https://www.psychinstitute.com)

Appendix A: Glossary of Terms

CGC – *Child Guidance Clinic* is a branch of the Family Court Social Services Division of the Superior Court of the District of Columbia. It carries out comprehensive, court-ordered clinical and forensic psychological evaluations.

CHIP – *Children’s Health Insurance Program* provides health insurance coverage to children whose family income is above Medicaid eligibility limits.

CFSA – *Child and Family Services Agency* serves as D.C.’s child welfare agency.

CMS – *Centers of Medicare and Medicaid Services* is a federal agency within the Department of Health and Human Services that administers Medicare and works with state governments to manage Medicaid, CHIP and health insurance marketplaces.

CSSD - *Court Social Services Division of the DC Superior Court*—a federally funded entity—serves as D.C.’s predisposition supervision and probation agency for juveniles.

Day Program – *Day program* is a community-based program for adults or children with serious behavioral health issues or developmental disabilities. These programs offer a structured environment where individuals can learn life skills and engage in services, such as vocational training, aimed at fostering independence.

DBH – *Department of Behavioral Health* provides prevention, intervention and treatment services to children, youth and adults with mental and/or substance use disorders. It works to develop, manage and oversee the District Public behavioral system.

DCPS – *District of Columbia Public School* runs D.C.’s public school system.

DYRS – *Department of Youth Rehabilitation Services* serves as D.C.’s local juvenile justice agency.

FFS – Fee-for-Service model for Medicaid refers to the fact that healthcare providers are paid directly by the state for each individual service they provide to a Medicaid beneficiary

FFT – *Functional Family Therapy* is a short-term, evidence-based therapy for families with youth experiencing behavioral issues such as delinquency, substance use and aggression.

ICPC – *Interstate Compact on the Placement of Children* is an agreement between state that established procedures for the administrative and legal placement of children across state lines.

HCA – *Human Care Agreement* is a contract between the District government’s Office of Contracting and Procurement (OCP) and a services provider for the purchase of social, health, or human services. HCAs allow placing agencies to use local dollars to place youth in out-of-home placements.

JJC – *Juvenile Justice Committee* is convened by CJCC to coordinate among youth serving agencies to improve outcomes for court-involved youth and those at risk of system involvement.

LOC – *Level of Care* refers to the classification of health care services based on their intensity and complexity. When a placing agency wants to place a youth in a Psychiatric Residential Treatment Facility (PRTF), it must get the placement approved by the Department of Behavioral Health (DBH) or the youth’s health insurance providers. If the PRTF placement is deemed medically necessary, DBH or the insurer will issue a Level of Care letter that approves the placement for a particular length of time. Youth must be placed in a PRTF within 60 days of the LOC being issued.

MCO – *Managed Care Organization* is a health plan or company that uses a managed care model to coordinate healthcare services. Rather than the state paying for each individual health service, the state pays the MCO a set monthly payment per member per month to manage costs and care.

Medicaid – *Medicaid* is a public health insurance program that pays for healthcare services for low-income and disabled people. In D.C., individuals can be enrolled in fee-for-service Medicaid, which pays provider directly for each service, or Managed Care Organization (MCO) plans that involve the District paying MCOs a set fee for each enrolled beneficiary.

Medical Necessity – *Medical necessity* means that a service or supply is required to diagnose or treat an illness or injury and that the intervention meets generally accepted standards of care. States can establish their own standards for medical necessity so long as they do not conflict with federal regulations.

MST – *Multisystemic Therapy* is an evidence-based, intensive home-based treatment program for families with at-risk youth who are experiencing serious antisocial behavior, such as delinquency, aggression and substance use.

OCP – *Office of Contracting and Procurement* manages the purchase of goods, services and construction on behalf of 79 District agencies.

OSSE – *Office of the State Superintendent for Education* serves as the D.C.’s state education agency.

PHP – *Partial Hospitalization Programs* provide structured, intensive mental health services for several hours a day, several days a week, allowing individuals to receive comprehensive support while living in the community. PHPs can be used as a step-down for individuals transitioning out of inpatient care and for those who need more support than can be provided by traditional outpatient services.

PRTF – *Psychiatric Residential Treatment Facility* is a non-hospital inpatient facility for children and youth under age 21 with complex mental health needs. PRTF services must be provided under the care of a physician and are eligible for Medicaid reimbursements

PRTF Review Committee – *PRTF Review Committee* is a multi-agency committee convened by DBH that reviews PRTF level of care applications submitted by placing agencies and makes eligibility determinations. If the committee deems that a PRTF is medically necessary, DBH will issue a level of care. It should be noted that some D.C. Medicaid MCOs (AmeriHealth and

Health Services for Children with Special Needs (HSCSN)) have their own internal LOC approval process.

RTC/RTF – *Residential Treatment Center or Residential Treatment Facility* is a residential program for individuals that don't need intensive psychiatric care under the care of a physician. These placements usually involve behavioral modification programs to address problematic behaviors. RTC are not as strictly regulated as PRTFs and are not eligible to receive Medicaid reimbursements. Such placements are paid for with local dollars through Human Care Agreements.

YSC – *Youth Services Center* is D.C's juvenile detention center.

Appendix B: Methods

The decision about whether to build a PRTF in the District will involve weighing the costs and benefits of the current system of relying on out-of-state PRTFs for children and youth who need that level of care, as compared to the costs and benefits of D.C. building and operating its own PRTF in or next to the District. These costs and benefits may be financial or non-financial. Financial costs considered include what different District agencies currently spend on out-of-state PRTF placements and projections of the initial and operating costs of the District building its own PRTF. CJCC considered nonfinancial costs and benefits of D.C. continuing its current system as compared to having its own PRTF on public safety, youth and family well-being, and agency operations.

Financial costs and benefits

The financial costs of D.C. building and operating a District-based PRTF were produced by the Department of Behavioral Health (DBH) in 2023. CJCC presents DBH's cost projections in this report for the convenience of readers; CJCC has not updated these projections nor run our own independent projections.

CJCC also requested that each youth-serving agency in the District provide data for fiscal year 2024 (October 1, 2023, to September 30, 2024) for the following:

- How many children and youth were referred to a PRTF
- How many children and youth were placed in a PRTF
- The number of PRTF denials
- Reasons for denials
- The amount of time from referral to placement
- The costs of placements from
 - Local funds, if the level of care is delayed or denied, or if the youth is not Medicaid eligible
 - Medicaid, if the level of care is approved prior to placement
 - Educational services

CJCC was able to obtain the costs of placement funded by Medicaid and the associated educational costs, but not the costs in local funds when agencies rely on HCAs or alternate placements for children and youth referred to PRTF placement.

Nonfinancial costs and benefits

Key informant interviews were sought with representatives from four District agencies that either directly serve children and youth, are involved in the placement or payment for PRTF placements for children and youth, or are involved in the juvenile justice system.²² These include:

²² Due to the federal government shutdown that began on October 1, 2025, CJCC was not able to secure an interview with representatives from the Court Social Services Division (CSSD), as it is a federal agency.

1. Department of Behavioral health (DBH)
2. Child and Family Services Agency (CFSA)
3. Department of Youth and Rehabilitative Services (DYRS)
4. Metropolitan Police Department (MPD) Youth and Family Engagement Division

Due to timeline and the federal government shutdown, we were not ultimately able to secure interviews with the Court Social Services Division (CSSD), the Department of Health Care Finance (DHCF), the Office of the State Superintendent of Education (OSSE), or a nonprofit services or advocacy organization for children and youth involved in the juvenile justice system.

Agency representatives were chosen by CJCC or by agency leads based on their role in current placement of children and youth in out-of-state PRTFs. Key informants were asked for their experiences and observations of the effects of D.C.'s reliance on out-of-state PRTF placements, and what might or might not change were D.C. to build and operate its own PRTF. Key informants were asked about the following domains:

- Youth and Family Access to Mental Health Services
- Education
- Family Contact and Engagement
- Agency Management and Cross-Agency Coordination
- Reentry Planning
- Potential Unintended Consequences of Having a Local PRTF

Key informant interviews were either individual or group interviews. Interviews were conducted virtually and took approximately an hour per agency. CJCC staff recorded the interviews but did not thematically code the transcripts, as would be appropriate in a qualitative research study. Instead, we relied on notes to derive themes from the interviews, referring to the recordings and automatically produced transcripts when needed to refresh memories or check accuracy of notes. As these interviews with key informants did not cover topics related to themselves personally but rather to their professional roles, CJCC did not seek IRB review. This report was circulated to interview participants to ensure that CJCC accurately captured the process for out-of-state placement, as well as the key informant perspectives and responses. Following the circulation of the draft report, the interview recordings were destroyed.

This report defines a child as anyone under the age of 18, and a youth as anyone under the care or commitment of a District agency up to the age of 21.

Limitations

The key limitation of this report is that CJCC staff were not able to interview youth and family members directly about their experiences due to the relatively short turnaround time for this report. As a substitute, we attempted to gain different perspectives through key informant interviews with advocates, attorneys, and case workers, but did not receive replies to requests for interviews, in part due to the federal government shutdown. Unfortunately, this report

lacks the directly reported experiences of the people most affected by D.C.'s reliance on out-of-state PRTF placements.

A second limitation is that CJCC was not able to obtain the costs of placement at PRTFs under Human Care Agreements, or the costs of alternate or inappropriate placements for those children and youth who were denied PRTF placement. This prevents a full comparison of D.C.'s current costs of placement against the projected costs of operating a local PRTF.

Finally, key informants from multiple agencies noted that they would expect having a local PRTF to improve health and well-being for children assessed to need that level of care, possibly leading to reductions in delinquent behavior or reductions in the need for hospitalizations. D.C. does not currently have empirical research to support expert opinion regarding projected gains in health and well-being for children, youth, and families.

Appendix C: Key Informant Interview Guide

Introduction

The Juvenile Justice Committee has been charged by the CJCC Principals with understanding factors that lead to long lengths of stay among committed youth at YSC. One issue that has been identified is the challenge that DYRS has with placement of youth at Psychiatric Residential Treatment Facilities (PRTFs). One proposal on the table, which would affect all youth-serving agencies in the District, would be for D.C. to develop its own local PRTF.

We would like to better understand your agency's perspectives about the qualitative costs and benefits of sending youth to out-of-state PRTFs, compared to those of D.C. having a local PRTF, both for public safety as well as for youth/family well-being. Some of these questions may not apply to your experience or your agency's role; please feel free to skip those questions. We hope to take no more than 45 minutes to an hour of your time.

Questions

Access to Services

1. In your experience and observation, how is care coordination for youth and families impacted by D.C.'s reliance on out-of-state PRTF placements? How do you think having a local PRTF could or might impact care coordination?
2. How is youth's access to intensive mental health services impacted? What might change if D.C. had a local PRTF?
3. How is access to recommended mental health treatment affected by D.C.'s reliance on out-of-state PRTF placements?
4. What are some of the outcomes youth experience when they are recommended for placement at a PRTF, but agencies are unable to identify an appropriate placement?
 - a. *Prompts if needed:* Do youth wait longer? Is staff time spent trying to find placements? Are youth placed in less preferred placements? Does that affect those youth or other youth in the same placement?

Education

5. In your experience and observation, how are youth's educational outcomes impacted by D.C.'s reliance on out-of-state PRTF placements? How do you think having a local PRTF could or might impact education outcomes?
6. Do youth experience any academic challenges when transitioning back to DCPS from out-of-state placements? What efforts does it take to support that transition? How would having a local PRTF affect education during that transition?
7. Do youth experience issues receiving credits from DCPS for classes they took in an out-of-state PRTF?
8. How would having a local PRTF impact youth's transition back to DCPS, academically, socially, and in terms of services and extra-curriculars?

Family Contact and Engagement

9. Is family engagement in youth's treatment impacted by D.C.'s reliance on out-of-state PRTF placements, and how? For youth placed out of state? For youth whose placement is delayed? For youth who are placed locally after trying to place them out-of-state?
10. Have youth and family expressed opinions or perspectives on out-of-state placements, such as a desire for distance or a desire to remain closer to home during placement?

Agency Management and Cross-agency Coordination

11. What is the impact of reliance on out-of-state PRTF placements on staffing needs at your agency, or staff time?
12. Has your agency experienced inter-agency coordination challenges around youth who are placed out of state?
13. How many youth would your agency likely place at a PRTF each year if you were able to find placements for all of them? Are there any who you would not place locally if there was a local PRTF? Why might that be?

Reentry Planning

14. What impact would having a local PRTF on reentry planning and services for youth when they return to the community?
15. Would a local PRTF impact your agency's ability to engage families in youth's reentry planning?

Summary and closing

16. What do you think might be unintended consequences of having a local PRTF, either positive or negative?
 - a. *Prompts if needed:* Might children who would be better served elsewhere or at a lower level of care be referred to the local PRTF? Might there be savings in staff time? Might the funding to build and maintain a PRTF eat into other priorities? Might there be better coordination with law enforcement?
17. To wrap up, what do you see as the main benefits of having a local PRTF in D.C., if any, and what do you see as the main downsides, if any?

Appendix D: The PRTF Referral and Placement Process in D.C.

Eligibility and Procedures

To be eligible for PRTF placement, a child must be assessed by a psychiatrist who makes a specific recommendation for a PRTF placement in a psychiatric evaluation. If a youth is court-involved, the Court can order that psychiatric and psychoeducational evaluations be completed by the Child Guidance Clinic (CGC).²³ If evaluations are ordered, the psychoeducational evaluation is completed by the CGC and the psychiatric evaluation is completed by DBH's Assessment Center, which conducts court-ordered assessments for family court involving child welfare, juvenile justice forensics and domestic relations.²⁴ Alternatively, if a youth is not court involved, an evaluation can be provided by a community-based psychiatric provider or be completed by the school system where appropriate.

Once the placing agency has gathered all the relevant supporting documentation regarding a youth's case, it has to submit a Level of Care (LOC) application packet to the Department of Behavioral Health's (DBH) PRTF Review Committee or to the youth's Managed Care Organization (MCO) and must present the case and make out medical necessity (i.e., explain why youth needs a residential placement and why those needs cannot be met in a lower level of care).²⁵ The placement packet includes the DBH Referral Form for PRTF Medical Necessity and the following supporting documentation:

- Psychiatric evaluation or diagnostic assessment completed within the last year,
- Psychoeducational evaluation completed within the last two years,
- Psychosocial summaries,
- Recent court reports,
- Social studies,
- Discharge summaries from last two hospitalizations if applicable,
- Treatment plan and discharge recommendations if a youth is in a facility or hospital,
- Current team meeting notes,
- Current Individualized Education Program (IEP) or 504 Plan,
- Release of information signed by the parent and youth, if they are over 16.²⁶

Once the packet has been submitted, DBH or the youth's MCO will schedule a time for the referring agency to present the case and will subsequently make a determination as to whether a PRTF is deemed medically necessary for a particular youth, and if so, for how long. If approved, DBH or the MCO will issue a Level of Care (LOC) letter that outlines how long the

²³ The Child Guidance Clinic is a branch within Family Court Social Services Division of the Superior Court of the District of Columbia that provides comprehensive clinical and forensic psychological evaluations - [Child Guidance Clinic | District of Columbia Courts](#)

²⁴ [Children, Youth and Family Services | dmh](#)

²⁵ Two D.C. Medicaid Managed Care organizations (MCOs), AmeriHealth and Health Services for Children with Special Needs (HSCSN) have their own internal application process to make out medical necessity. Medical Necessity applications for youth enrolled in Fee-for-Services (FFS) Medicaid or other MCOs are submitted and approved by the District's Department of Behavioral Health (DBH).

²⁶ [DBH PRTF Medical Necessity Determination Process](#)

youth has been approved to receive treatment at a PRTF. A youth must be placed in a PRTF placement within 60 days of the LOC being issued, though the placement agency can request a 30-day extension if there are delays.

Placing agencies must also submit the youth's placement packet to out-of-state PRTFs that are D.C. Medicaid providers so that the facilities can review the packet and make a determination as to whether the youth can be accepted into the program. Placing agencies will often submit placement packets to PRTF providers while working to obtain a Level of Care letter. This parallel planning aims to reduce the amount of time it takes to identify an appropriate placement for youth. If the placing agency is unable to identify a D.C. Medicaid PRTF provider that will accept the youth, it can seek out PRTF providers outside of the D.C. Medicaid provider list and must enter into a single case agreement with the facility to place a youth. This process involves the Office of Contracting and Procurement (OCP) and can take up to a year, as the placing agency must complete a site visit and OCP must work with the placement provider to finalize the single case contract.

Once a PRTF has been identified for a youth who has been adjudicated delinquent, the placing agency must request a court order to place the youth in an out-of-state facility.²⁷ To get the court order approved, the placing agency must demonstrate that the youth is in need of treatment in a residential facility and that there are no equivalent facilities in the jurisdiction in which the youth resides that could meet their needs. If the youth and family agree with the agency's placement plan, the court will sign the order. However, youth and families have the opportunity to request a court hearing to contest the placement if they do not agree with the placing agency's plan, which can delay placement.

After the placing agency has obtained the LOC and identified a PRTF provider who has accepted the youth, it must submit a Request to Place a Child in a Residential Facility to the Interstate Compact on the Placement of Children (ICPC) in order to get the child's placement approved by the receiving state.²⁸ The following documents must be submitted for ICPC approval:

- Form 100A,
- Acceptance letter from the facility,
- Statement assuring financial responsibility (LOC, contract, human care agreement),
- Article VI signed by a judge for youth with delinquency adjudications,
- Disruption letter that indicates who is responsible for the child's removal from facility if the placement disrupts,
- Most recent court order and/or social summary,
- Psychiatric, psychological and/or developmental assessment completed within the last two years,
- School reports and IEPs,

²⁷ These court orders are commonly referred to as Article VI Court Orders, since a hearing and court order are a requirement of D.C. Code § 4-1422, Authority to enter into and execute Compact, Article VI, Institutional care of delinquent children.

²⁸ [Business Process - Interstate Compact for the Placement of Children \(ICPC\) Final2020.pdf](#)

- Medical report if available.

Once a youth's ICPC has been approved, the placing agency can then coordinate with the PRTF placement provider to determine an admission date for youth. Once an admission date has been identified, the placing agency must make travel arrangements for the youth to be placed. If the youth has been awaiting placement at the Youth Services Center (YSC), secure transportation to the placement will be required.

D.C. Medicaid Reimbursements for PRTF Providers

There is a perception among some PRTF providers that D.C. has a relatively low Medicaid reimbursement. However, since the District does not currently have its own PRTF, there is no established daily reimbursement rate for PRTF in D.C.'s Medicaid State Plan. The District actually pays the daily Medicaid reimbursement rate established by the state in which the PRTF is located (see Appendix E for per diem PRTF reimbursement rates). If a PRTF does not have an arrangement with their own state's Medicaid program, then DHCF looks at how much MCOs or private insurers have paid for PRTF placements. If neither of these reimbursement rates are established, DHCF will negotiate a daily rate with the PRTF itself.

If the District opts to operate its own PRTF, the daily reimbursement rate would be negotiated in the State Plan. Reimbursement rates are calibrated based on various factors, including staffing numbers, quality of services, and building configuration. DHCF has an enrollment process for PRTFs to become D.C. Medicaid providers and can assist providers in completing this process. The requirements of the enrollment process are established by federal law. While DHCF does not actively recruit PRTF providers, they are willing to work with any providers interested in enrolling in D.C. Medicaid. DHCF circulates a monthly enrollment list of current D.C. Medicaid PRTF providers.

Placing agencies noted that the number of PRTF providers on the D.C. Medicaid provider list has shrunk over the years, in part due to the administrative burden of the provider enrollee process. While DHCF used to mandate that PRTF providers enrolled in D.C. Fee-for-Service (FFS) Medicaid had to be recognized by MCOs, this is no longer the case. Providers now have to complete enrollments not only with DHCF but with all Medicaid MCOs. PRTF reimbursements are further complicated by the fact that MCOs are only responsible for paying for the first thirty days of a youth's placement. Once those 30 days end, the youth coverage reverts to FFS Medicaid, complicating the billing process for providers.

While there has been a lot of focus on D.C.'s Medicaid reimbursement rates, many providers do not find it worthwhile to enroll in D.C. Medicaid because of the small volume of placements from the District (only 23 District youth were placed in out-of-state PRTFs in FY24) and the administrative and billing requirements involved in enrolling as a D.C. Medicaid provider. DBH also has an additional credentialing process for PRTFs that enroll to become D.C. Medicaid providers.

Appendix E: D.C. Fee-for-Service (FFS) Active Psychiatric Residential Treatment Facilities – Current Per Diem Rates as of 10/28/2024

DC FFS ACTIVE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES
CURRENT PER DIEM RATES AS OF 10/28/2024

| PID | NAME | STATE | ORIGINAL ENROLLMENT DATE | CURRENT RATE | EFFECTIVE DATE |
|-----------|---|-------|--------------------------|--------------|----------------|
| 019197300 | DEVEREUX HOSP & CHILDRENT CTR | FL | 07/01/91 | \$586.43 | 01/01/24 |
| 020005745 | THE DEVEREUX FOUNDATION, INC. | GA | 08/14/20 | \$507.59 | 10/01/22 |
| 031456600 | HARBOR POINT BEHAVIORAL HEALTH INC | VA | 08/30/90 | \$442.67 | 07/01/24 |
| 032305400 | GULF COAST YOUTH SERVICES DBA GULF COAST TREATMENT CENTER | FL | 08/01/97 | \$586.43 | 01/01/24 |
| 035597400 | NEWPORT NEWS BEHAVIORAL HEALTH CTN | VA | 04/04/03 | \$560.95 | 07/01/24 |
| 036315800 | NEW HOPE CAROLINAS, INC. | SC | 09/04/03 | \$500.00 | 10/01/22 |
| 037056100 | UHS OF SAVANNAH, LLC. (Formerly COASTAL HARBOR TREATMENT CENTER) | GA | 09/30/05 | \$351.62 | 10/01/19 |
| 038227400 | UHS OF LAUREL HEIGHTS, LP | GA | 01/30/07 | \$597.65 | 10/01/22 |
| 038678700 | KEYSTONE CONTINUUM, LLC DBA NATCHEZ TRACE YOUTH ACADEMY | TN | 04/25/07 | \$450.00 | 05/04/21 |
| 056540700 | WOODBOURNE CENTER, INC. | MD | 06/01/15 | \$826.43 | 10/01/24 |
| 058363200 | CORNELL ABRAXAS GROUP, INC | PA | 01/08/16 | \$537.47 | 01/01/24 |
| 073390300 | GRAPTON SCHOOL INC | VA | 11/01/02 | \$560.95 | 07/01/24 |
| 077087822 | 11100 BILLINGSLEY ROAD OPCO LLC DBA RECOVERY CENTERS OF AMERICA AT CAPI | MD | 10/23/24 | | 10/23/24 |

Source: DCHF