Post PRTF Implementation FAQs (as of 06/09/2026)

Health Risk Assessment (HRA)	
Question	Response
How often do they (MCOs) need to do their assessments?	No changes to the model of care; High Priority Population language added to contract is as follows: 3. Members under age 21 receiving care in a psychiatric residential treatment facility (PRTF) through the EPSDT benefit's "Psych Under 21" provision, during the PRTF stay and for the first three (3) months after transitioning from the PRTF to the community, or longer if determined by the member's needs. All PRTF members must be classified as High Intensity during the PRTF stay and at least three (3) months after discharge to the community. MCOs do not have flexibility to re-stratify members to moderate or low intensity during that time. One contact per month is required for all high intensity members. The initial contact and one contact every six months must be in person. These are the minimum contact requirements. The Care Manager/MCO is responsible to make contacts as clinically necessary.
Do they (MCOs) have background checks on their staff?	Yes; background checks are completed during the recruitment process for CM representing the respective MCO.
What is the expectation for completion of the assessment? Staffed? One on one with client? Length of time?	CCMC contract section 8.5.3 reads: "Following the initial HRA, Care Managers must complete an HRA Reassessment or update an existing HRA for any individual receiving Care Management Within ten (10) Days of a Triggering Event, unless there are extenuating circumstances, and no more than thirty (30) calendar days. If the Reassessment takes place beyond the ten (10)-day timeframe, the Contractor must document the reason(s) why this occurred."

Post PRTF Implementation FAQs (as of 06/09/2026)

The most recent Contract amendment states "Initial and reassessment HRAs must be in-person (8.5.1.6)," what is the MCO to do if the PRTF prefers HRAs be completed with member by zoom/Teams meetings? Are the MCOs expected to complete in-person HRAs for the out-of-state PRTFs? If so, how?	The PRTF should be informed that an in-person assessment is required. If there are extenuating circumstances (not a "preference"), these must be documented with substantial evidence explaining why in-person is not possible. For members in out-of-state PRTFs, please consult with DMAS regarding the specific member(s). HRAs must be completed by an MCO's qualified Care Manager (8.5, Health Risk Assessments). For members in PRTFs, the initial and reassessment HRAs must be in-person (8.5.1.6, HRA for Members in a Psychiatric Residential Treatment Facility). The in-person requirement extends to any Member in the High Intensity Care Management category. 8.5.2.1 (Mode of Administration and Accommodations). DMAS may waive in-person contact requirements in extenuating circumstances, such as a pandemic. No other party is listed as having the ability to waive the in-person requirement. The contract is silent with respect to the one-on-one nature of the assessment to the extent that it does not exclude anyone else from participating in the assessment. Section 8.5.1.2, HRA Documentation, appears to contemplate that others will contribute towards the completion of the assessment as the HRA "must Document the source of information for the HRA (e.g., the Member, Providers, facility staff, family/Caregivers)."
The most recent Q&A document suggests MCOs HRAs must be updated to include	Please see CCMC contract section 8.5.3 related to triggering events.

Post PRTF Implementation FAQs (as of 06/09/2026)

contractual verbiage in 8.5.1.6, what is the TAT on updated HRAs?	
Care Coordination/Documentation	
Who is going to be gathering all of this information that is being requested? A significant amount of the paperwork requested we have received from other sources and cannot send it to another facility. Will this be completed by the case manager because they receive all of the work from the residential placement?	MCOs should use the notification regarding the IACCT to become engaged with the process, including sharing information as allowable for the purpose of the assessment; MCOs remain (or become, for youth currently in PRTFs) responsible for coordinating and facilitating non-PRTF healthcare; MCOs should establish communication and explain the supports that can be provided as early in the process as possible, requesting to be added to the treatment team.
With the additional time spent on assessments and care planning with the MCOs, will there be billing codes that the facility can utilize to offset the expense of the clinician's time?	Chapter 5 pages 21-22 of the residential treatment services provider manual list covered services in the residential per diem: Resident care services consisting of room and board, daily supervision, treatment planning, care coordination, skills restoration, ADL restoration and crisis interventions. These services are considered covered under the daily reimbursement per diem rate.
Is there a way for this new time to be included in the current cost reporting activities?	Response same as above; care coordination is already included in the residential per diem.
When will all PRTFs be assigned MCO case management and when will PRTFs to be expected to hear from assigned workers? We have 1/19 residents assigned and were told last week that all should be assigned and should have made contact with facilities.	Acentra Health will include the MCO contact in the IACCT inquiry notification emails. This is the point on which the MCO should initiate contact with the PRTF to begin care coordination.

Post PRTF Implementation FAQs (as of 06/09/2026)

	Clarification made regarding the members in question, the issue has been resolved via email.
If a PRTF is not communicating with the MCO, what are the MCOs supposed to do?	Please contact DMAS BH staff at enhancedbh@dmas.virginia.gov for assistance.
Miscellaneous	
Are Out-of-State residential providers required to enroll separately with MCOs? The current understanding is that in many states, once a provider is enrolled with the state Medicaid program, participation extends to MCOs operating under that program's umbrella.	The enrollment process is the same for all providers. Once enrolled in PRSS, they must then contact the MCO to begin their credentialing process.
What is the required or expected frequency of MCO participation in treatment reviews with the facility? I am also interested to better understand what has helped successful engagement with various MCOs/Facilities.	As each milieu has their own standard of operations, MCOs also have their own protocol for participating in treatment team meetings. Therefore, it is advised that the PRTFs and MCOs collaborate on a case-by-case basis, providing participation in treatment team meetings as medically necessary. Providers and MCOs alike have reported positive experiences with meeting and engaging in care coordination (to include PRTF provider tours).
Claim denials for professional services	Under the new MCO Carve In, DMAS has been alerted of two PRTF providers that have received denials for claims submitted under FFS for professional services billing. If your facility receives a denial of services due to the use of the practitioners NPI, resubmit the claims using the PRTF facility NPI for both servicing/billing. This is a workaround until a determination is made on whether the practitioner can be included as the servicing provider as usual prior to the 11/1

Post PRTF Implementation FAQs (as of 06/09/2026)

	implementation changes. **Only do this if you receive a denial of service.**
1) Ancillary appointments from a PRTF (minors) How should health plans handle requests for transportation to ancillary appointments where the minor placed in a PRTF would be unaccompanied?	Youth 12 and below cannot travel unattended. Additionally, given the vulnerability and acuity of this population, children receiving transportation from a PRTF to ancillary appointments should be accompanied by: • A PRTF BH attendant/escort, **or** • Parent/guardian (or LDSS worker if in foster care) • When needed, plans should also consider whether a BH paid attendant as a specialty service would be clinically appropriate on a case-by-case basis (arranged in advance) *References:* *CCMC Contract Section 5.14.13: Transportation Services for Minors "An escort or personal assistant is a parent, Caregiver, relative or friend who is authorized by the Contractor to accompany a Member or group of Members who have special needs or who are minor children [defined as under age eighteen (18)]. No charge must be made for escorts or personal assistants."* *NEMT FFS Member Manual: "Minors aged 17 and under must be escorted by a parent, guardian, relative or friend. The escort must be age 18 or over unless it is the parent."* *NEMT FFS Attendant Requirements*
2) Out-of-state PRTF transportation For out-of-state PRTF transportation, what is the expectation for DSS/LDSS involvement or accompaniment (if any)?	The DMAS and VDSS expectation is that minors would be accompanied by their guardian (including LDSS worker for youth in foster care) or an attendant/escort known to the child. See above regarding minor transport. *References:* *See above*
When accompaniment is required or requested, is the MCO expected to cover travel expenses for the parent or LDSS case worker (cost of flight, travel, meals, hotel etc.) if needed?	Per the CCMC Contract, transportation expenses may include the cost of an attendant to accompany the member, including the cost of their transportation, meals, lodging, and salary unless the attendant is a family member. LDSS case workers are not considered family members for these purposes.

	References: *CCMC Contract Section 5.14.17 Transportation Expenses "Transportation expenses… include: 3. The cost of an attendant to accompany the Member, if medically necessary; and 4. The cost of the attendant's transportation, meals, lodging, and salary if the attendant is not in the Member's family.* *DMAS FFS Transportation Provider Manual, Chapter 4: Covered Services and Limitations "Travel Reimbursement will be reimbursed at the state employee travel, hotel, per diem, mileage reimbursement rate."*
MCO's requesting copies of the CANS and IACCT from the PRTF provider, should that request be made to and satisfied by the originator of the document?	Acentra Health sends an email to the MCO which contains the IACCT assessor's email and language about the IACCT assessor sending over the assessment. MCO's can reach back out to request the documents.