Prescribed Pediatric Extended Care Rate Study — Questions and Feedback Submitted after February 18, 2025 Stakeholder Meeting

April 23, 2025

<u>Submission #1:</u> Thank you for leading the discussion and sharing the information on the Prescribed Pediatric Extended Care Rate Study. It was good to hear the information and to understand what was considered in the rate study. As requested, we are submitting feedback and a follow up question.

- Based on what we are seeing for the cost of similar services that will be offered in the PPEC model we believe the daily rate is too low when we consider the cost of personnel and overhead. To provide services for 6+ hours our cost is $700 per day. Could there be a **consideration for more than 4 hours at a higher rate than the proposed $443. We have found working parents need at least 6 – 10 hours of care to work/attend school. The matrix/rate that is proposed limits a provider's ability to optimize the family and child's potential. The additional services of social work and case management further supports the success of the** family. We add these services in as value added.

  Response: DHSS and Mercer agree that children may spend up to 10 hours per day at the PPEC facility while parents are working or attending school. As shown on slide 22 of the February 18, 2025 presentation, the PPEC full day rates were modeled based on the assumption that the PPEC facility would be open and staffed for 10 hours per day. The reference on slide 29 to the full day rate being "more than 4 hours" is for billing guidance purposes (i.e., a provider cannot bill the full day PPEC rate unless they provide more than 4 hours of PPEC services to a child in a given day).

  DHSS appreciates your desire to also provide social work and case management services. However, because those services are not included in the PPEC service definition, they are not required services and therefore will not be considered in the rate study.

- We would also suggest therapy be billed outside the bundled cost of the full and half day rate. This supports providers and allows the therapy team to set goals with families that are not **dictated by the bundled reimbursement but by the rehabilitation needs/abilities of the child. Potentially these rehabilitation services could allow the child to return to a lower level of care** and ease caregiver support.

  Response: DHSS has reviewed this feedback and plans to move forward with a PPEC model that includes therapy services within the per diem rate, consistent with the draft regulation. As mentioned during the stakeholder meeting, the rate study includes consideration for one hour of therapy per child per day, but this does not preclude providers from being able to bill additional hours of therapy outside of the PPEC per diem rate.

- **Can DHSS please provide additional details regarding the intent and rationale of only including FFS patients in PPEC Eligibility? We would recommend managed care patients be included.** This limits the number of children care can be provided for.

  Response: To clarify, DHSS does not intend to limit PPEC eligibility to FFS children. Once PPEC is approved as a Medicaid State Plan service and added to the Managed Care contract, it will be available to children ages 0-6 in both FFS and Managed Care.

Submission #2: Thank you for the leading and facilitating the Prescribed Pediatric Extended Care (PPEC) Rate Study Stakeholder Meeting on February 18, 2025. The meeting provided clarity on the detailed process followed to conduct the rate study, the key cost components included, the sources **informing those costs, and the draft model rate ranges. We appreciate DHSS's commitment to bring PPEC services to MO to better serve children with medical complexities via an integrated, more cost effective, and socially enriched environment. Most importantly, we believe PPECs can help these children optimize their health/wellbeing, learn, and grow to their full potential. As requested, we are submitting feedback and questions regarding which we would appreciate your review and response.**

- **Based on our research & discussion with an existing PPEC operator in multiple states, the proposed draft range would be reasonably set if the proposed rates did not include 1 hour of** therapy (ST, PT, or OT services). In order for the model to be **fi**nancially viable and support new entrants into the market, we recommend the PPEC service bundle exclude therapy services. If DHSS is unwilling to modify the bundling of 1-hour of therapy, can DHSS please share the **specific PPEC state comparisons that included therapy services? This information will support** our e**ff**orts to ensure the economic viability and sustainability of the rate structure.

  Response: Thank you for this feedback. As mentioned above, DHSS plans to move forward with a PPEC model that includes one hour of therapy services within the per diem rate. In terms of Medicaid fee schedule rates in other states, Mercer reviewed seven states with published Medicaid PPEC per diem rates ranging from $240.00 per day to $389.49 per day.

- In alignment with item #1, we highly recommend DHSS move forward with the process that **enables any additional therapies beyond 1 hour to be billed to MO Medicaid (per meeting, DHSS indicated additional billing needs to be approved via a separate channel). While other** sources of funding may exist for therapies (i.e. MO First Steps), the business model to support the use of employed/contracted therapists necessitates that all therapy services needed by qualifying PPEC children are adequately covered and reimbursed.

  Response: As indicated in the above responses, the draft PPEC rate study includes one hour of therapy services per child per day. This does not preclude providers from being able to bill additional hours of therapy outside of the PPEC per diem rate to entities that cover those

services. Any additional therapy services beyond that one hour per day may be covered through appropriate payors (i.e., Private Insurance, First Steps, Medicaid, etc.).

- **Can DHSS please provide additional details regarding the intent and rationale of only including FFS patients in PPEC Eligibility? Why are managed care patients excluded? Is there an anticipated plan/timeline to expand PPEC services to managed care? Based on the existing count of PDN FFS patients (81 current PDN patients 0-6 years old in state of MO), it does not seem like the PPEC model would be financially viable for any local MO market (i.e. patients** typically need to be within 20-30 miles of the center).

  Response: Please refer to response to Submission #1.

Submission #3: Thank you for the leading discussions and welcoming feedback on the Prescribed **Pediatric Extended Care Model. I was able to listen to the meeting that described the model, expectations, and requirements. I have also been able to review proposed regulations..**

- We would suggest a review of the DoN requirements to allow for work in a Comprehensive **Outpatient Rehabilitation Facility in substitution of working in an Acute Care Facility.**

  Response: DHSS appreciates this feedback, but this suggestion is beyond the scope of this rate study.

- We would suggest ages be expanded to include older than 6 years of age. Our **recommendation would be up to age 18.**

  Response: DHSS appreciates this feedback but does not plan to extend these services to children older than 6 years of age.

- We would suggest therapy be billed outside of the day rate. Many of these children will have goals that could support a more intensive therapy model than one hour per day.

  Response: DHSS appreciates this feedback. DHSS plans to move forward with a PPEC model that includes therapy services within the per diem rate, consistent with the draft regulation. As mentioned above, the rate study includes consideration for one hour of therapy per child per day, but this does not preclude providers from being able to bill additional hours of therapy outside of the PPEC per diem rate.

- **Transportation seems to be a barrier. Medicaid transportation requires a family member ride** with the child under a certain age and will not transport family member back home.

  Response: DHSS has reviewed this comment. The draft PPEC regulation and service definition do not include transportation as a component of the PPEC service, and DHSS does not plan to

change this. As a result, transportation costs will not be included in the rate study. DHSS will monitor this going forward to understand if any barriers to access emerge.

- We suggest there is good alignment with DESE licensing requirements and the requirements **for the PPEC license through DHSS. We would also suggest continuing education requirements** be reviewed. The current MOPID system does not seem to be a good **fi**t for the level of personnel that will be working in the PPEC model.

  Response: DHSS appreciates this feedback, but this suggestion is beyond the scope of this rate study.

- **Could there be some consideration, even though this is a medical service, that there is a** payment on enrollment like there is with subsidy. The cost of employing nurses and the **overhead costs still exist, with no way to recuperate, when people are absent.**

  Response: Medicaid does not allow for payment upon enrollment; it requires that a service be actively delivered in order for a provider to bill. DHSS and Mercer agree that providers may experience some absenteeism in the PPEC service delivery model. The rate study provides consideration for absenteeism through the staffing assumptions. For example, the draft regulation requires a PPEC facility serving 7-9 children to have at least one RN, one RN or LPN, and one direct care professional (CNA/CMT) on staff. This means the provider's staffing costs would be the same regardless of whether they serve 7, 8 or 9 children. The rate study assumes three staff for every eight children (midpoint of the 7-9 range). Therefore, if only seven children show up on a given day, the provider may not be able to fully cover all staffing costs, but if nine children show up on a given day, the provider would receive funding in excess of their staffing costs. Furthermore, in cases where a child is at the facility more than 4 hours but less than 10 hours, the rate study assumes 10 hours of staffing regardless of if the child leaves early on a given day.

- **Could there be a consideration for a payment that is greater than 4 hours (7+ hours). Currently** there is a half day rate and a full day rate that goes up to 4+ hours. Family and person served **needs seem to be greater than 4+ hours but the rate will limit providers to meet any additional** hours.

  Response: Please refer to response to Submission #1.