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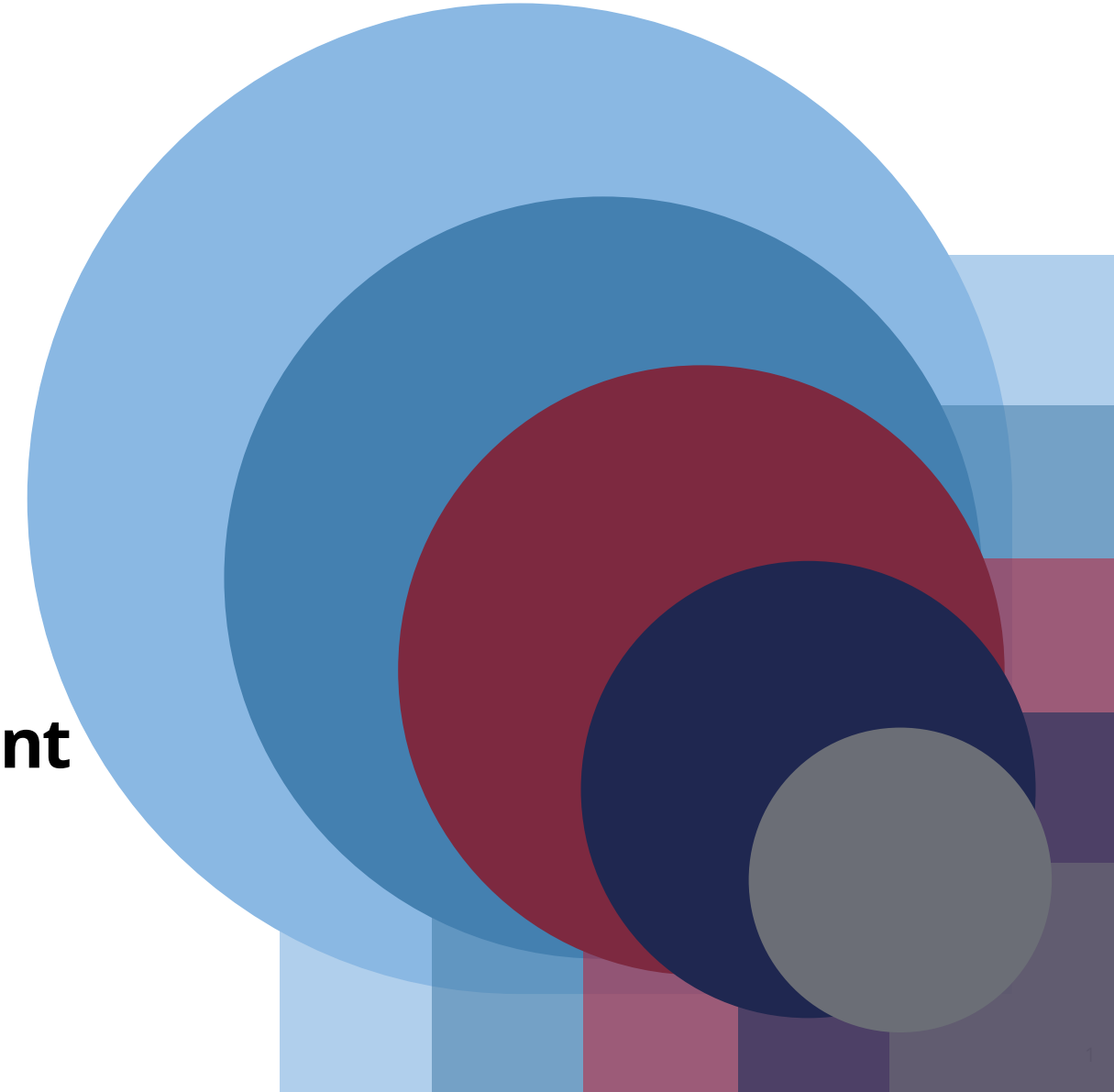
Ohio Department of Developmental Disabilities

APRIL 18TH, 2025

DODD ICF Stakeholder Engagement Meeting

ICF Direct Care Rate Update



Direct Care ICF Provider Workgroup Meeting Agendas

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A high-level overview of agenda topics for the first two provider workgroup meetings

PROVIDER ENGAGEMENT

Meeting 1

Meeting 1 will walk through the project objectives in depth as well as the current direct care rate methodology for direct care involving case mix reliant on acuity scores determined by the ODDP. A new direct care rate approach and its impact on providers will be shared at the end of the meeting

1. Project Overview
2. Current State Impacts on Providers
3. Data Analysis & Key Cost Drivers
4. Proposed Direct Care Rate Methodology
5. Aggregate Impacts

Meeting 2

Following Meeting 1, provider level impacts will be sent out to their respective provider. Meeting 2 will focus on topics that are collected through provider feedback.

Project Overview

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Direct Care Rate Update | Project Overview

DODD ICF Direct Care rate methodology project overview, highlighting key milestones

CHALLENGE

There is a belief the ODDP assessment **does not recognize appropriate management of behavioral needs** of individuals. Analysis indicated **a lack of correlation between provider ODDP case mix scores and ICF direct care costs**. Further, the results from the assessment add administrative workload to ICFs and DODD staff but **only directly impact ~20% of ICF providers** under the current rate methodology.

Given these challenges, the DODD Medicaid Administration team evaluated alternative rate methodologies without the ODDP assessment, specifically alternative approaches to develop the Direct Care component of rates.

APPROACH

1 Evaluate Current State & Set Goals

Evaluated the direct care rate methodology and quantified its impact using provider cost reports, determining **total dollars** and **number of providers impacted.**

Set goals governing alternative approaches.

2 Review Cost Report Data

Reviewed cost report data to **identify relationships between metrics and high direct care spend** by providers, analyzing direct care spend with **considerations for peer groups and add-ons.**

3 Develop Financial Impact Model

Developed financial model to allow for review of possible rate methodologies.

4 Iterate Rate Cap Modeling Scenarios

Developed and quantified the impact **of various direct care rate methodologies** using different metrics. Iterated scenarios to achieve DODD ICF goals, aiming for a **simpler and cost-neutral approach**.

OUTCOME OF PROPOSED METHODOLOGY

Developed an alternative direct care reimbursement calculation that:

- **Minimizes provider impacts** with respect to the dollar amount and/or number of providers
- **Reduces the workload** of quarterly assessment administration processes and simplifies the rate calculations
- Creates a methodology that is **easy to replicate** annually with the provider cost report data

Direct Care Rate Update | Goals

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DODD ICF Direct Care rate methodology goals, highlighting key objective areas

GOALS	
	**Limit Financial Impact** Develop an approach that is close to cost neutral in aggregate and limits the financial impact on provider stakeholders
	**Payments Based on Provider Operational Need** Develop an approach that continues to link Direct Care per diems to providers' actual costs to deliver care
	**Reimbursement Simplicity** Target an approach that emphasizes simplicity, reducing the level of effort and administrative workload on providers required for rate updates
	**Maintain or Reduce Number of Impacted Providers** Develop a methodology that maintains or reduces the number of impacted providers to limit overall impact on provider stakeholders

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Current State

Current State| Direct Care Per Diem Illustrative Example

If a provider's cost per case mix unit is below the peer group ceiling (Ln 8 – Maximum Cost Per Cas Mix Unit), their final Direct Cost Per Diem is equal to reported allowable direct care costs plus inflation.

			Provider A (capped)	Provider B (uncapped)
1	Adjusted Direct Care Costs		$499,280	$550,000
2	Adjustments to Direct Care Costs – Calculated		0	0
3	Allowable Direct Care Costs	Ln 1 + Ln 2	$499,280	$550,000
4	Inpatient Days		1,580	2,200
5	Direct Care Per Diem	Ln 3 / Ln 4	**$316**	**$250**
6	Annual Case Mix Score (Of Last Quarter of Cost Report Period)		1.06	1.10
7	Cost Per Case Mix Unit	Ln 5 / Ln 6	$298	$227
8	Peer Group Ceiling for Current FY		$277	$277
9	Allowable Cost Per Case Mix Unit	Lower of Ln 7 or Ln 8	$277	$227
10	Direct Care Per Diem Prior to Inflation	Ln 9 * Ln 6	**$294**	**$250**
11	Inflation for Direct Care		1.06	1.06
12	Direct Care Per Diem	Ln 10 * Ln 11	$312	$266

Provider	Total Inpatient Days	Difference in Direct Care Per Diem	Total Direct Care Impact	Total % Impact on Direct Care Per Diem due to Case Mix
Provider A	1,580	-$22	-$34,760	-7%
Provider B	2,200	0	0	0%

*Values rounded

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Current State | Maximum Cost Per Case Mix Impact

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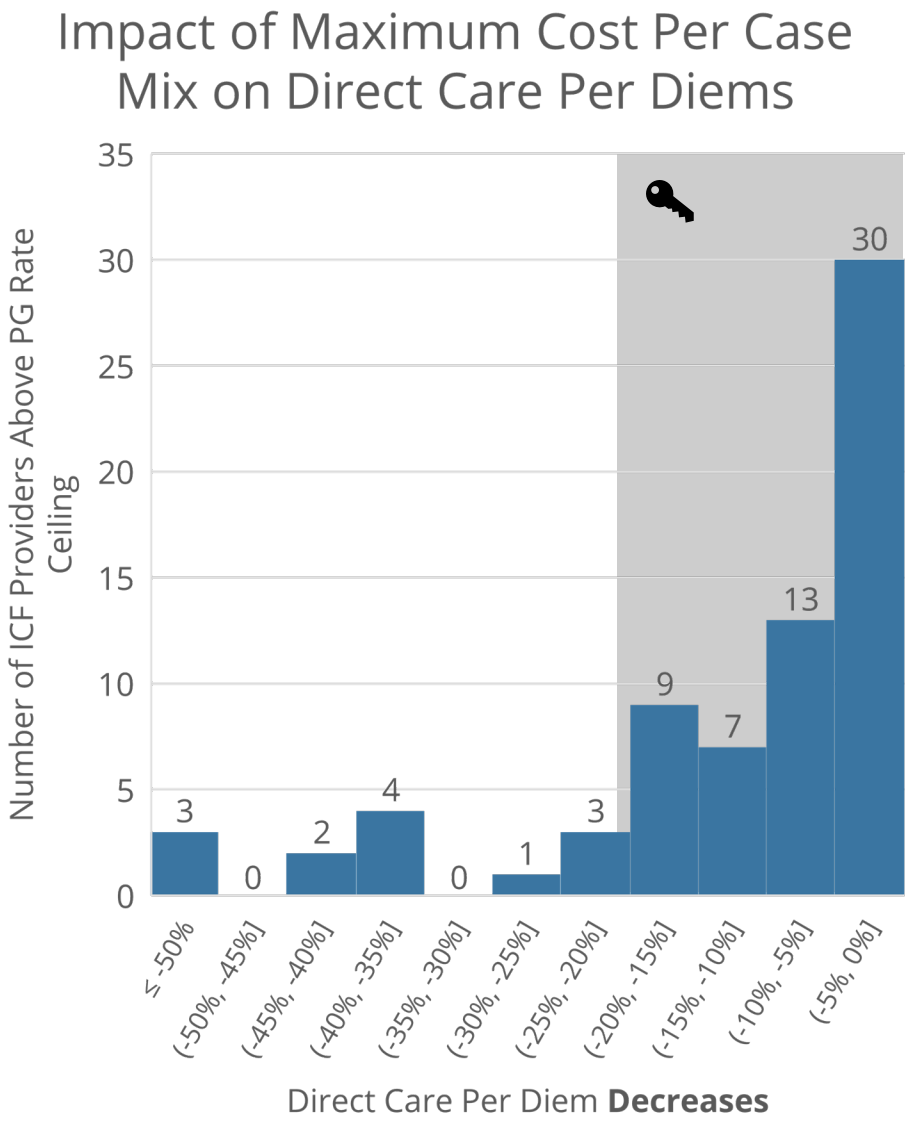
Overview of the current cost per case mix direct care rate approach and what peer groups are impacted the most and by how much

KEY DATA

- ~80% of ICF providers' **direct care per diem do not change** due to cost per case mix rate approach. Direct Cost Per Diems are **equal to reported allowable direct care costs** plus inflation
- The cost per case mix **caps ~$18M (4.15%) of total reported direct care costs**

Current Cost Per Case Mix Unit Impact by Peer Group

Peer Group	Count of Capped	Amount DC $ Capped	Average % Impact to Direct Care Per Diem
1	16	$12,425,000	11.0%
2	7	$379,000	3.9%
3	28	$2,793,000	10.2%
4	20	$2,110,000	20.3%
5	1	$79,000	14.6%
TOTAL	**72**	**$17,786,000***	**12.6%**



* Impact analysis included ICF providers that had fully completed 2023 cost reports, calculated FY25 Direct Care Per Diems, and consistent NPIs across all data sources

Shaping Reimbursement Changes

Shaping Reimbursement Changes | Scenario Testing

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Overview of the metrics and approaches that were tested when developing the alternative direct care rate methodology

BLS Wage Data

Compare **DODD ICF staff wages** to **BLS state-wide and regional wages** for similar occupations

Hours/IP Bed Day

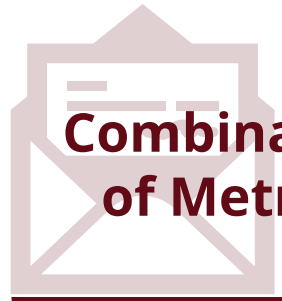
Compared provider reported **hours per IP bed day** relative to Peer Group averages

DODD Weighted Average Staff Wage (WASW)

Compared providers **average staff wage** relative to Peer Group average wages

DC Cost/IP Bed Day

Compared provider reported **Direct Care Cost / Day** relative to Peer Group averages



Combination of Metrics

Created **scenarios** using a **combination of metrics** to determine the overlap between **multiple cost drivers**

For each approach, direct care per diems are adjusted if the ICF's reported metric(s) exceed the established benchmark/threshold

Shaping Reimbursement Changes | Scenarios Scorecard

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Evaluated direct care per diem capping approaches and their alignment with project goals

Goals for Modeling Scenario				
Ceiling Metric(s)	**Limits Financial Impact**	**Payments Based on Provider Operational Need**	**Reimbursement Simplicity**	**Maintain or Reduce Number of Capped Providers**
BLS Wage Data	✓	✗	✓	✗
Hours / IP Bed Day	✗	✓	✓	✓
Weighted Average Staff Wage (WASW)	✗	✓	✓	✗
DC Cost / IP Bed Day	✓	✓	✓	✓
Combination of Metrics	✗	✓	✓	✓

Proposed Direct Care Rate Methodology

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Proposed Methodology| Direct Care Per Diem Calculation

Description and overview of the determination of direct care per diem costs under the proposed rate methodology

Direct Care

Uses total direct care per diem; compares provider direct care cost per diem to one standard deviation above the peer group average

	Total Allowable Direct Care Costs
÷	Inpatient Days
=	**Provider Direct Care Cost Per Diem**

	Average Direct Care Cost Per Diem
+	1 Standard Deviation
=	**Maximum Direct Care Cost Per Diem**

One for each Peer Group

Allowable Direct Care Cost Per Diem

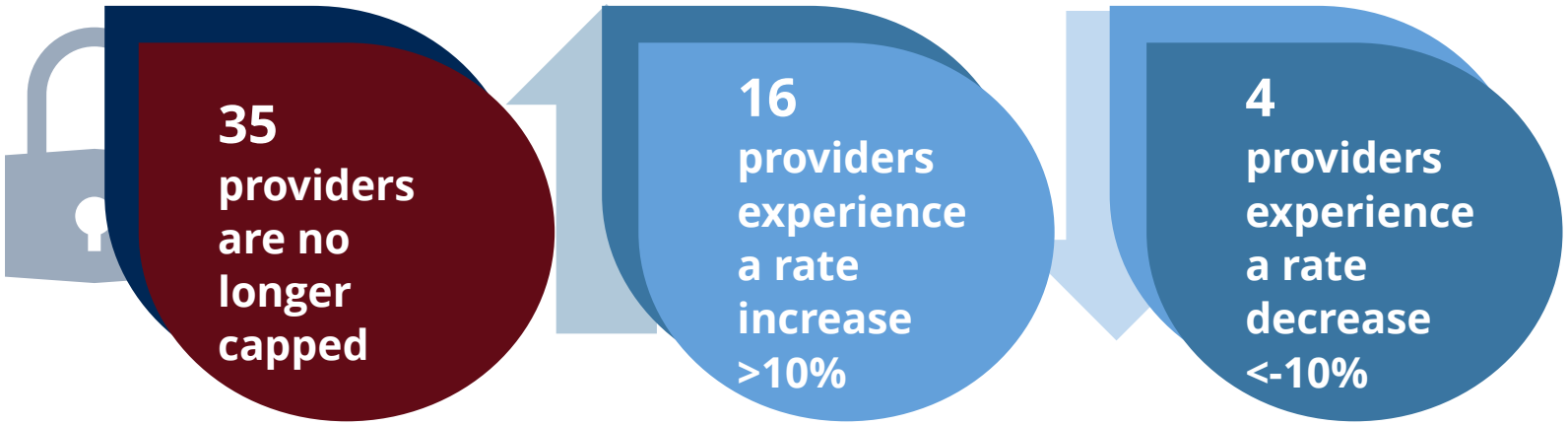
Lesser of **Provider Direct Care Cost Per Diem** and **Maximum Direct Care Cost Per Diem**

	Allowable Direct Care Cost Per Diem
×	**Inflation Factor**
=	**Provider Direct Care Per Diem**

Proposed Methodology | Maximum Direct Care Per Diem Impact

Overview of the proposed maximum direct care rate methodology and what peer groups are impacted the most and by how much

PEER GROUP	COST/DAY STD DEV	NEWLY CAPPED	STILL CAPPED	COUNT	CAPPED AMT
1	1.00	0	5	5	$8,436,000
2	1.00	3	3	6	$830,000
3	1.00	5	18	23	$2,825,000
4	1.00	10	10	20	$1,105,000
5	1.00	3	1	4	$108,000
6	1.00	0	0	0	$0
Total	**--**	**21**	**37**	**58**	**$13,304,000***



Caps 75% of previously capped dollars

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Appendix

Shaping Reimbursement Changes| Metric Summary

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Calculation summary for each of the modeled metrics

Hours Per Inpatient Bed Day = [Total Nursing and Habilitation Hours[1]] / [Total Inpatient Days[2]]

Weighted Average Staff Wages[8] = WEIGHTED AVERAGE [Total Wages Paid[3] / Total Hours Paid[4]]

Cost Per Inpatient Bed Day = [Total Reimbursable Direct Care Costs[5]] / [Total Inpatient Days]

Imputed Occupancy Percentage = MAX[Reported Occupancy %[6], Imputed Occupancy %]

% Tax, Benefits, & Staff Development of Total Costs = [Total Payroll Taxes, Fringe Benefits, and Staff Development[7]] / [Total Reimbursable Direct Care Costs]

1. Total Nursing and Habilitation Hours = Attachment 6, Line 24
2. Total Inpatient Days = Schedule A-1, Line 13
3. Total Wages Paid = Attachment 6, Lines 2 - 23
4. Total Hours Paid = Attachment 6, Lines 2 – 23
5. Total Reimbursable Direct Care Costs = Schedule B-2, Line 45
6. Reported Occupancy = Total Inpatient days divided by 365; divided by Medicaid Certified Beds
7. Total Payroll Taxes, Fringe Benefits, and Staff Development, Schedule B-2, Line 44
8. Weighted Average Staff Wage = average wage weighted on the total hours paid for each nursing and habilitation staff type