ICF ODDP Replacement Memo

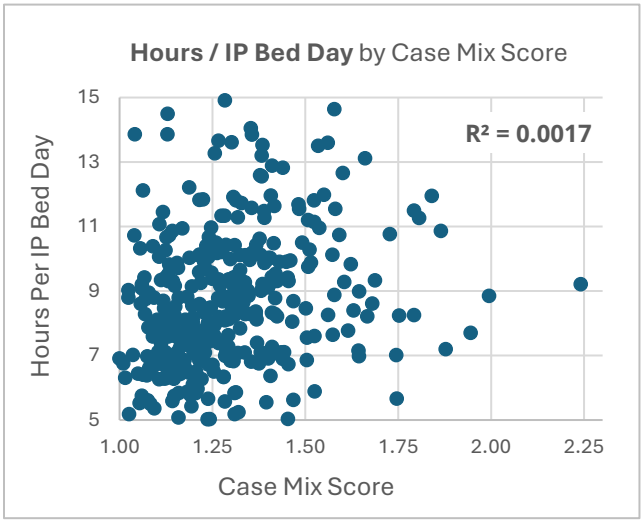
10/14/2025

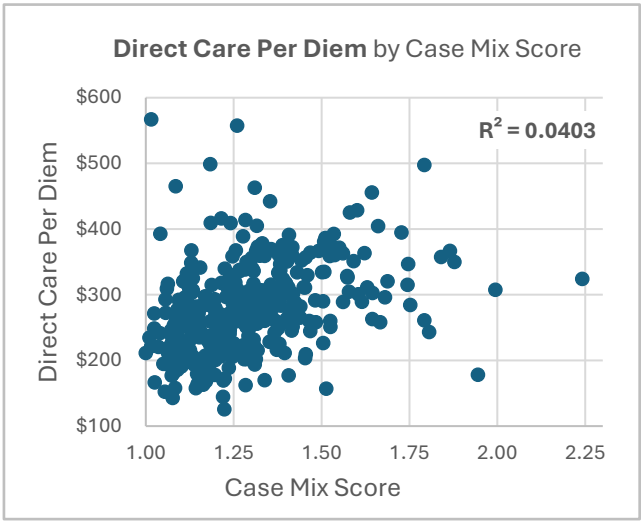
Background

For years, providers have told DODD that the ODDP does not reliably predict waiver or ICF costs, particularly what is needed to serve individuals with high behavioral needs. We initially evaluated how well the ODDP predicted costs in our waiver program and found little correlation. When we decided to choose a new acuity tool to better identify individuals' needs for waiver services, we expanded this analysis to determine if the ODDP still accurately identified acuity for ICF residents (and therefore, correlated with higher direct care hours or costs for ICFs with higher acuity case mixes.)

ODDP Case Mix Analysis

Our review of the ODDP found that the developed case mix score is no longer correlated to higher direct care service hours or higher direct care costs. For example, you would expect to see service delivery hours, and correspondingly, direct care costs, increase as the ODDP case mix scores increase. However, when analyzed, this relationship was not observed as demonstrated by the low R-squared statistical measures in the graphs below[1]. R-squared values range from 0 to 1, with 0 indicating the predictor variable (case mix score) has no linear relationship with the outcome variable (hours / costs).



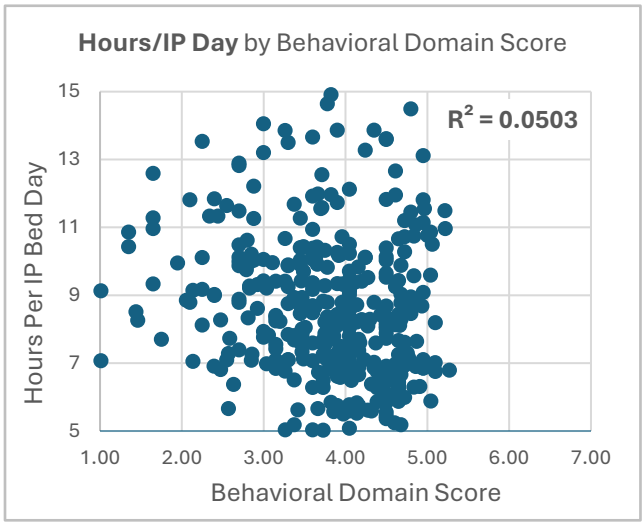


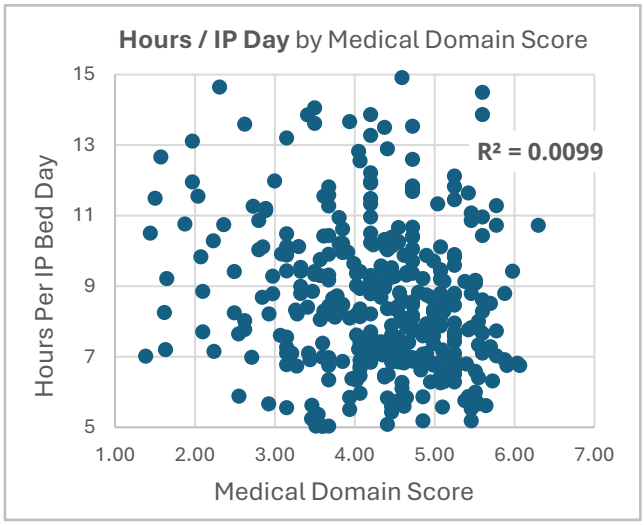
For ICF residents, the ODDP is not a good predictor of high costs associated with high behavioral acuity. Specifically, when comparing reported hours per IP bed day to ODDP

[1] Costs, hours, and ODDP case mix scores reflect cost reports and case mix scores used for SFY25 rates.

Behavioral Domain[2] scores, a clear relationship is not observed. Even within Peer Group 4 there is not a clear relationship between ODDP scores and hours/day.

Even more, when we examined the Medical Domain Score from the ODDP separately, we found that it also did not exhibit a clear relationship with the number of direct care hours per day for an ICF provider.





We analyzed the same questions based on cost and came to the same conclusion. We considered different explanations for these findings: Hours and costs were measured several different ways, for example, by excluding identified outliers, considering contracted hours and comparing different staff hours and costs. We reached onsistent conclusions each time: the case mix scores are not predictive of an individual's service needs.

An additional review of provider data reinforces these findings. The table[3] in the Appendix shows that providers within the same peer group and with nearly identical ODDP case mix scores often have substantial differences in service delivery hours per bed day and Direct Care costs. For providers with such similar characteristics and case mix scores you'd expect reported service delivery hours and costs to reflect a similar level of need, however, this is not the case. For example, the two providers in the table below demonstrate this. Provider 2 in Peer Group 1 reports more than double the hours and costs of Provider 1, despite similar case mix scores.

[2] Behavioral Domain and Medical Domain scores based on a snapshot of ODDP scores for current residents as of August 2024

[3] Provider Comparison of Direct Care Hours and Costs Among Similar Case Mix Scores

Provider	Peer Group	Case Mix Score	Direct Care Cost Per Diem	Hours Per IP Bed Day
Provider 1	1	1.2364	$188.63	4.26
Provider 2	1	1.2624	$302.80	10.17

These differences are observed throughout peer groups and continue to validate that case mix scores do not accurately reflect actual direct care hours or costs.

ICF Reimbursement Goals

The time and expense of updating the ODDP to better predict cost would be significant. It would require time and expertise to update the tool and to conduct additional time studies to validate its results. The administrative tasks and time imposed on 440 facilities to use the ODDP, when its results impact the reimbursement of only 80 of them, are also high. This is a significant amount of ongoing work, for perhaps minimal value.

In looking at alternative options, we established several goals for a replacement:

1. **Limit Financial Impact:** Develop an approach that, at a minimum, is cost neutral in aggregate and minimizes disruption for providers.
2. **Reimbursement Simplicity:** Target an approach that emphasizes simplicity to improve understanding and reduce the level of effort and administrative workload on providers.
3. **Maintain or Reduce the Number of Impacted Providers:** Develop a methodology that limits overall impact on providers.
4. **Focus on Operational Need:** Develop an approach that continues to link resulting Direct Care per diems to providers' actual costs to deliver care.

Proposed Reimbursement Approach

Before we considered a new acuity tool to cap ICF direct care costs, we developed an alternative approach based on comparing peer group direct care costs. This accomplishes the goal of recognizing and capturing the increased costs for the staff and service provided to residents with high acuity. It is by no means a disincentive to serve those residents. The use of rate ceilings to establish maximum reimbursable costs is consistent with the current methodology and necessary to control costs and operate within budget. The ceilings are established by facility peer group, based on similar operational profiles. They are established at 1 standard deviation above the peer group average, capturing >97% of total reported Direct Care costs. Moreover, fewer facilities are capped, and fewer dollars are capped under this methodology. We do not believe this incentivizes or disincentivizes any long-term behaviors as the ceilings are recalibrated annually. And while this is a departure

from our reimbursement from our waiver reimbursement path, it makes sense because ICFs complete cost reports that allow us to compare both the number of direct care hours provided at a site and the costs of those services, which waiver providers do not.

Because any changes to the reimbursement system need to be cost neutral, some providers will benefit, and some will not. We recognize this as do you. Where we differ is in your conclusion that providers serving individuals with high medical needs are disproportionately impacted.

Hence our analysis of facilities serving residents on ventilators. We all agree that these 5 facilities serve residents with high medical needs in addition to those on ventilators. We found that, when considering the add on, that the overall costs at these ICFs were reimbursed fully.

Provider Name	Total Reported Costs (Direct, Indirect, & Capital)	Proposed Capped Costs (Direct, Indirect, & Capital)[4]	Add-On Dollars[5]	Final Provider Reimbursement
Heinzerling Memorial Foundation	$16,538,080	($693,063)	$6,637,500	$22,482,517
Sunshine, Inc. Of Northwest Ohio	$14,557,983	($2,986,343)	$4,069,800	$15,641,440
St. Joseph Home Of Cincinnati	$13,211,450	($2,912863)	$4,292,100	$14,590,687
Hattie Larlham Center For Children With Disabilities	$21,853,029	$898,502	$7,057,800	$29,809,331
Stillwater Center	$23,726,191	($2,235,351)	$4,852,800	$26,343,640

Table 1: Reimbursement Analysis of Facilities Receiving Ventilator Add-On Payments

We have heard the argument that it is unfair to include the add-on in this way, and we disagree. The goal of the add-on is to more fully reimburse the costs incurred by the facility. Our analysis of all cost centers for these facilities showed that this is in fact the case under the new methodology.

We have also heard a suggestion that the Department should develop another add-on (apart from the current IBSRAO program or proposed Peer Group 6) to address any failure of the ODDP to recognize higher acuity behavioral needs for adults. The Department

[4] Positive capped amounts represent indirect care or capital amounts paid in excess of reported costs due to efficiency incentives for indirect care and/or fair rental value surplus for capital

[5] Total add-on payments represent a $900 add-on payment for facilities servicing residents on ventilators and represent the number of add-on payments processed in CY24

recognizes that some homes that serve many individuals with higher behavioral needs may have direct care costs outside one standard deviation from other ICFs in their peer groups, which is part of our reasoning for creating Peer Group 6. But continuing to build on an acuity tool that is not effectively measuring acuity does not seem like a responsible path forward.

Conclusion

We think this plan makes sense, makes our reimbursement system simpler, and will still allow ICFs to recover reasonable costs necessary to provide care for individuals with high acuity. Finally, it may be helpful to note that this decision does not preclude a transition to a new assessment tool at some point in the future should the Department and providers determine it is worth the time and expense.

Our intent is to make this transition as smooth as possible for providers. To support this, DODD is exploring the idea of providing two years of supplementary transition funding for ICF operators. This additional investment is designed to help mitigate any immediate financial impact for providers whose Direct Care costs are capped by a greater percentage compared to SFY26 rates developed with the case mix methodology. Details regarding how the transition funding would be implemented and how it may affect individual providers will be discussed further during the next ICF Reimbursement Workgroup meeting.

DODD values provider input and we appreciate your ongoing engagement throughout this process. Following our next workgroup meeting, where we'll discuss the supplementary transition funding, we'd like to understand your final position on the proposed Direct Care reimbursement changes as we look to conclude discussions on this topic by the end of October.

Appendix

Provider	Peer Group	Case Mix Score	Direct Care Cost Per Diem	Hours Per IP Bed Day
Provider 1	1	1.2364	$188.63	4.26
Provider 2	1	1.2624	$302.80	10.17
Provider 3	2	1.3769	$333.50	10.62
Provider 4	2	1.3802	$225.12	7.10
Provider 5	3	1.6804	$295.86	8.61
Provider 6	3	1.6607	$404.35	13.11
Provider 7	4	1.2876	$257.01	7.09
Provider 8	4	1.2666	$337.52	13.66
Provider 9	5	1.3383	$260.23	8.28
Provider 10	5	1.3900	$324.00	11.27

Table: Provider Comparison of Direct Care Hours and Costs Among Similar Case Mix Scores