Ohio ICF Reimbursement Methodology

Information Meetings

March 2017

PCG Health

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Agenda

- Introduction and Background
- Reimbursement Methodology
  - Direct Care
  - Indirect Care
  - Capital Costs
  - Other Protected Costs
  - Quality Incentive Program
- Timelines for Implementation
- Questions

Introduction

- The current ICF Reimbursement methodology is more than 20 years old
- In 2011 DODD took oversight of the ICF program from the Ohio Department of Medicaid
- In 2012 DODD released a White Paper on the future of the ICF program
- In recent years methodology has been “patched”
  - Incentives for Downsizing/Conversion
  - Direct Support Personnel Payment
  - Artificial adjustments to ceilings
  - “Rollback”

What We Heard

Since DODD took over administration of the ICF program, we have heard a lot from stakeholders about the methodology.

- Direct Care component and Individual Assessment Form (IAF):
  - “Trigger” system doesn’t accurately group individuals because it doesn’t take into account total needs
  - Too much volatility in scoring
  - No connection to other assessment instruments used on the waiver side
- Capital: Cost based system does not provide appropriate incentives to renovate or negotiate a favorable lease
- Peer Groups: Current distinctions by bed size is too broad
- Nothing to incentivize quality
- “Outlier” program too limited

What Has Been Done

- The ICF Reimbursement workgroup started meeting regularly in the FY14-15 biennium to discuss reimbursement related topics for ICFs on a regular basis.
  - Since October 2015 when work began in earnest on the new reimbursement methodology the group has met 11 times.
- The legislature recognized the need to modernize the ICF reimbursement methodology:
  - In House Bill 64 (FY 16-17 budget bill) the legislature required DODD to contract with a reimbursement expert to make recommendations to the ICF reimbursement methodology.
  - An RFP was issued and PCG was awarded the contract and began work in the fall of 2015
  - PCG worked closely with the ICF Reimbursement workgroup to develop and share recommendations

What Is Being Recommended

- Direct Care: Replace the IAF with the Ohio developmental disabilities profile (ODDP)
  - Replace “trigger” system with cumulative scoring
  - Allows better comparison between ICF and waiver
  - Only requires new assessment when there is a significant change in condition
- Capital: Replace Cost based system with Fair Rental Value
- Peer Groups: Expand from 3 to 5 to better align cost structures
- Introduce Quality Incentive Payment
- Expand Pediatric Ventilator Outlier program to adults

Direct Care Reimbursement

The Case for Change

Before recommending a new acuity tool, PCG wanted to see how accurately the IAF measures consumer acuity.

Findings

- Regression analysis showed a strong relationship between the adaptive and medical domains and acuity scores; weaker relationship for the behavioral domain
- The IAF captures **frequency** of activities and behaviors; but not **duration** and **complexity**
- Acuity and provider costs show a stronger relationship in larger facilities
- A facility's overall acuity scores was not a strong predictor of direct care costs
- The use of "trigger questions" potentially distorts consumer acuity needs

The Case for Change

Issues connected directly to the IAF "trigger" scoring system include:

Findings

- Scoring does not incorporate many of the acuity indicators identified in the assessment
- Scoring isn't sensitive to potential "multiplier effects" emerging with multiple adaptive needs
- The triggers do not reflect the spectrum of intensities in consumer need seen in real life
- A resident's overall movement up or down through the RAC groups isn't intuitive, continuous, or sufficiently progressive

Assessment Tool: Lessons from Other States

PCG examined how other states measure consumer acuity. Our findings included:

- There is no “gold standard” for assessment in the ICF setting
- Ohio’s Resident Acuity Classification (RAC) system is similar to acuity classification systems in other states
- There were no compelling arguments for revising Ohio’s method of acuity adjustment by facility case mix
- PCG’s analysis of acuity was focused on transitioning from the IAF to one of the two existing tools used by DODD
  - Level of Care (LOC) assessment
  - Ohio Developmental Disabilities Profile (ODDP)

Ohio Developmental Disabilities Profile (ODDP)

PCG has recommended that DODD transition from the IAF to the ODDP

- ODDP is currently in use by DODD for waiver population
- It makes sense to use a single tool between ICFs and the community setting if feasible
- Since many ICF providers also provide waiver services, there should already be some familiarity with the tool
- ODDP is a validated acuity adjustment instrument used in other states as well as Ohio
- ODDP questions are typically scored cumulatively
  - No more “triggers” which automatically move individuals into a higher grouping
  - Robust, comprehensive set of indicators

Assessment Tool Scoring

ODDP Structure

- Like the IAF, the ODDP is organized into three basic domains: 1) Adaptive Needs, 2) Maladaptive Behaviors, and 3) Medical Conditions.
- In our proposed scoring method, PCG ignored some residential and adaptive need questions relevant to the waiver setting, but not to the ICF.
- Examples of Residential Information not scored for ICF reimbursement include:
  - Individual's living arrangement
  - Home modifications
  - Needed one-time assistive or adaptive devices
  - Technological devices in patient's living arrangement

Assessment Tool Scoring

Questions and Domain Weights

- In the ODDP's original development, questions and domains were treated equally, without weighting of particular questions or domains. However, some states have chosen to weight certain domains (typically, maladaptive behavior) more heavily in scoring.
- PCG does not believe there is a reliable basis for weighting individual questions in overall scoring.
- PCG adopted a cumulative scoring methodology, with equal weight to each question in each domain.
- Based on time study results, PCG also determined that weighting the maladaptive behavioral domain generates a better fit between assessment scores and resource use indicated in the time study.

Acuity Classifications

Upon completion of the time study, individuals were assigned into new acuity classifications

- Under the IAF, placement into a RAC groups was based on score
  - “Trigger questions” could cause individuals to swing several levels, depending on specific responses
- The ODDP classifies consumers based on their individual score relative to their peers
  - Six levels of acuity, based on the percentile in which an individual’s score falls
- Using the ODDP, most facilities saw a reduction in overall case mix score
  - The time study sample average decreased from 1.66 to 1.27

Recommended Acuity Classifications

Current IAF Acuity Classifications	Recommended ODDP Acuity Classifications
RAC Group 6: Typical Adaptive Needs	**Level 6:** 25th percentile (lowest acuity)
RAC Group 5: Chronic Behaviors and Typical Adaptive Needs	**Level 5:** 26th-50th percentile
RAC Group 4: High Adaptive Needs and Non-Significant Behaviors	**Level 4:** 51st-75th percentile
RAC Group 3: Chronic Behaviors and High Adaptive Needs	**Level 3:** 76th-90th percentile
RAC Group 2: Overriding Behaviors	**Level 2**: 90th percentile
RAC Group 1: Chronic Medical	**Level 1**: 95th percentile (highest acuity)

Purpose of the Time Study

To implement a new acuity instrument, acuity scores have to be "translated" into consumer resource use. The most reliable way to do this is to correlate acuity scores with a time study of residents' use of direct care staff time.

- Time studies play an essential role in the development of reimbursement methodologies
- 100% Time Tracking is used to identify the amount of "time and activity" that program staff devote to various activities performed.
- Time study results were collected and reviewed to determine the amount of time spent across all activity categories and to ensure the development of fair and appropriate rates for ICFs
- PCG is continuing to analyze time study data to ensure validity

In short, the time study results made it possible to tie new consumer ODDP acuity scores to ICF staff activity and costs.

PCG Approach to Acuity Framework

To determine the effects of transitioning to the ODDP, PCG used the following approach.

Step 1: Develop a random sample of Ohio ICFs

- ICF providers were sampled randomly for statistical validity

Step 2: Assess acuity of consumer sample using the ODDP

- Acuity of residents in ICF sample group assessed using ODDP tool

Step 3: Conduct a time study

- PCG conducted one-time, 100% time study of direct care staff activities

Step 4: Determine how a consumer's acuity impacts direct care and resource use

- PCG examined relationship between consumer acuity and ICF resource use

Step 5: Calibrate acuity tool scoring to reflect resource use

- Establish acuity levels based on trends in acuity and resource use

Time Study Methodology

To assess the impact of transitioning to the ODDP, PCG performed a time study from August to September 2016

- 59 ICFs included in sample
- Activities tracked in 15-minute increments over a two-week period, using an online time-tracking application
- Included consumer facing and non-consumer facing activities
  - Care planning and meetings
  - Direct Care (Medical, ADL, Behavioral)
  - Administrative
  - Other (Time-off, trainings, general oversight)
- PCG “weighted” resource use based on who was performing activity
  - Medical Director: Highest wage-weight
  - Nurse Aides: Lowest wage-weight

Peer Groupings

- The current 2-group system doesn't represent differences among providers **within** the same peer group
  - Larger facilities are better able to differentiate direct and indirect costs, leading to significant reporting differences as well as economies of scale between, say, a 9-bed facility and a 36-bed facility
  - Costs for 8-bed homes are subject to less variability than smaller homes. Smaller homes are not scaled to take on costs incrementally
- PCG has recommended that DODD transition to four peer groups
  - Note: Handful of homes currently making up Peer Group 3 would become Peer Group 5

Current and Proposed Grouping Systems		
	Peer Group	**Bed Count**
Current Grouping System	Peer Group 1	9+
	Peer Group 2	4-8
Proposed Grouping System	Peer Group 1	17+
	Peer Group 2	9-16
	Peer Group 3	8
	Peer Group 4	4-7

Reimbursement Ceilings: Direct Care

With proposed changes to the way acuity is captured, reimbursement ceilings would also be affected. These ceilings are set as a percentage over a peer group's median.

- **Current Method**
  - The facility in the peer group with the **median bed days** acts as the basis by which the ceiling is set for the entire peer group
- **New Method**
  - Base the calculation on the facility with the **median Cost per Case Mix Unit (CPCMU)** within each peer group, **NOT** median bed days.
  - Establishing the median for reimbursement on median provider costs rather than bed days offers a more intuitive baseline of typical costs
  - Inclusion of four peer groups more adequately accounts for differences in cost profiles, with appropriate ceilings

Reimbursement Ceilings

- Under the current two peer group system, roughly 35% percent of facilities in both groups would hit their reimbursement ceiling
- However, based on analysis of the costs of the time study sample of facilities, fewer facilities would hit their ceiling under the new methodology
- The four different peer groupings allows for a more specific reimbursement methodology that better recognizes cost differences among facilities of various sizes
- More facilities will cover their costs, because the ceilings are more representative of their actual costs

Day Programming Recommendations

At this time, there are no substantial changes related to day programming reimbursement. However, a few items are currently being discussed

Reporting

- An additional Cost Report worksheet has been proposed that breaks out day programming costs from other residential direct costs.
- PCG recommends that this worksheet capture the following information:
  - If day programming contracted out, provide the name of each entity serving as a contractor,
  - The amount of payment per contractor, including a total and daily rate
  - The number of residents in each program.

Implementation

- **Calendar Year 2017**

Indirect Care Reimbursement

Indirect Cost Considerations

PCG has made the following recommendations regarding the indirect cost reimbursement methodology:

- Expand the current facility groupings to include four distinct peer groups based on an ICF's bed count
  - Better compensation for facilities
  - Encourages certain facilities to downsize and get a higher per diem
- Adjust percentages for setting ceilings and efficiency incentives for the proposed peer groups
  - Make reimbursement more reflective of actual costs

Indirect Cost Considerations

Issues under the current methodology

- Since larger facilities typically report higher indirect costs, their median costs are higher, translating to a higher per-diem rate
- However, the current methodology does not account for differences **within** peer groups

Median of Current Peer Group		Median Based on Bed Count	
Peer Group 1	$ 63.41	17+	$ 66.58
		9-16	$ 55.90
Peer Group 2	$ 59.67	8	$ 56.72
		4-7	$ 60.59

- As seen above, the largest facilities (17+ beds) increase the median for all of Peer Group 1
- Meanwhile, the 8-bed facilities decrease the median in Peer Group 2

Reimbursement Ceilings: Indirect Care

Since PCG is recommending that DODD transition to four peer groups with more accurate medians, the percentage used to calculate rate ceilings can be lowered

- The new Peer Group 1 (17+ beds) rate ceiling would be calculated at 3.5% over the median
  - Lower than other groups because this facility size has most stable cost profile

Current Percentages		Recommended Percentages	
	Ceiling %		Ceiling %
Peer Group 1	12.40%	**Peer Group 1**	3.5%
		Peer Group 2	7.0%
Peer Group 2	10.30%	**Peer Group 3**	7.0%
		Peer Group 4	7.0%

- All other Peer Groups (4-16 beds) rate ceilings would be calculated at 7.0% over the median
- While the percentage used to calculate rate ceilings is lower under the new methodology, the use of a more accurate baseline for calculation will likely improve reimbursement for most facilities

Efficiency Incentives: Indirect Care

Under the new methodology, the percentage above the ceiling rate to calculate efficiency incentives is lower:

- The new Peer Groups 1 - 3 efficiency incentive would be calculated at 2.5% over the ceiling rate

Current Percentages		Recommended Percentages	
	Eff. Inc.%		Eff. Inc.%
Peer Group 1	3.55%	**Peer Group 1**	2.5%
		Peer Group 2	2.5%
Peer Group 2	7.0%	**Peer Group 3**	2.5%
		Peer Group 4	5.0%

- Noting how economies of scale can also affect efficiency, PCG has recommended the smallest Peer Group (4-7 beds) have a slightly higher efficiency incentive percentage (5%)
- While efficiency incentives are lower, a facility's overall indirect cost per diem rate would be more reflective of true costs

Capital Reimbursement

Capital Reimbursement

Traditional

Reimbursement for capital costs is based on historical cost of long-term assets. Depreciation, interest expense and lease payments are reimbursed.

Fair Rental Value (FRV)

Estimates the current value of capital assets as the basis for payment of a fee for capital. Pays a simulated rent, or return on the appraise value of the facility's assets. The State essentially rents the facility from the operators for purposes of providing care to Medicaid recipients.

Key Differences

FRV reimbursement flips the trajectory of payment for capital assets when compared to a traditional depreciation method. It also differentiates real economic value from financial accounting value.

Pros and Cons of FRV

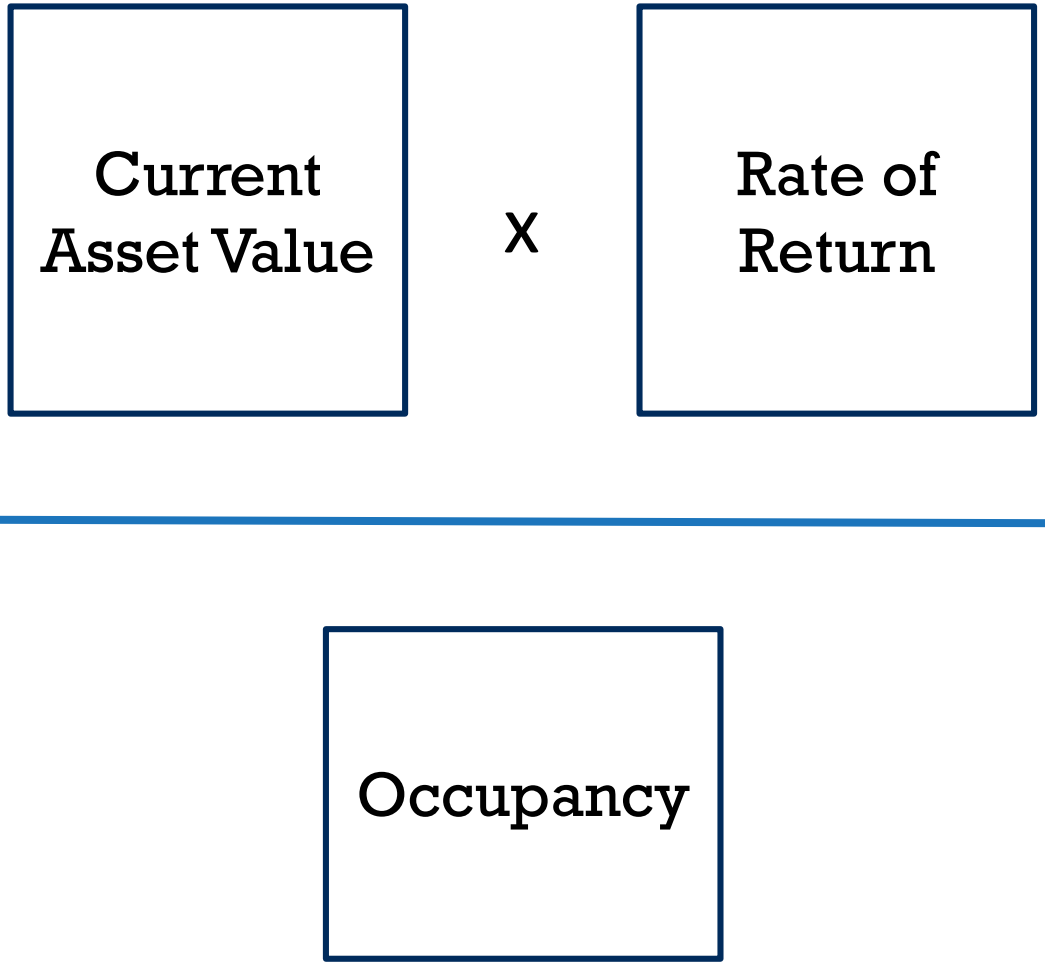
Pros

- Traditional depreciation reimbursement typically exceeds payments in the early years, but essentially turns into a negative cash flow for facility
- Accounts for increases in the value of assets
- Reduces incentives for destabilizing financial actions (i.e. refinancing) which can adversely affect quality of care
- There is flexibility for DODD to insert various controls
- Increases predictability for all parties
- Incentivizes providers to maintain facilities

Cons

- A significant effort is required to initially implement a FRV system (low level of effort after system is established)
- Requires additional data collection from providers
- Potentially more costly to the state in the long-run.

The Basic Formula



Current Asset Value (CAV)

(Total Square Footage x Value per Square Foot) + Total Equipment Value

- Square Footage
  - Data Source: Reported by facility
  - Capped between 200 and 800 feet per bed (1,000 for downsized facilities)
  - Absence of Data: Minimum square footage/bed will be applied
- Value per Square Foot
  - Data Source: RS Means Construction Cost Estimator
  - Applied by county, updated annually
- Total Equipment Value
  - $4,000 per bed for all providers
- Land Value
  - 10% of CAV will be added to account for land

Depreciation and Re-Aging

- Age Adjustment
  - Cost of renovation will be converted to an equivalent number (or fraction) of new beds for weighted age adjustment
  - Facility specific estimated bed value based on total square feet, number of licensed beds and the county specific value per square foot

  - Example:
    - Initially constructed in 1993
    - Re-Aged to 1995

Bed Value		
1,876 Total Sq Ft / 4 Licensed Beds	x $167.11	= $78,375

Project Type	Project Description	Project Year	Project Cost	New Bed Equivalent	Age (years)	Weighted Age
Replacement	Roof	1999	$ 6,286	0.08	17	1.36
Addition	Living space	2009	$15,820	0.20	7	1.41
Replacement	Specialized Tub	2011	$12,916	0.16	5	0.82
		Original Beds		3.55	23	81.72
		Total		**4.00**		**85.32**
		Effective Age			21	

Example Calculation

Assumptions:

- 10 bed facility
- Franklin County provider: RS Means Construction Cost Estimator is $165.35 per square foot
- 4,000 Total Square Feet
- Initial construction in 1990
- 1,000 square foot major renovation in 2005
- Occupancy is 95% of Total Bed Days Available

Calculation		
Total Square Feet:		4,000
Value per Square Foot:	x	$165.35
Subtotal:		$661,400
Total Equipment Value ($4,000/bed):	+	$40,000
Subtotal:		$701,400
Depreciation (1.5% per year of effective age):	0.33	($236,723)
Subtotal:		$464,677
Land Value (10% of Current Asset Value)	+	$70,140
Subtotal:		$534,817
Fair Rental Value (9% Rental Rate):		$48,134
Occupancy:	÷	3,468
Fair Rental Rate:		**$13.88**

Other Protected Costs

There will not be any changes to the way other protected costs are reimbursed under the new reimbursement methodology.

Quality Incentives

Quality Incentive Payments

PCG and the DODD Quality Incentive Workgroup have developed a program to reward high quality providers

- In the past, no firm parameters to incentivize quality beyond compliance
- Pay-for-performance or other value-based programs generally absent from the ICF setting
- Program recommendations reflect two years of discussion of most appropriate metrics for capturing quality specific to ICFs

The goal of this new program is to challenge providers to go above and beyond compliance to cater to the specific needs of their consumers with the highest quality possible.

- Participating providers will receive a “bonus” based on reported quality
- Providers will be encouraged to better monitor quality and maintain documentation through submitted reports
- Program implementation allows new dollars into the system to promote value-based reimbursement

Quality Incentive Program

The Quality Incentive Program will award a per-diem add-on to high quality providers

- Similar program implemented in the nursing home setting in Ohio
- Program tracks 13 quality indicators reported by participating providers
- Quality reporting consists of additional data submitted through annual cost reports, as well as a new provider self-score report with supporting documentation to demonstrate fulfillment of criteria
- Indicator domains include
  - Quality of Life: Community
  - Quality of Life: Participation
  - Quality of Life: Health, Wellness and Safety
  - Quality of Life: Staffing
- Providers are not required to participate and will not be penalized if they choose not to do so

Quality Incentive Scoring Method

For providers interested in participating in this program, the scoring method will consist of the following elements:

- A “point” system will be used to calculate the per diem add-on amount
- Points will be assigned a monetary value based on the number of participating providers and total funding available
  - Estimated $6-10 mil
- Based on responses, providers will be awarded points based on quality
  - Minimum 20 points to be eligible to receive add-on

This program will allow providers to better assess and track quality and be rewarded for it

Timelines for Implementation

Implementation Considerations

- DODD has opted to delay implementation of the following reimbursement components until FY2019:
  - ODDP-based acuity adjustment
  - Four Peer Groups
  - Revised Direct and Indirect Ceilings
  - Fair Rental Value Capital Reimbursement
- By postponing implementation for a year, the DODD will be able to collect ODDP data for the entire ICF population as well as all capital information required for FRV calculation.
- This will allow DODD to potentially modify the recommended methodology to address possible negative effects on providers.

Implementation Considerations

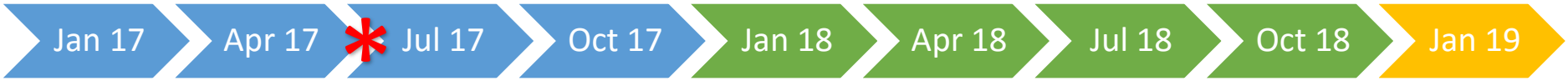
PCG and DODD understand the substantial changes to the reimbursement methodology can be concerning

Stop- Loss/ Stop Gain

- In order to ease transition, PCG has recommends a stop-loss/stop-gain mechanism that will help providers absorb losses over time without threatening the overall budget.
- In the first year of transition, FY 2019, providers would be guaranteed a decrease of no more than 3.5% of their previous year's rate.
- In the same year, providers benefiting from the new rate structure would only be allowed an increase of 3.5% of the previous year's rate.
- In the second year of transition, FY 2020, the stop-loss/stop-gain percentage would be increased to 7%.
- The third year of transition, FY 2021, would see full-implementation of the rate structure with no stop-loss/stop-gain mechanisms.

This will minimize "surprises" for providers while transitioning to the new rate structure

Implementation Timeline



Jan 2017

Employee Retention Reporting

FRV Data Reporting

Apr 2017

ODDP Assessment of All ICF Residents for Analysis

Jul 2017

Joint IAF-ODDP Assessment

Jan 2018

Cost Reporting for Day Programming

Cost Reporting for FRV Equipment Costs

Quality Incentive Reporting

Jul 2018

Four Peer Groups

ODDP Acuity System

Direct Care Methodology

Indirect Care Methodology

FRV Methodology

3.5% Stop-Loss/Stop-Gain

ODDP Assessment Only

* FY18 per diem rates will remain frozen from FY17, but providers may request a rate reconsideration for case mix score changes of 25% or more.

Implementation Timeline

Jul 2019

Quality Incentive Pay-for-Performance Begins

7% Stop-Loss/Stop-Gain

Jul 2020

Stop-Loss/Stop-Gain Ends

Full Implementation!

Questions

www.publicconsultinggroup.com