**OPRA Rate Model Feedback**

***Context***

In anticipation of DODD/Deloitte’s rate model work, we gathered a small group of OPRA board members to consider changes to the current model.

***Recommendations: Rate Model***

Using the existing HPC rate model, we offer the following adjustments and considerations[[1]](#footnote-1):

1. DSP Hourly Wage
	1. Base the hourly wage on **SOC category 31-0000** “Healthcare Support Occupations” until the new SOC for DSPs is available (2028).
	2. Beginning January 1, 2026, **use the 75th percentile** for “Healthcare Support Occupations” in the “Health Care and Social Assistance” sector. This is like the OhioRISE model which was designed to address workforce challenges.
2. Supervisor Hourly Wage
	1. Continue basing the hourly wage on **SOC 39-1020** “First-Line Supervisors of Personal Service Workers”.
	2. Beginning January 1, 2026, use the **75th percentile** for “First-Line Supervisors of Personal Service Workers” in the “Health Care and Social Assistance” sector. This is like the OhioRISE model which was designed to address workforce challenges.
3. ERE as a Pct. of Wages
	1. **No changes**. The percent in the current rate model (30%) aligns with BLS data on “Employer Costs for Employee Compensation” in the Health Care and Social Assistance Sector. We should be clear where this percentage comes from in the model.
	2. Note the “Employer Costs for Employee Compensation” used by BLS includes:
		1. Paid leave
		2. Supplemental pay (overtime, shift differentials, bonuses)
		3. Insurance
		4. Retirement and savings
		5. Legally required benefits
4. Productivity Assumptions
	1. The current model underestimates “non-billable time”.
		1. It does not factor in enough time for training given the range of professionals providing HPC (med admin, behavior support, etc.), mandatory and “best practice” training, and turnover rates (new employee training).
		2. It does not factor in enough time for “indirect” services – documentation, training on individual ISPs, staff meetings, ISP meetings, etc.
	2. We propose changing the model to reflect 1 hour of “non-billable” time/day or 260 “non-billable” hours/year and **increases the productivity factor to 1.14**. Examples of non-billable time:
		1. Two-week orientation = 80 hours
		2. Daily documentation (.5 hours/day) = 130 hours
		3. Staff meetings, team meetings, MUI investigations/conversations, etc. (.5 hours/week) = 26 hours
		4. Training on ISPs, annual CPR, med admin (new vs. renewal), behavior support, professional development (.5 hours/week) = 26 hours
		5. Travel time between clients/locations (.5 hours/day) = 130 hours
5. Administrative Overhead
	1. **No changes**.
	2. Note, the current model indicates this percentage includes training. We want to be clear this includes provider cost to conduct training, NOT the productivity “loss”/adjustment – we are including that in the productivity assumptions.

***Other Considerations***

1. Annual Adjustment
	1. The rate model should be **adjusted annually based on BLS data**.
	2. We recommend doing one of the following:
		1. Adjust annually based on the Employment Cost Index (ECI) for the previous 12 months – “Wages and salaries and benefits in private industry, 12-month percent change, Healthcare and Social Service Industry”.
		2. Adjust by rolling average of the above for the most recent 5-year period. For example, applying this historically would have meant:
			1. January 1, 2024 rate increase = 3.84%
			2. January 1, 2023 rate increase = 3.52%
			3. January 1, 2022 rate increase = 2.82%
			4. January 1, 2021 rate increase = 2.26%
			5. January 1, 2020 rate increase = 2.14%
2. Cost of Doing Business Categories[[2]](#footnote-2).

Looking at Regional Price Parity (RPP) data for regions in Ohio, it appears we could move to two cost of doing business categories rather than one – with areas of the state at or below the average RPP being in CODB A category, and areas of the state above average in CODB B. Consider:

1. CODB A: Roll current CODBs 1-4 into 4
2. CODB B: Roll current CODBs 5-8 into 8
3. Comparison to Other Rates

The adjustments to the model results in a proposed rate of **$40.41 beginning January 1, 2026**. This compares to:

* ODM Home Health Aide (as of 1/24): $38.27
* ODM Hospice – Continuous Home Care, per hour (no quality incentive, no add-on): $53.24 – $61.48
* OhioRISE – Intensive Home-Based Therapy delivered by a “Qualified Mental Health Specialist” (non-degreed) - $38.57
1. Access Rule

Ohio’s HPC service is categorized as “home-based habilitation” and is not subject to the payment adequacy provision – which applies only to homemaker, personal care, and home health aide. CMS specifically notes:

* [Habilitation services] are likelier to include at least some activities in a provider-operated facility or residential setting, which **changes the expected costs of providing and allocation of the payment for these services**.
* The comments we received **affirm our decision not to apply the HCBS payment adequacy policy we are finalizing at §441.302(k) to habilitation or other facility-based services** (in which services are delivered in a provider-operated physical location and for which facility-related costs are included in the Medicaid payment rate) due to the number of additional or variable expenses associated with facility-based services.
* Because of differences in [habilitation] services, **we do not believe we can set an appropriate minimum performance level for these services at this time**.

The only way to achieve the 80/20 provision is to drop the admin/overhead percentage to 5% - which will not “enlist [or retain] an adequate supply of providers.” It is **not feasible for providers of “home-based habilitation”** services to operate with a 5% overhead – the precise reason CMS excluded services that are “likelier to include at least some activities in a provider-operated facility or residential setting” from the provision.

1. See January 1, 2026 tab on attached Excel spreadsheet. [↑](#footnote-ref-1)
2. See “CODB” tab on attached spreadsheet. [↑](#footnote-ref-2)