

South Dakota Private Intermediate Care Facility (ICF/IID) Rate Study

Presented to:

**South Dakota Department of Human Services
Division of Developmental Disabilities**

Presented by:

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A. Executive Summary

The South Dakota Department of Human Services (DHS), Division of Developmental Disabilities (DDD) contracted with Guidehouse Inc. ("Guidehouse"), to conduct a rate review of Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and provide recommendations for rate update. Guidehouse's rate recommendations are based on a cost analysis of South Dakota's two private ICF/IID facilities, as reflected in their most recently submitted 2022 cost reports.

This report of Guidehouse's rate review and reimbursement recommendations details the process used to analyze provider costs, develop findings related to future anticipated costs, and weigh the relative merits of alternative rate methodologies. In developing recommendations for rate update, Guidehouse conducted a program review of South Dakota's private ICF/IID program as well as a cost review of submitted cost reports for each facility. The report describes in depth the components and rationale behind Guidehouse's cost analysis, as well as the inflation assumptions used to trend facility cost data forward to anticipated provider costs in State Fiscal Year (SFY) 2025, when new rates are expected to be implemented.

Table 1 below presents the rate calculation used to arrive at Guidehouse's recommended statewide State Fiscal Year (SFY) 2025 benchmark rate of \$921.31. This proposed benchmark rate reflects the higher of the two facilities' anticipated daily costs. The report discusses how each of the component expenses and trend factors were derived, as well as the justification for setting the benchmark rate at the maximum daily facility cost over other alternative approaches.

Table 1: SFY 2025 Private ICF/IID Rate Calculation

Private ICF/IID SFY 2025 Rate Calculation									
Provider	Program Costs	Support Costs	Capital Costs	Total Costs	Trend	Trend-Adjusted Costs	Medicaid Bed Days	Cost per Day	Proposed SFY 2025 Benchmark Rate
	A	B	C	$D = A + B + C$	E	$F = D * E$	G	$H = F / G$	I = Max(H)
Provider 1	\$9,203,157	\$2,282,490	\$225,516	\$11,711,163	12.0%	\$13,120,433	14,241	\$921.31	\$921.31
Provider 2	\$1,215,598	\$139,357	\$20,885	\$1,375,840	9.3%	\$1,503,880	1,753	\$857.89	

Guidehouse estimated the fiscal impact of this proposed benchmark rate by multiplying current and proposed benchmark rates by the total 15,994 bed days reported within the system. Assuming expected utilization remains on par with past utilization, implementation of the proposed benchmark rate would require approximately \$1.6 million in new spending, made up of \$658,377 in State dollars to cover the Medicaid State Share. The details of this calculation are presented in Table 2 below.

Table 2: State Fiscal Year 2025 Fiscal Impact Analysis

State Fiscal Year 2025 Fiscal Impact Analysis*						
Rate Description	Rate	Bed Days	Total Cost (Rate x Bed Days)	State Share (Total Cost x [1-58.55% FMAP])	Total Impact (Benchmark – Current)	State Impact (Benchmark – Current)
Current	\$822.00	15,994	\$13,147,068	\$5,449,460	\$1,588,364	\$658,377
Benchmark	\$921.31		\$14,735,432	\$6,107,837		

* Figures are estimates only for study purposes and do not reflect proposed DHS budget recommendations

The anticipated fiscal impact represents a roughly 12 percent increase in spending over the current reimbursement rate and largely reflects the similar 12 percent inflationary trend applied to the facility costs of Provider 1. The SFY 2025 proposed benchmark rate represents Guidehouse's recommendation only, subject to further State approval and implementation. Actual rates and required budgeting will be established based on appropriated funding from the Legislature.

B. Introduction

The South Dakota Department of Human Services (DHS), Division of Developmental Disabilities (DDD) contracted with Guidehouse Inc. (“Guidehouse”), to conduct a rate study of private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and provide recommendations for rate update. In South Dakota, an ICF/IID is defined as an institution with four (4) or more beds for individuals with intellectual/developmental disabilities that provides “active treatment” along with residential services. Active treatment includes “specialized and generic training, treatment, health services, and related services that lead to the acquisition of the behaviors necessary for the person supported to function with as much self-determination and independence as possible and to prevent regression or loss of current optimal functional status.”¹

Currently, two private ICF/IID facilities operate in South Dakota. Each facility submits annual cost reports detailing expenses incurred in operating the facility. In developing recommendations for rate update, Guidehouse conducted a program review of South Dakota’s private ICF/IID program as well as a cost review of submitted cost reports for each facility. Rate recommendations rely on projected resource needs for the two facilities based on historical expenses reported in their cost reports.

C. Cost Analysis

Data Sources

Guidehouse received the most recent cost report submissions for the active private ICF/IID facilities operating within the state. Cost reports reflect the facilities’ historical costs in State Fiscal Year (SFY) 2022 for Provider 1 and Calendar Year (CY) 2022 for Provider 2. These reports served as a basis for developing cost profiles of each facility for the purpose of the rate study. Additionally, Guidehouse utilized the Medicare Economic Index (MEI) as a metric for inflation. The MEI is developed by the federal Centers for Medicare & Medicaid Services (CMS) specifically as a measure of practice cost inflation to estimate annual changes in physician operating costs. However, the MEI frequently serves as a reliable proxy for changes in healthcare costs more generally.

Cost Analysis Methodology

Guidehouse analyzed the submitted cost reports and divided all allowable costs into three overarching cost centers: Program, Support, and Capital Costs. Program costs refer to costs associated directly with care delivery, such as the wage and benefits paid to compensate direct care staff. The support cost category covers indirect services delivered to residents, such as housekeeping and dietary services, that are needed to support the program but are not considered direct medical services. The support category also includes personnel and non-personnel related administrative expenses. Capital costs include expenses for buildings, fixtures, and equipment. A detailed description of the different types of costs assigned to each cost center is presented in Table 3.

¹ South Dakota Administrative Rule: 46:17:01:01(1).

Table 3: Private ICF/IID Cost Center Composition

Private ICF/IID Cost Centers		
Program Costs	Support Costs	Capital Costs
Direct Care Staff Wages Direct Care Staff Fringe Benefits Consulting Services Nursing Services Other Therapeutic Services	Utilities Housekeeping Laundry Food Supplies Administrative Staff Office Operating Expenses Insurance Accounting Training Hiring and Retention Costs	Buildings Equipment Property Insurance Maintenance Vehicle Purchase / Operation / Insurance

The rationale for sorting the different types of costs into distinct cost center groupings is two-fold. First, distinguishing ICF/IID costs by cost center facilitates comparison of relative costs between the two facilities while also placing these costs within a broader context of ICF/IID and other institutional operations nationally. By normalizing the expenses in each cost center into cost per bed day or a percentage of total facility costs, it becomes easier to benchmark to ICF/IID operational profiles more broadly. For instance, capital costs should be a relatively low proportion of overall costs. By grouping all capital-related costs together into a cost center, it is possible to determine whether capital spending is unusually high or low in comparison to typical practice, or whether expenses lie beyond a threshold that warrants further investigation and potential cost adjustment.

These sorts of concern lead to the second reason for distinguishing different cost centers. In the event that a cost adjustment appears necessary to promote greater efficiencies in support costs or control capital spending, adjusting rates by cost center permits interventions into the reimbursement structure while maintaining appropriate expenditures relative to each cost center. For example, if the State prioritized a targeted wage increase for direct care staff, rate increases could be modeled as an adjustment to the program cost center rather than applying a percentage increase to the overall rate. While Guidehouse used cost center breakdowns for comparison purposes, we ultimately calculated cost-informed rates based on provider-submitted costs, without further adjustment to the baseline costs.

It is also important to note that Guidehouse's cost center assignments do not necessarily follow the formats used in the South Dakota cost reports or the corresponding financials submitted by the facilities as supporting documentation. Cost center assignments reflect the judgment of Guidehouse rather than the cost categories used by providers. Cost categorization by the two providers differ from Guidehouse's assignment by cost center and sometimes also vary significantly between the two facilities.

The cost categories and expenditures reported by Provider 1 are detailed in Table 4, along with

a listing of how Guidehouse assigned reported expenses.

Table 4: Provider 1 Expenses by Cost Center

Provider 1 Cost Centers		
Cost Type	Cost Description	Cost
Program Costs	Routine Care	\$7,123,783
	Ancillary Costs	\$1,393,526
	Program Costs	\$8,517,309
Support Costs	Admin & General	\$998,185
	Housekeeping and Maintenance	\$585,155
	Dietary	\$472,271
	Cafeteria - Paid Meals	\$56,781
	Support Costs	\$2,112,392
Capital Costs	Depreciation-Buildings and Fixtures	\$185,968
	Depreciation-Equipment	\$39,548
	Capital Costs	\$225,516
Costs to Be Allocated	Employee Health and Welfare	\$855,946
	Costs to Be Allocated	\$855,946
	Total Costs	\$11,711,163

In addition to the three cost centers already identified, both facilities reported types of costs that overlap multiple cost centers. These costs, frequently personnel-related costs such as payroll taxes, unemployment insurance, and retirement benefits, impact both the program and support categories and so need to be split between them. Those costs were allocated across the program and support categories based on the relative base expenditures of each cost center. The allocation factors are shown below in Table 5. These factors represent the percentages of costs that are exclusively program or support and provide a ratio for allocation of costs that fall into more than one category.

Table 5: Derivation of Allocation Factors

Allocation Factors				
Totals by Cost Center			Percent of Total	
Provider	Program	Support	Program	Support
Provider 1	\$8,517,309	\$2,112,392	80.1%	19.9%
Provider 2	\$870,745	\$116,558	88.2%	11.8%

These ratios are used to incorporate allocated costs into the Program and Support categories, multiplying the appropriate factor by the allocated cost total for each facility. After allocating expenses that cross categories, total cost profiles emerge for each facility. Medicaid bed days, the aggregate count of days and clients that are served annually under Medicaid, were sourced from the cost reports provided. These were used to assess the cost per bed day in each facility, allowing for a standardized comparison of costs between facilities. These costs are shown below in Table 6.

Table 6: Cost Center Expense per Bed Day

Cost Center Expense per Bed Day					
Provider	Medicaid Bed Days	Program	Support	Capital	Cost per Day
Provider 1	14,241	\$646 (78.6%)	\$160 (19.5%)	\$16 (1.9%)	\$822
Provider 2	1,753	\$682 (86.9%)	\$91 (11.6%)	\$12 (1.5%)	\$785

Cost analysis by bed day indicated some significant differences in relative costs between the two facilities. Although overall costs between the providers was similar, with only a difference of \$37 per bed day, Provider 2 appeared to incur relatively higher program costs than Provider 1, with relatively lower support costs. Overall, the ratio of program and support costs for both facilities fell within expected ranges. Typically, program costs will fall between 70-90 percent of all facility expenses, with reciprocal percentages for support costs. Capital costs for both facilities were only 2 percent of total expenses. It is possible that the difference in program and support cost ratio for Provider 1 may also be an artifact of Guidehouse's cost allocation methodology, considering that this facility's costs were reported at a higher level of generality. In summary, while there is a material difference between per day support costs in the facilities, these costs were determined to be within a reasonable range and were not capped in the rate development.

Inflation

Inflation factors were derived from the Medicare Economic Index (MEI). Since each facility used a different base period for cost reporting, inflation factors were developed independently for each facility to trend costs forward from their respective base period to SFY 2025. In the case of Provider 2, CY 2022 costs were inflated by 9.3 percent. Provider 1 facility costs were trended by 12.0 percent to account for an additional six months of inflation between its SFY 2022 cost report and the new rate effective date. Annual indices and inflation factors were generated for the periods of CY 2022–SFY 2025 and SFY 2022–SFY 2025 and are shown below in Tables 7 and 8. Each annual index is averaged over the four quarter indices provided by CMS.

Table 7: Average Annual Medicare Economic Index (MEI)

Annual Index		
SFY 2022	CY 2022	SFY 2025
1.132	1.161	1.269

The inflation factor for each period is derived by dividing the index for SFY 2025 by the index from the appropriate base period. This calculation generates an inflation percentage that is multiplied by each facility's base cost, resulting in a cost trended to SFY 2025.

Table 8: Inflation Percentage

Inflation Percentage	
SFY 2022 – SFY 2025 (Provider 1)	CY 2022 – CY 2025 (Provider 2)
112.0%	109.3%

D. Rate Methodology and Recommendations

Guidehouse calculated average daily costs for each facility. It is possible to translate these costs into reimbursement rates in multiple ways. For example, costs and bed days can be aggregated and/or averaged across all facilities to yield a blended standard rate. Alternatively, unique provider rates can be established for each facility, resulting in multiple rates rather than a single, statewide rate. A third option is to set a standard, statewide rate equal to the trended costs of the most expensive facility, selecting a rate sufficient to cover the costs of all participating facilities. Guidehouse's rate calculations were designed to facilitate rate development for each of these reimbursement scenarios.

For both providers, allowable costs from each category (Program, Support, and Capital) are summed to produce a total cost. Total costs for each facility are then inflated according to the adjustment factor appropriate to the facility's respective base reporting period. These trend-adjusted total costs are then divided by each facility's Medicaid bed days to derive a separate cost per day per facility. This calculation is detailed in Table 9 below. The proposed benchmark rate of \$921.31 reflects the higher of the two facilities' daily costs.

Table 9: SFY 2025 Private ICF/IID Rate Calculation

Private ICF/IID SFY 2025 Rate Calculation									
Provider	Program Costs	Support Costs	Capital Costs	Total Costs	Trend	Trend-Adjusted Costs	Medicaid Bed Days	Cost per Day	Proposed SFY 2025 Benchmark Rate
	A	B	C	$D = A + B + C$	E	$F = D * E$	G	$H = F / G$	$I = \text{Max}(H)$
Provider 1	\$9,203,157	\$2,282,490	\$225,516	\$11,711,163	12.0%	\$13,120,433	14,241	\$921.31	\$921.31
Provider 2	\$1,215,598	\$139,357	\$20,885	\$1,375,840	9.3%	\$1,503,880	1,753	\$857.89	

In developing specific rate recommendations, Guidehouse considered the relative merits of each of the rate approaches discussed at the beginning of this section. Guidehouse first determined that a statewide blended rate based on average costs would be inappropriate for ICF/IID services and participating providers. While setting a standard rate based on average provider costs is common in Medicaid, this approach is more favorable in systems characterized by numerous participating providers and relatively invariant care needs, in which payers can

harness market competition under a standard rate to incentivize efficiency and streamline service delivery to align with reasonable cost assumptions. However, few of these sorts of conditions hold in South Dakota's private ICF/IID environment, where the two operating facilities reflect the system priority to maintain a minimum ICF/IID capacity to serve individuals in need at appropriate institutional and community levels of care. Cost assumptions for these services are based on the experience of only two facilities, without a broader baseline of typical provider cost profiles. Furthermore, institutional costs per facility can vary significantly depending on the specific, individual resource needs of facility residents. For these reasons, a blended rate approach is less likely to set a reasonable standard for payment and incentivize value in service delivery, and more likely to render reimbursement arbitrary, dividing the payment system between winners and losers that fails to cover all facility costs or account thoughtfully for differences in costs driven by resident acuity.

Guidehouse is ultimately recommending a single, statewide rate of \$921.31, established at the trended cost of the higher of the two ICF/IID facilities currently in operation. Even though an approach that establishes multiple rates per facility remains a viable option, there are several good reasons to maintain a standard rate across the system. First, this approach offers administrative benefits, insofar as a simpler rate structure facilitates easier payment processing. Second, in the specific case of Provider 2, facility costs are based on a low average census (roughly 5 residents per day) and, for this reason, are more susceptible to significant fluctuation in costs depending on individual resident needs. While its operations are less expensive based on the most recent cost report, the additional reimbursement from a standard rate provides a potential cushion against significant changes in acuity in its census. Third, a standard rate structure is the current approach used by DHS, and we do not recommend a change to the rate structure in place without a compelling reason to alter the approach. We note that while DHS has administered multiple ICF/IID rates in the past, based on costs per facility, beginning June 1, 2023, the Department moved to a standard rate of \$822 for both facilities to align with Legislative appropriated funding during the 2023 Legislative Session specific to private ICF/IID.

E. Fiscal Impact

To determine the potential fiscal impact of our proposed benchmark rates, Guidehouse compared expenditures based on current service utilization at the present \$822 rate with equivalent utilization under the benchmark rate. As a proxy for expected utilization, Guidehouse relied on the combined total Medicaid days reported by the two providers in their cost reports. The bed days for each facility, listed per facility in Table 9, sum to a total of 15,994 annual bed days, or a billed census of approximately 44 residents per day across the system.

Assuming Medicaid census and utilization in SFY 2025 remains on par with historical experience, expenditures can be calculated and compared by multiplying the 15,994 bed days by the current or benchmark rates to generate the two spending scenarios. Expenditures at the current rate equal \$13.1 million, in comparison to \$14.7 million at the benchmark rate. At the expected utilization, implementation of the benchmark rates would require approximately \$1.6 million in new spending, made up of \$658,377 in State dollars to cover the Medicaid State Share, based on South Dakota's SFY 2025 blended FMAP of 58.55 percent. The details of this calculation are presented in Table 10 below.

Table 10: State Fiscal Year 2025 Fiscal Impact Analysis

State Fiscal Year 2025 Fiscal Impact Analysis*						
Rate Description	Rate	Bed Days	Total Cost (Rate x Bed Days)	State Share (Total Cost x [1-58.55% FMAP])	Total Impact (Benchmark – Current)	State Impact (Benchmark – Current)
Current	\$822.00	15,994	\$13,147,068	\$5,449,460	\$1,588,364	\$658,377
Benchmark	\$921.31		\$14,735,432	\$6,107,837		

* Figures are estimates only for study purposes and do not reflect proposed DHS budget recommendations

The anticipated fiscal impact represents a roughly 12 percent increase in spending over the current reimbursement rate and largely reflects the similar 12 percent inflationary trend applied to the facility costs of Provider 1. The SFY 2025 proposed benchmark rate represents Guidehouse's recommendation only, subject to further State approval and implementation. Actual rates and required budgeting will be established based on appropriated funding from the Legislature.