System Modernization

Business Operations Committee

March 18, 2026

OPRA's Mission, Vision, Guiding Principles

- **Mission**: To build and serve a community of great providers.
- **Vision**: All people with intellectual and developmental disabilities who rely on supports get them from great providers.
- **Guiding Principles:**
  - Providers must be trusted to support people with developmental disabilities and run effective businesses.
  - Providers must receive sufficient funding to deliver services that meet the needs of people they support in an ever-evolving society.
  - All services across the spectrum must be recognized as valuable and vital to every person we support.

Provider Certification & Oversight

A Key to Greatness

Things to Think About

- What should different provider types need to demonstrate at entry (e.g., financial stability, staffing, infrastructure)?
- What should providers be expected to self-assess or attest to annually?
- Where do you see potential landmines, burdens, or unintended consequences?
- What would make this approach work — or not work — in practice?
- Where should we be cautious about overcorrecting or adding complexity?

Today

- Nearly 14,000 providers (most independent)
- Entry is relatively easy
- Providers largely remain once enrolled
- Oversight is spread “evenly” across everyone

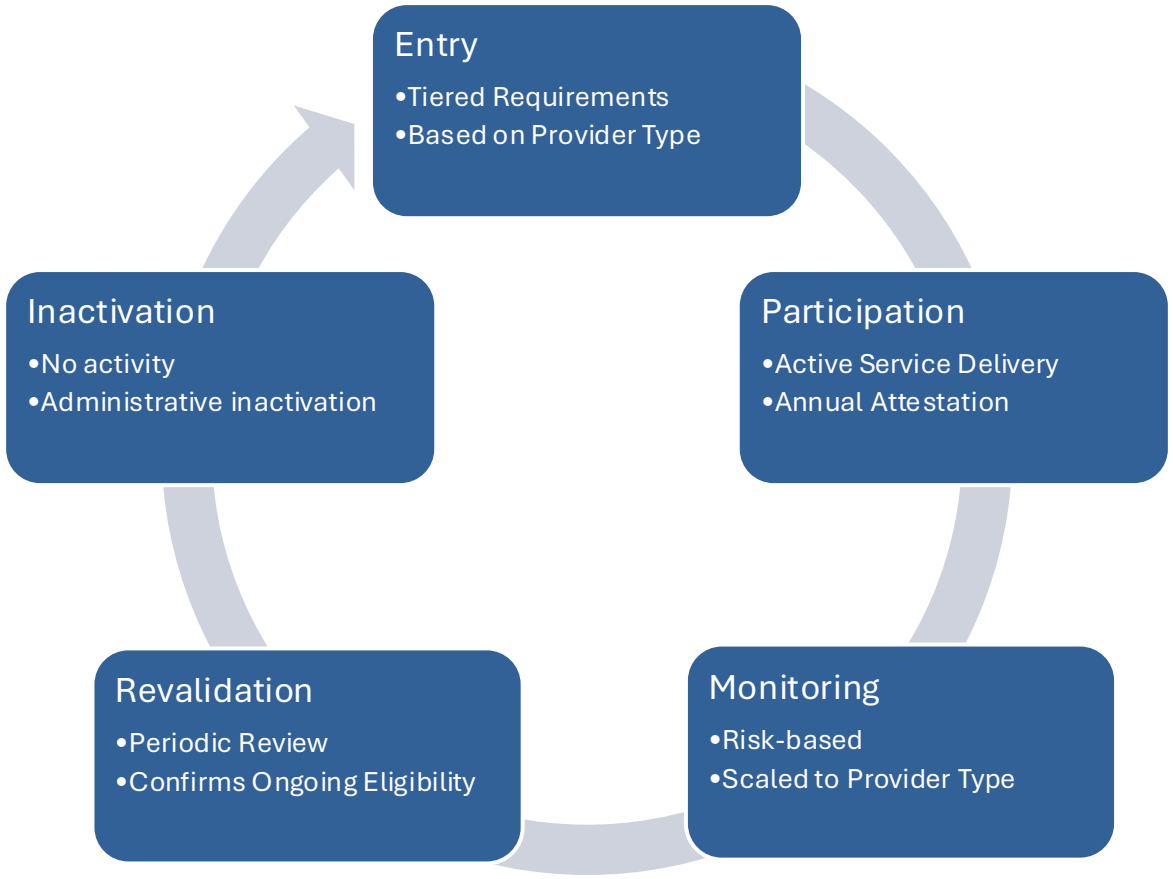
- Delays and backlogs in compliance reviews
- Limited ability to focus on higher-risk situations
- Inconsistent expectations across providers
- Strain on system capacity

The Shift

- One size fits all
- Reactive
- Point-in-time approval
- Spread thin
- Designed for access

- Structured, tiered entry
- Proactive
- Ongoing accountability
- Risk-based oversight
- Designed for quality and sustainability

The Lifecycle of a Provider



Entry

- **Baseline requirements** for all providers:
  - Background checks, Medicaid enrollment, insurance, compliance standards
- Additional requirements based on provider type:
  - **Agency providers**: financial stability, governance, workforce plan
  - **Non-agency providers**: service caps, surety bond, limited scale
  - **Independent providers**: service caps, limited to 1–2 individuals or family-based supports
- Entry tied to scope of services and level of responsibility

Proactive

- Stronger entry standards reduce risk upfront
- Identified client required for non-agency/independent providers
- Service caps prevent unstructured growth

Participation

- Certification becomes ongoing participation, not a one-time event
- Annual attestation of compliance and active service delivery
- Revalidation at defined intervals
- Providers must be actively delivering services to remain enrolled

Monitoring

- Risk-based oversight aligned with:
  - Provider type and size
  - Service volume
  - Performance history
- Reduced frequency for low-risk providers
- Targeted oversight for higher-risk situations
- Moves away from uniform review cycles

- **Lower Risk (stabilizers):**
  - National accreditation
  - Strong compliance history (few/no citations)
  - Annual self-assessment / internal quality review
  - Stable workforce and low turnover
  - Consistent service delivery and billing patterns
  - Affiliation with “hub”
- **Higher Risk (triggers):**
  - Rapid growth in size or service volume
  - New providers (early lifecycle)
  - High staff turnover or staffing instability
  - Billing anomalies or irregular patterns
  - Repeated compliance or incident concerns

Designed for Quality & Sustainability

- Higher, proportionate bar for entry and participation
- Supports strong, stable providers
- Reduces inactive and minimally active providers
- Improves use of:
  - Medicaid funding
  - Certification & compliance resources
- Aligns with workforce and operational realities
- **Raises the bar for participation — aligned with the expectation that people receive services from great providers**

The Result

- Reduce the likelihood that **underprepared or unstable organizations** enter or remain in the system.
- Deter and **mitigate fraud, waste, and abuse** through structural safeguards rather than reactive enforcement.
- Improve **accuracy and integrity** of the provider registry.
- Reduce **regulatory backlog** by directing certification and compliance resources where they are most needed.
- Reward strong, stable providers with **predictable and proportionate oversight**.
- **Strengthen public confidence** in the stewardship of both Medicaid funding and regulatory capacity.

Things to Talk About

- What should different provider types need to demonstrate at entry (e.g., financial stability, staffing, infrastructure)?
- What should providers be expected to self-assess or attest to annually?
- Where do you see potential landmines, burdens, or unintended consequences?
- What would make this approach work — or not work — in practice?
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Setting Size & Proximity

Are we asking the right questions and using the right data to make them?

Things to Think About

- Are we asking the right questions about setting size and proximity?
- Does the idea of conditional flexibility make sense in today's environment?
- Where do you see opportunities and risks in moving away from fixed limits?
- What factors should matter most in determining when flexibility is appropriate?
- What would we need to better understand before making policy changes?

Today

- Size and proximity limits apply to licensed settings (waiver and ICF)
- Do not apply in the same way to unlicensed or non-service-based living arrangements
- The standard varies based on setting type, not necessarily:
  - Individual needs
  - Preferences or choice
  - Outcomes or quality
- Does not fully account for:
  - Workforce availability and stability
  - Operational sustainability
  - The realities of delivering services today

Myth v. Reality

Myth

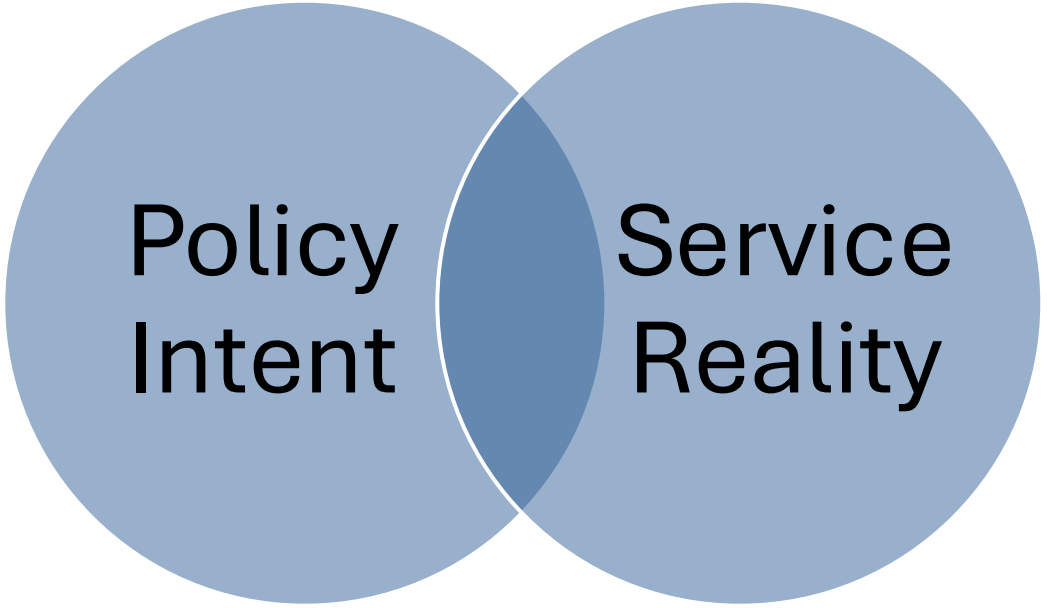
- Smaller settings naturally lead to more individualized care
- Smaller settings result in more community integration
- Limiting size ensures higher quality
- Proximity restrictions prevent institutional characteristics

Reality

- The ability to provide personalized, meaningful support depends on staffing, stability, available resources, and thoughtful service design
- Community access is driven by workforce capacity, not size alone
- Quality is influenced by leadership
- Institutional characteristics are shaped by how services are delivered, not just location

What We’re Asking

- Rather than a hard and fast number or distance:
  - What problem are size and proximity limits intended to solve today?
  - Are size and proximity the right levers to achieve that?
  - When might flexibility support better outcomes?



Data Informed Decisions

- Relationship between size and cost
- Capacity gaps (especially for specialty populations)
- Impact of proximity on staffing and stability
- Whether integration is driven by size or service design
- Trends over time

General Direction

- Not proposing blanket expansion
- Exploring flexibility under defined conditions:
  - Workforce stability
  - Demonstrated quality outcomes
  - Sustained demand
  - Specialty needs
  - Cost efficiency

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