**Questions we might anticipate in House Health:**

**Wages & Workforce**

1. You mentioned that wages increased after the last budget increase. What is the current average wage for DSPs, and how does it compare to wages in competing industries like retail, fast food, or healthcare support roles?
	* **Current average wage - Waivers**
		+ **Formally**: DODD’s Compensation survey, as of **July 2024**
			1. Average starting wage: $16.04
			2. Average wage as: $17.04
		+ **Informally**
		+ **Waivers:** Survey of a subset of our members in **February 2025**
			1. Average starting wage: $17.20
			2. Average wage w/o OT, shift diff.: $19.62
			3. Average wage with OT, shift diff: $21.30
		+ **ICF**: Surveyed our members **December 2025**
			1. 75% report a starting wage at or above $18
			2. 100% report an average wage at or above $18
	* **Competing Industries**:
		+ Target: $15-$24
		+ Walmart: $17-$24
		+ McDonalds: Up to $18 (including $3+ if you work over 25 hours/wk)
		+ **Developmental Centers: $21.63** (plus hiring bonus, shift differentials, state benefits)
2. Given the improvements in vacancy rates, do you have data on **staff retention**? Are providers still experiencing high turnover, or has stabilization occurred?
	* The rate increases have helped with filling vacancies, increased starting wages, average wages, and quality. **We are still seeing turnover – people still leave for jobs where there’s the possibility for on-going increases, not just one-time**.
	* **Formally**:
		+ **Across all industries, BLS reports a 3.4%** turnover rate.
		+ DODD’s Compensation survey, as of July 2024: Turnover rate went from 52% in 2022 to **48%** in 2023.
3. What impact have the wage increases had on the **quality of care**? Do you have any measurable outcomes beyond provider surveys?
	* With increased wages, providers have been able to hire and retain **more qualified staff**.
	* Additionally, when looking at **ICF quality data**:
		+ **100% of ICFs are participating in the quality indicator program**.
		+ The majority of ICFs are participating in and **achieving all 5 quality indicators**.
		+ We are **open to discussing similar quality indicators on the waiver** side.
4. If wages remain stagnant, what do you anticipate will happen to workforce levels over the next two years? Are we at risk of workforce shortages leading to service disruptions?
	* Wages remaining stagnant – competition with other industries.
	* Limited workforce.
	* **If we wait two years, it will take three years+ for increases to get to providers…to DSPs**
	* Risk of losing ground
	* Turnover data
5. Are there **regional disparities** in DSP wages across Ohio? Do rural areas face different challenges than urban ones?
	* Everyone is facing workforce challenges
	* Smaller workforce in rural v. urban
	* More options in urban areas
	* Rural – sometimes the largest

**Rate Increases, Budget Impact & Unfunded Mandates**

1. Why are the specific requested rate increases (**3.4% in 2026 and 2.3% in 2027**) necessary? How were those figures determined?
	* What **we need is the ongoing is mechanism**.
	* These are the **stop gap**.
	* **Based on CPI until DODD establishes the methodology**.
2. What would happen if these rate increases are not approved? Would providers have to cut services, reduce staff, or take other measures?
	* Where we were in 2022 or 2023 – **it wouldn’t take us long to get back there**.
	* Lower quality, higher turnover, reduced services
3. What **unfunded mandates** are providers currently absorbing? Are there state or federal regulations adding costs without funding to support them?
	* **Overtime** is a great example…there’s not reimbursement for OT.
	* Compliance **costs evolve over time, but rates don’t evolve**.
	* How rates are constructed – the **rate model is outdated**.
	* **Admin component of rate** model doesn’t fully factor:
		+ Overtime
		+ Employer mandate – EREs, insurance.
		+ Liability insurance
		+ Training
		+ Equipment
4. What is the total projected cost to the state of these increases? How does this compare to the cost of **inaction** (e.g., increased emergency placements, hospitalizations, institutionalization, or families leaving the workforce due to lack of services)?
	* **Total = $61.9M**
	* **$23 million in 2026 (State Share)**
	* **$38.9 million in 2027 (State Share)**
	* Let’s compare that to the **cost of person on vent – cost of hospitalization - $5000/day – expense to Medicaid program.**
5. **Where is the waste?** Are there inefficiencies in how funding is allocated, rules that require unnecessary administrative burdens, or outdated requirements that drive up costs without improving outcomes?
	* Fresh look to answer thoroughly.
	* Costs related to **compliance** and **billing**:
		+ **Plans of Correction** when you’ve already fixed an issue
		+ Billing in 15-minute units **when daily rate is available**
		+ **Hiring staff just to keep up with rules**

**Administrative Simplification & Long-Term Sustainability**

1. Are there opportunities for **administrative simplification** that could reduce costs and ease the burden on providers? Could any reporting requirements, compliance processes, or assessments be streamlined without sacrificing accountability?
	* **Assessments** – six assessments to get to services.
	* Revisions, **rebilling** – if they don’t bill to penny.
	* **Appeals, plans of correction**.
2. Can you elaborate on your proposal for a **mechanism for ongoing increases**? How would this differ from the current budgeting process?
	* Stability, predictability, consistency
	* Based on **data**
	* Method **based on costs**, not inflation
	* Sensitive to **not commit future legislature** – ease the fears
3. What role should **DODD** play in ensuring stable funding and avoiding future crises? Should Ohio explore alternative funding models to make provider rates more predictable?
	* **DODD should play leading role**
	* **Proactive**
	* **Based on data**
	* **In partnership with stakeholders**
4. Have providers been able to make long-term investments (e.g., training, technology, career pathways) with the previous funding increases, or have they been mostly used for **wage stabilization**?
	* **Yes**, we have stories from providers who have been able to:
		+ Offer **retirement benefits** for the first time or increase employer match;
		+ Increase employer share of **health insurance**
		+ Give **bonuses**
		+ Invest in **training** that leads to improved quality.

**Other Financial Considerations**

1. How do **waiver rates compare to the actual cost** of service delivery? Are providers operating at a loss, breaking even, or able to reinvest in quality improvements?
	* **If they do more than “break even” it’s frowned upon – they want to be able to reinvest in quality.**
	* Many operate at a loss and rely on lines of credit or fundraising.
	* If you can raise money you survive.
2. Are providers seeing increased costs due to **inflation, insurance, or compliance burdens** that are not accounted for in current rate-setting?
	* Yes, **current rate model is outdated and does not account** for things like:
		+ Employer mandate – EREs, insurance.
		+ Liability insurance
		+ Training
		+ Equipment
3. You mentioned that the Governor’s budget **fills the gap left by ARPA funds** but does not include new increases. Can you clarify how **ARPA funds were used** and why additional funding is still needed?
	* Throughout the HB33 discussions, DODD and stakeholders were clear ARPA funds would be used in part to support the wage increases.
	* They also committed to continuing those increases with GRF, and we are thankful to see those continued.
	* In the case, **continuation means flat-funding**. To continue **to increase DSP wages, additional funding is need**.

**WILD CARD…What if Medicaid is cut…**

1. As a coalition, **we are working at the federal level** to make sure Congress understands the importance of Medicaid to people with disabilities, their families, and the providers who support them.
2. We do believe that, because of the **employer mandate**, if Medicaid expansion in Ohio ends, it will have an impact on provider costs.