Modernizing Ohio's Developmental Disabilities System

OPRA Policy Committee

July 28, 2025

Ohio Provider Resource Association

Our Goal

- To begin shaping a **clear, compelling modernization proposal** that can be presented to the next Governor's administration in early 2027.
- This plan will **balance bold system reform with practical strategies** for implementation – grounded in data, driven by outcomes, and designed to improve the lives of people with disabilities and those who support them.

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Problems We're Trying to Solve

- The **system is growing rapidly** — both in population and cost — and is on an unsustainable trajectory without reform.
- **Workforce shortages** make it impossible to expand services under the current structure.
- Local and state spending are increasing but **not always aligned with core functions or strategic goals**.
- **Oversight and administrative duplication drive up costs** with little added value.
- **Provider network is fragmented**, with variable quality and limited capacity for specialized needs.
- **Compliance with federal regs**: conflict free case-management and cost neutrality.

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Before We Dive In…

- Drop your questions in the chat. We'll answer what we can as we go.
- Looking at data tends to make you want *more* data. For today, we're trying to stay high level and focus on what **policymakers are likely to see**.
- You'll have time to reflect, react, and talk in breakout rooms. This will not be your only chance to weigh in.
- It's possible you'll catch a number that looks off. We did our best to clean and verify, and…this isn't perfect.
- We could have looked at dozens of data points. We chose the ones that matter most to decision-makers and align with the **priorities we've been working on together**.

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State of State

- Medicaid: Federal, State, Acute Care

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Current Medicaid Climate

- **Medicaid is now the largest payer in many state budgets**
  - Over **28% of total state spending** is Medicaid (state + federal dollars), often **outpacing education and transportation combined**.
  - **Medicaid is growing faster than most other state-funded programs**
  - Nationally, **Medicaid spending has grown ~6–8% annually**, driven by enrollment, aging populations, and increased service use.
- **Nationally, Home and Community-Based Services (HCBS)** are the fastest growing part of Medicaid
  - HCBS now makes up **more than 60% of long-term services and supports (LTSS)** spending, up from less than 20% two decades ago.
  - **Federal scrutiny is increasing** around **cost, access, and oversight**
  - CMS is tightening requirements related to **quality, compliance, and conflict-free case management** in HCBS programs.
  - **Cost neutrality requirements** are under more pressure
  - States must still demonstrate HCBS waivers are less costly than institutional care, but waiver **per-person costs are rising** in many states.
- **Ohio's own Medicaid budget has more than doubled** over the last decade
  - The program now represents over **$35 billion**, with HCBS waiver spending and managed care growth as key drivers.

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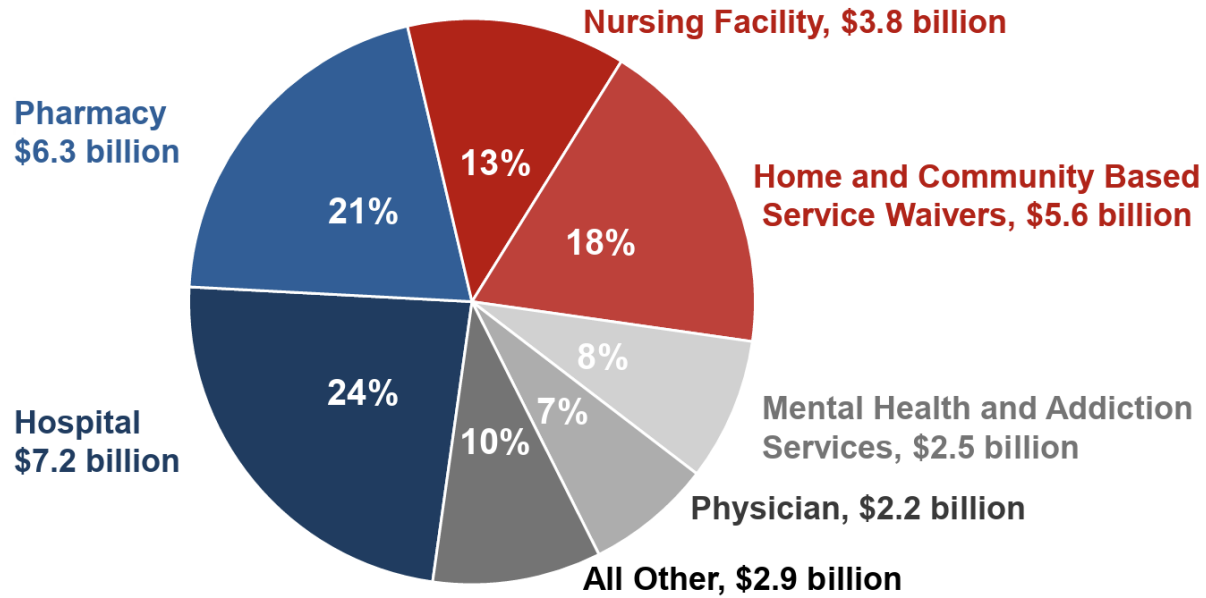
Ohio Medicaid Spending

Hospitals, drugs, and long-term care providers account for 76 percent of Ohio Medicaid spending (in 2024)



Source: Medicaid Caseload and Expenditure Forecast Report, Medicaid Expenditures by Provider Type, CY 2022-2024 (page 15), Ohio Office of Budget and Management (February 3, 2025).
Other includes intermediate care facility, durable medical equipment, dental, hospice, renal, ambulance, ambulatory surgery center, Medicaid schools program, wheelchair van, vision.

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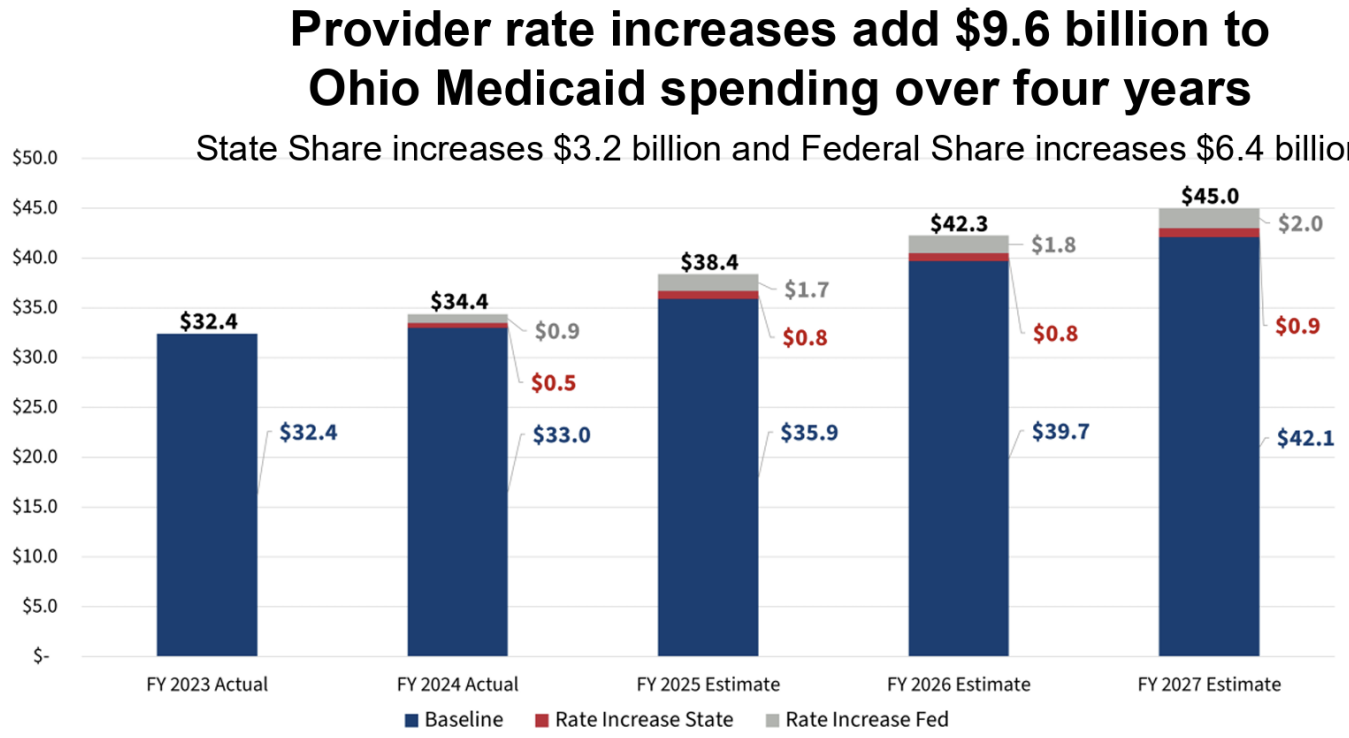
Source: JMOC Testimony of Greg Moody March 2025

Ohio Rate Increases



H.B. 96 includes $1.7 billion in state share for provider rate increases

Source: Ohio House Medicaid Committee Testimony, Director Kimberly Murnieks, Ohio Office of Budget and Management (February 11, 2025).

Source: JMOC Testimony of Greg Moody March 2025

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Managed Care: Acute Care Services

	ABD FFS	ABD Managed Care	ABD MyCare
Total Enrolled	157,618	197,480	141,687
Total Cost	579,717,876	246,997,670	301,706,439
PMPM	NA	$1,250	$2,129
Avg Per Member	$3,678	NA	NA
Difference		98.5% less	53.3% less
Total if FFS compares to ABD in MyCare	$335,568,722		
Potential monthly savings to Medicaid program	$244,149,154		
Potential annual savings to Medicaid program	**$2.9B**	This is 10% of Medicaid's current budget	

State of State

- Long Term Services & Supports: Ohio Data & Medicaid Policy

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Cost Drivers

- **Growing population** — more people entering services, earlier and living longer
- **Workforce shortages** — driving up recruitment, training, and overtime costs
- **Rising acuity** — increasing support needs, medical complexity, and behavioral health
- **Per-person waiver costs are increasing**, not just total enrollment
- **Local match policies** — expanding waiver use without systemic cost containment
- **Fragmentation** — thousands of providers, duplication of oversight, and inefficiencies

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Medicaid Policy: Conflict Free CM

In the context of **1915(c) waivers** and **Targeted Case Management (TCM)**, **conflict-free case management** means separating key roles in the service system to prevent conflicts of interest.

Specifically, **the same entity should not**:

- **Determine eligibility**, and
- **Provide case management or deliver services**

Figure 14. Conflict of Interest Crosswalk

Chart developed under New Editions contract for CMS

Conflict of Interest Crosswalk	TCM	1915(c)	1915(i)	1115
Regulation	Section 1915(g) of the Social Security Act	Section 1915(c) of the Social Security Act	Section 1915(i) of the Social Security Act – especially 1915(i)(1)(E)	Section 1115 of the Social Security Act
Applicable rule COI citation	COI: §441.301(c)(1)(vi)	42 CFR §441.300-365 COI: §441.301(c)(1)(vi)	42 CFR §441.710 COI: 42 CFR §441.730(b)	Overall: 42 CFR §431.400-428 Nothing specific to COI
Other technical guidance	CMS HCB training series	Technical Guide CMS HCB training series	CMS HCB training series	
Must eligibility determination be independent of case management?	Yes, when provided to individuals receiving HCBS under 1915(c) or (i)	Yes	Yes	See requirements of authority in which service(s) originated
Must case management be independent from assessment?	Yes, when provided to individuals receiving HCBS under 1915 (i)	No	Yes	CMS guidance indicates case management for HCBS under a 1115 waiver is subject to COI rules[65]
Must case management be independent from service provision?	Yes, when provided to individuals receiving HCBS under 1915(c) or (i)	Yes, unless only willing and qualified provider option approved by CMS	Yes, unless only willing and qualified provider option approved by CMS	CMS guidance indicates case management for HCBS under a 1115 waiver is subject to COI rules
Requirement for only willing and qualified provider?	Yes, when provided to individuals receiving HCBS under 1915(c) or (i)	Yes	Yes	Must be in accordance with CMS approval of 1115 waiver terms and conditions

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Medicaid Policy: Cost Neutrality

- Ohio's HCBS waiver costs have steadily increased and now exceed the average costs of institutional care — a direct violation of the federal cost neutrality requirement.
  - **Federal rule:** States must ensure average per-person waiver costs do not exceed institutional (ICF) costs to maintain CMS approval.
  - **Ohio trend:** Since ~2022, per-person waiver costs have surpassed median ICF costs — breaching federal cost neutrality for the first time.
  - **Waiver growth is accelerating** faster than ICF costs, driven by rising acuity, service intensity, and unchecked local match expansion.
  - **Policy urgency:** Without intervention, Ohio risks **federal scrutiny**, possible waiver restrictions, or required system-wide corrective action.

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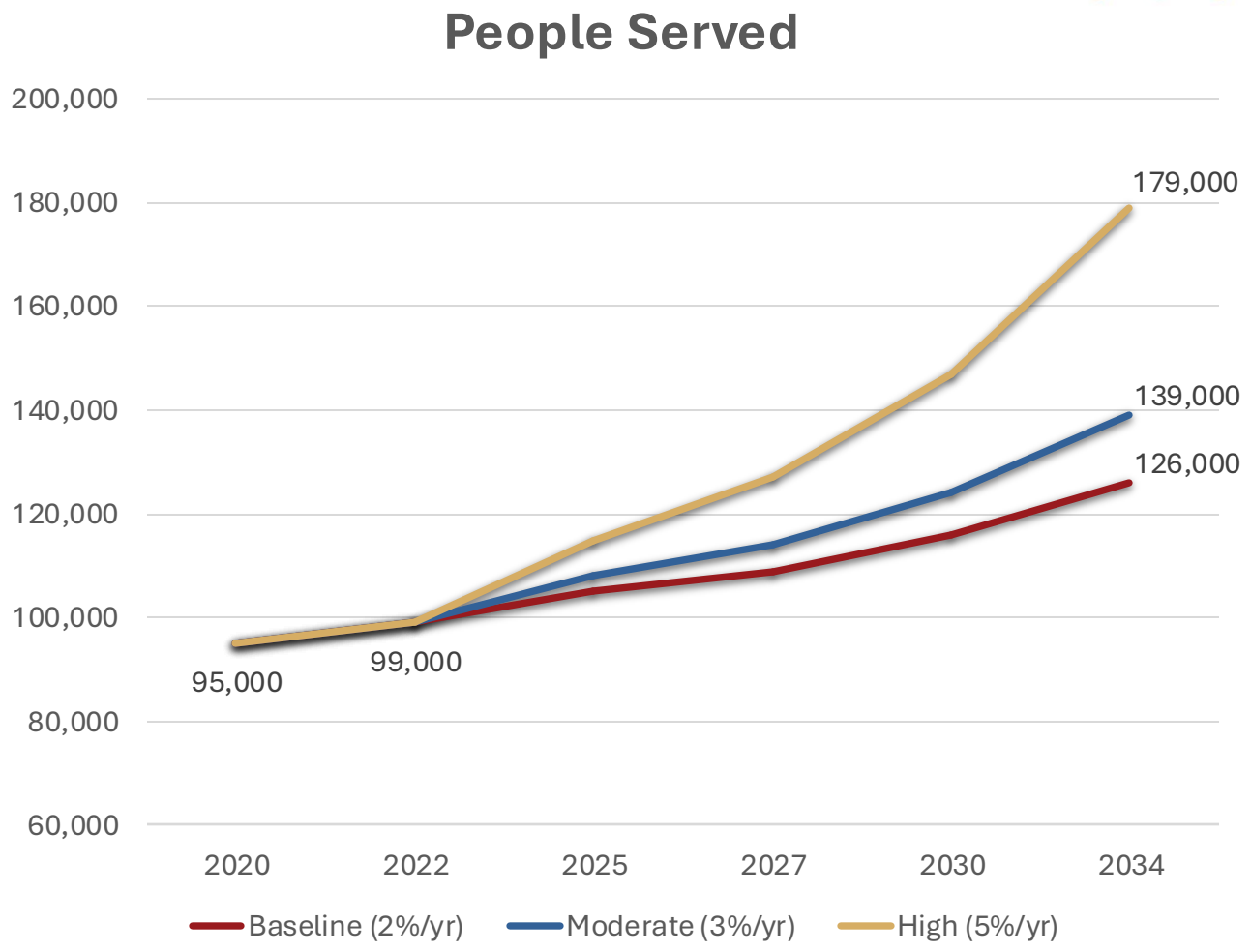
Growing Demand

System size could grow by 30%–85% over the next decade depending on policy response.

- **Baseline growth alone adds tens of thousands** of people to the system.
- **High-growth scenario** driven by medical complexity, autism, co-occurring BH/IDD, and improved longevity.
- This will likely **double demand on a workforce**.



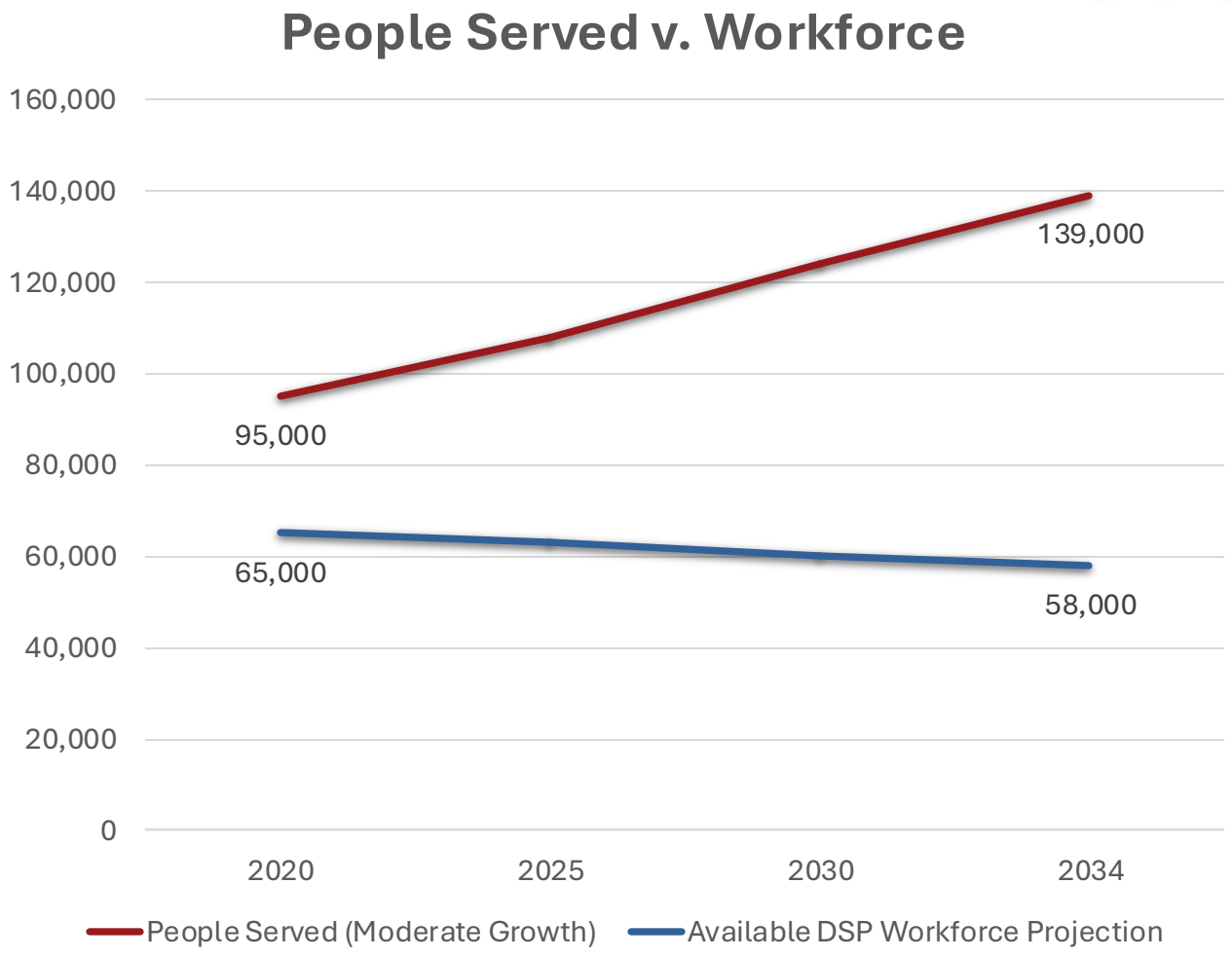
Data Source: DODD Data Portal + OPRA Projections

Shrinking Workforce

Demand for services is projected to grow 30–40% over the next decade as more people enter services earlier and live longer.

Workforce supply remains flat or declines, driven by:

- Retirements from an aging workforce
- High turnover and vacancy rates
- Declining labor force participation in direct care sectors
- **Current projections show a gap of 20,000+ DSPs by 2034** without targeted intervention.

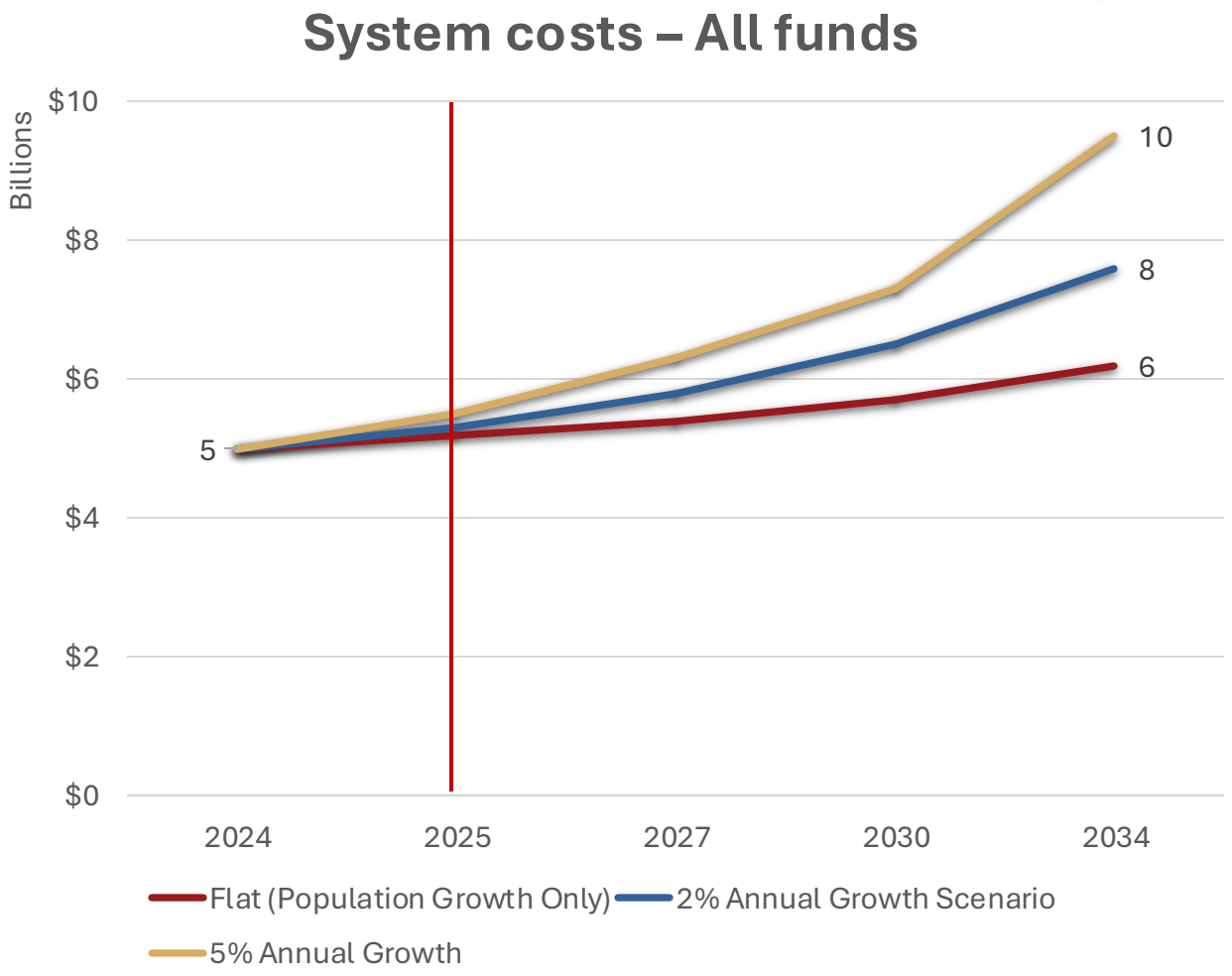


Data Source: DODD Data Portal + OPRA Projections

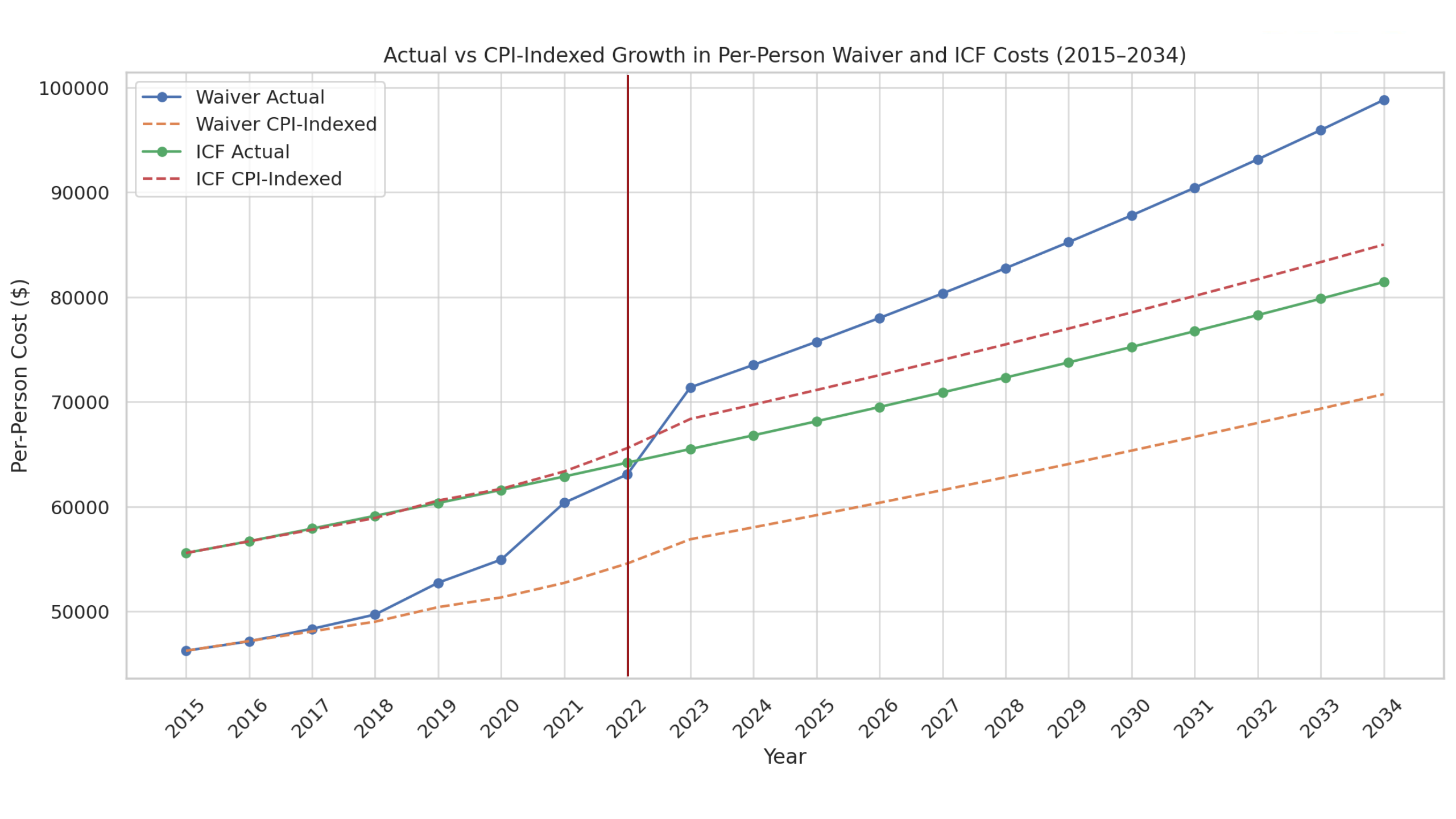
Spending Projections

Ohio's DD system spending could rise to $6–10 billion annually by 2034 without reform—driven by growth in population, acuity, and costs.

- Even with no inflation, **population growth alone drives spending up 25%.**
- With **normal health cost growth (2–5%), spending could double by 2034**.
- Without reform, local match obligations and state budgets will face unsustainable pressures.

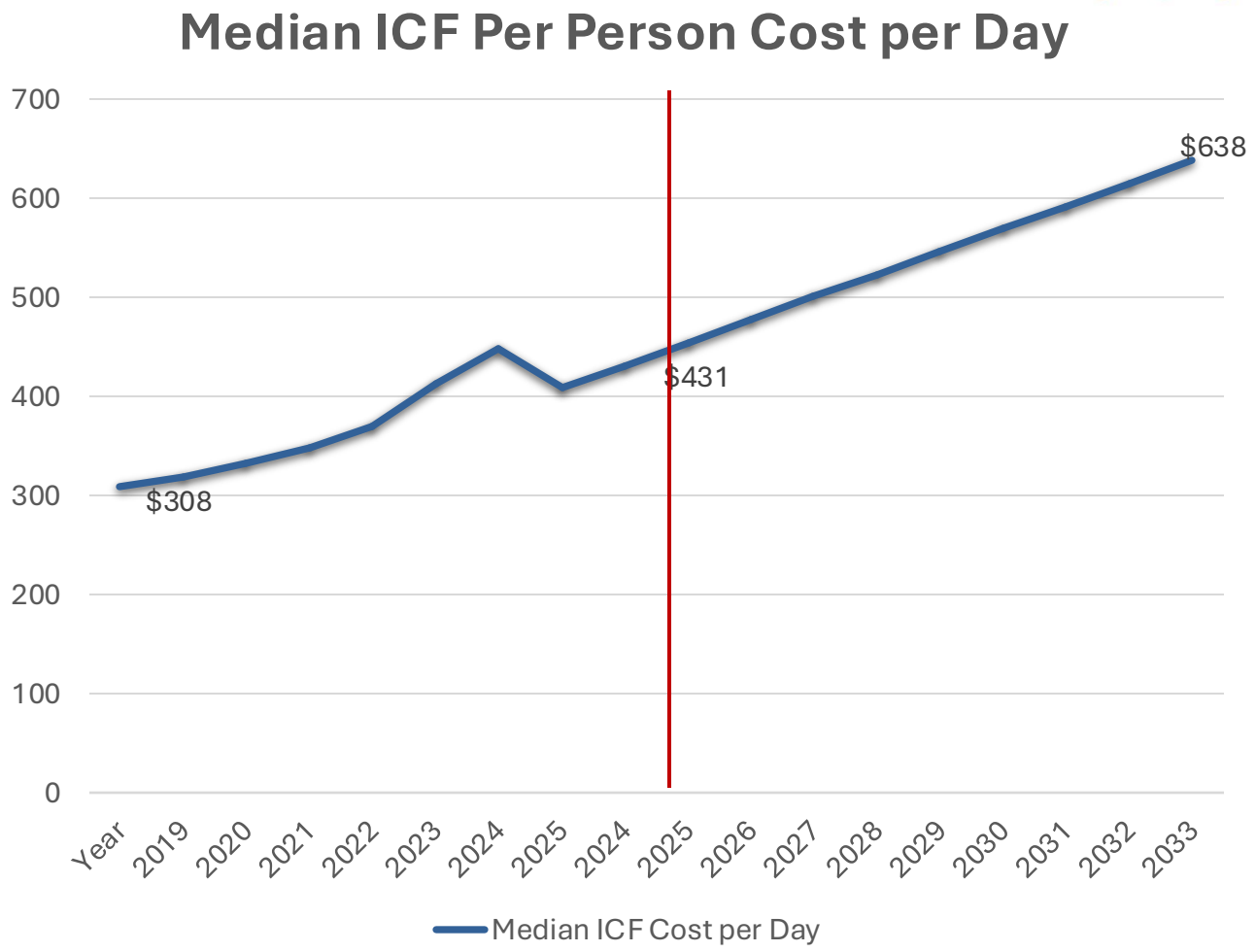


Data Source: DODD + OPRA Projections


Actual vs CPI-Indexed Growth in Per-Person Waiver and ICF Costs (2015–2034)
Waiver Actual
Waiver CPI-Indexed
ICF Actual
ICF CPI-Indexed
Per-Person Cost ($)
100000
90000
80000
70000
60000
50000
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
Year

ICF Growth

- **Direct care costs are driving growth, not admin.** Spending increases align with acuity and staffing needs, not inefficiencies.
- **Smaller ICFs cost more per person.** Community-based homes have higher staffing and capital costs per individual.
- **Capital investment is falling behind**.
- **ICF costs are stable compared to waiver growth.** ICF spending is growing slowly and predictably, unlike the waiver system.



Data Source: ICF Cost Report Data

Top Five Categories of ICF Growth

Category	% Growth (2019-2025)
Purchased Nursing	969%
Direct Care Therapies	150%
Medical Supplies	119%
Non-Reimbursable	58%
Admin & General	55%

Data Source: ICF Cost Report Data

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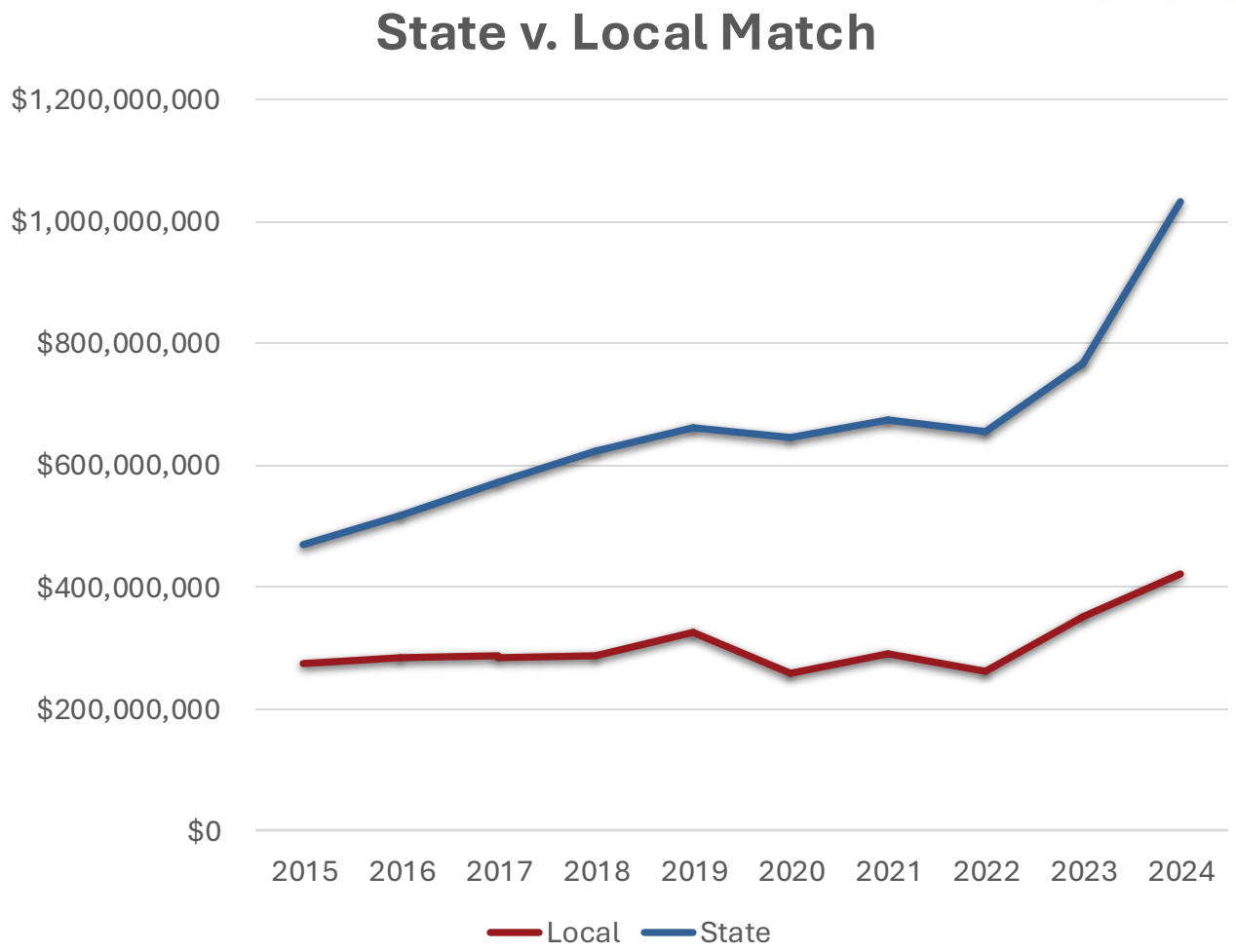
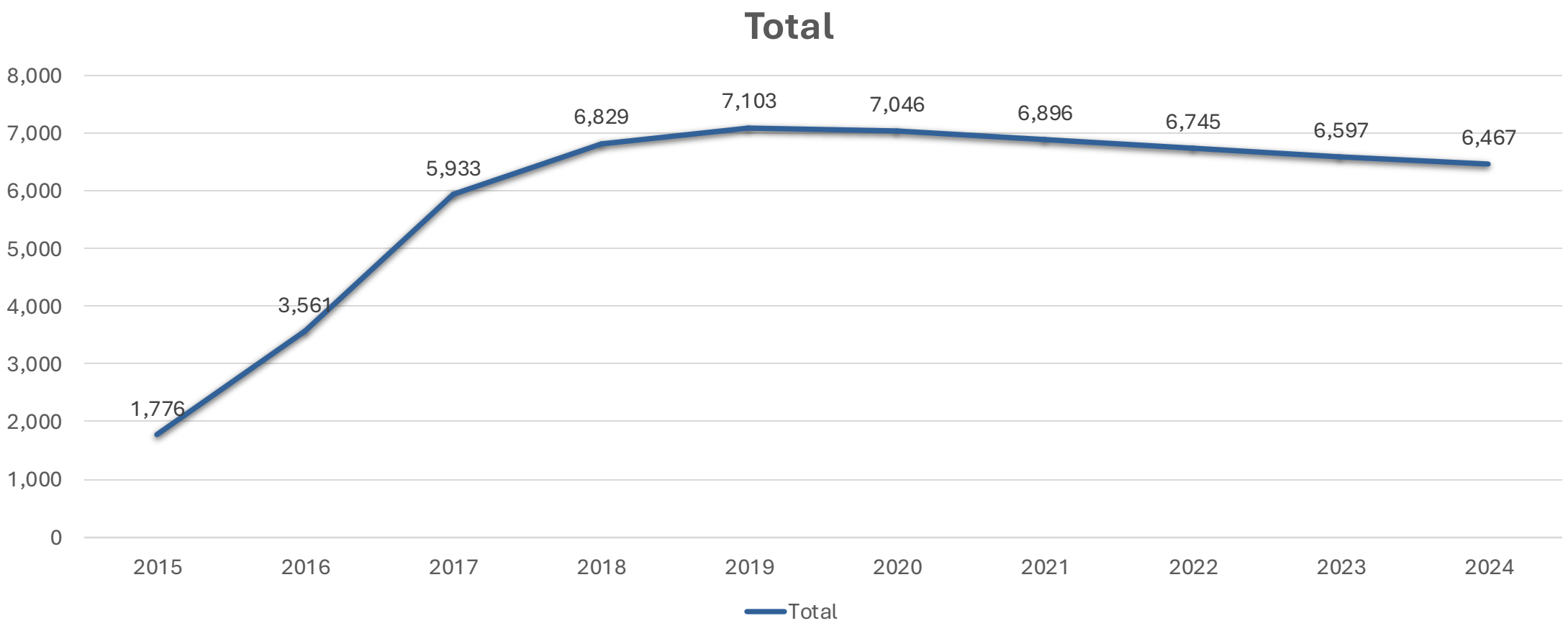
Waiver Growth

- **State (GRF) match has increased by 122%** — from $225M in 2015 to $500M in 2024.
- **Local match has increased by just 34.5%** — from $275M in 2015 to $370M in 2024.
- **The state is shouldering a much larger share of the increase in waiver costs**—while local contributions have grown only modestly.
- Waiver enrollment has increased only modestly over the same time.
- Much of the cost growth appears to be driven by **rising per-person waiver costs**, not just population increases.



Data Source: DODD provided

State Funded Waivers



Data Source: DODD provided

State Funded Waiver Growth

Overall Growth (2015–2024):

- Total state-funded waivers increased from **1,776 in 2015** to **6,467 in 2024**
- That's an increase of **4,691 waivers** — a **264% growth** over the 10-year period
- The biggest growth is in **State Assisted IO** (SAIO) – which accounts for over 40% of total increase.
- **Exit waivers** have also grown significantly.

State-funded/assisted waivers are only part of the state's funding for HCBS. DODD also allocates funds to county boards to offset their obligations.

- **SAIO**
  - First year: 2015 (6 waivers)
  - 2024: 2,023 waivers
  - Growth: **+2,017 waivers** (**+33,617%**)
- **ICF/IID Exit**
  - First year: 2016 (19 waivers)
  - 2024: 1,155 waivers
  - Growth: **+1,136 waivers** (**+5,979%**)
- **SELF Waiting List Reduction**
  - First year: 2016 (85 waivers)
  - 2024: 606 waivers
  - Growth: **+521 waivers** (**+613%**)
- **Regular Waiting List Reduction**
  - First year: 2016 (131 waivers)
  - 2024: 516 waivers
  - Growth: **+385 waivers** (**+294%**)

Data Source: DODD provided

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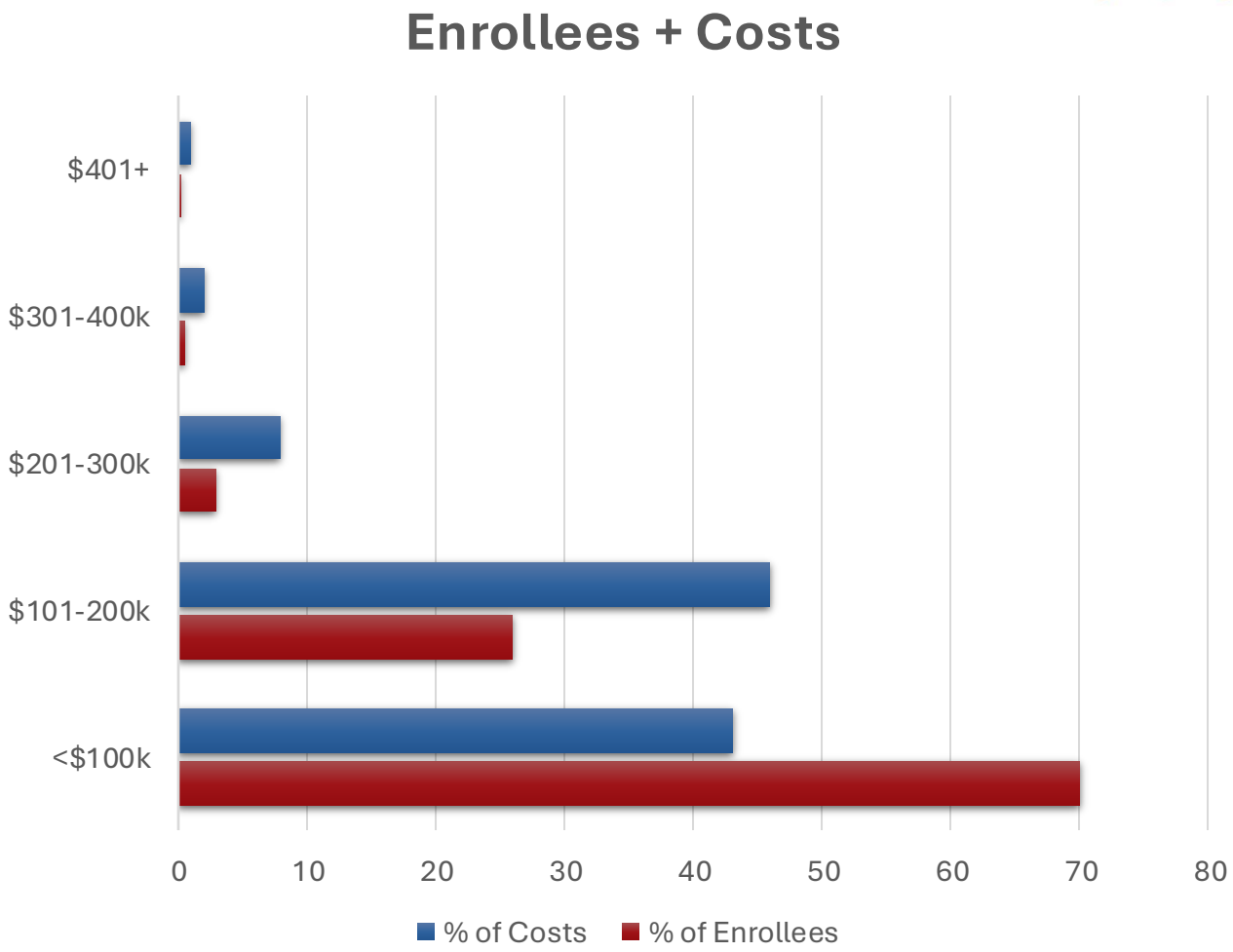
IO Waiver Costs

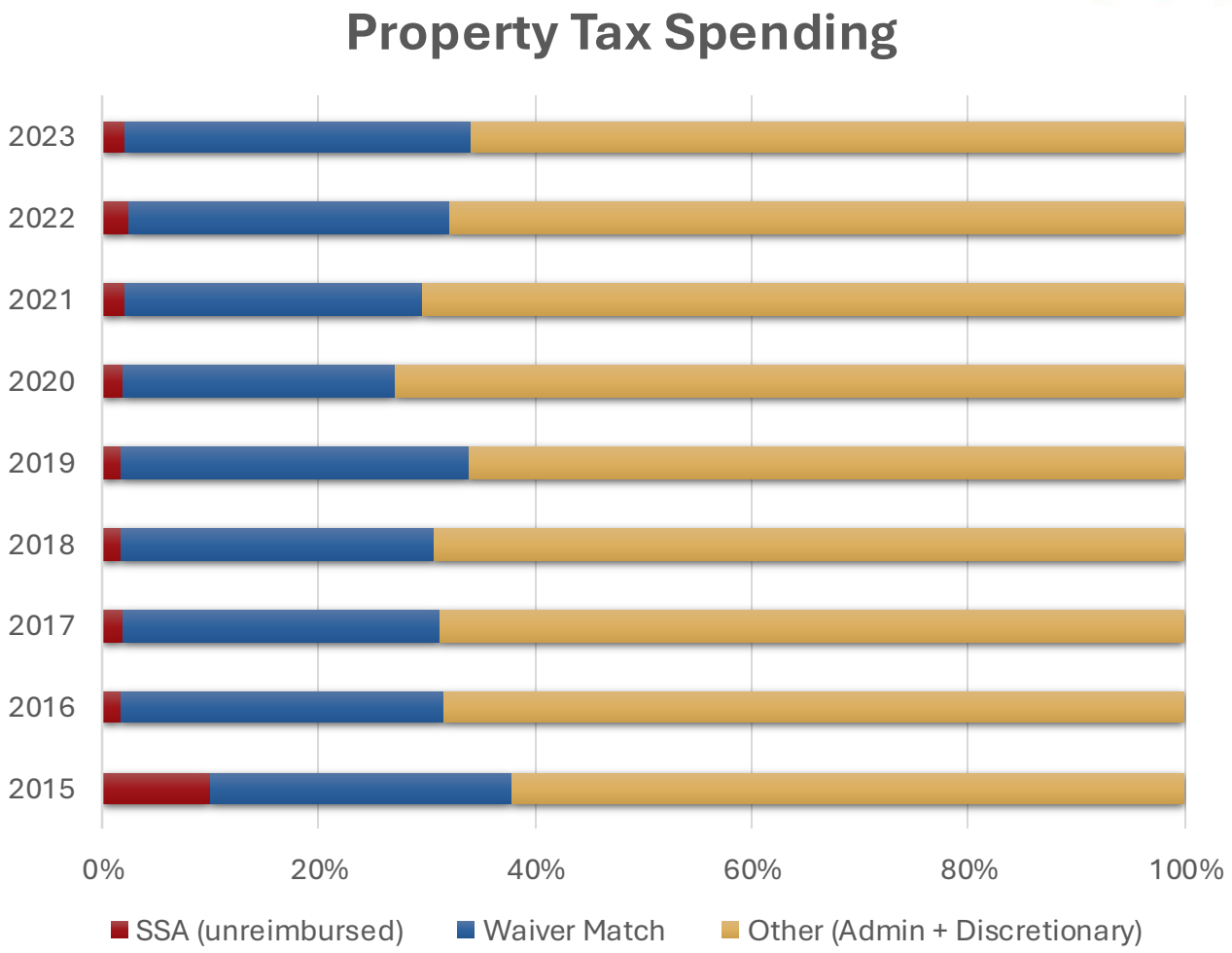
- **Most Waivers Cost Less Than $100K:**
  - **70% of enrollees** fall under the $100,000 annual cost mark and account for **43% of total spending**.
- **A Small Group Drives the Majority of Costs:**
  - Just **under 30% of enrollees** cost more than $100,000/year and account for **57% of total costs**.
  - **156 people (3.5% of waiver enrollees) make up 12% of all waiver spending**.
- **High-Cost Bands Grow Sharply:**
  - The average cost increases significantly above $140,000, reaching up to **$422,490** for the highest tier.
- **Stop Loss, Hardship, State Funded Waivers**
  - Provide financial assistance to CBs but drive up GRF and do not contain overall waiver spending.



Data Source: DODD provided

Levy Dollars

- In 2023, County Boards received **$1.1 billion** in local levy revenue.
- Of that, **31%** went toward **waiver match** and **unreimbursed SSA services**.
- The remaining **69%** funds administrative overhead, optional programming, and discretionary spending.



Data Source: County Board Cost Reports obtained on DODD website

Match Variation

- **% of Tax Levy Used for Match**
  - Minimum: 0.0%
  - Maximum: 60.7%
  - Median: 28.4%
- **% of Total Revenue Used for Match**
  - Minimum: 0.0%
  - Maximum: 44.8%
  - Median: 18.9%

Data Source: County Board Cost Reports obtained from DODD website

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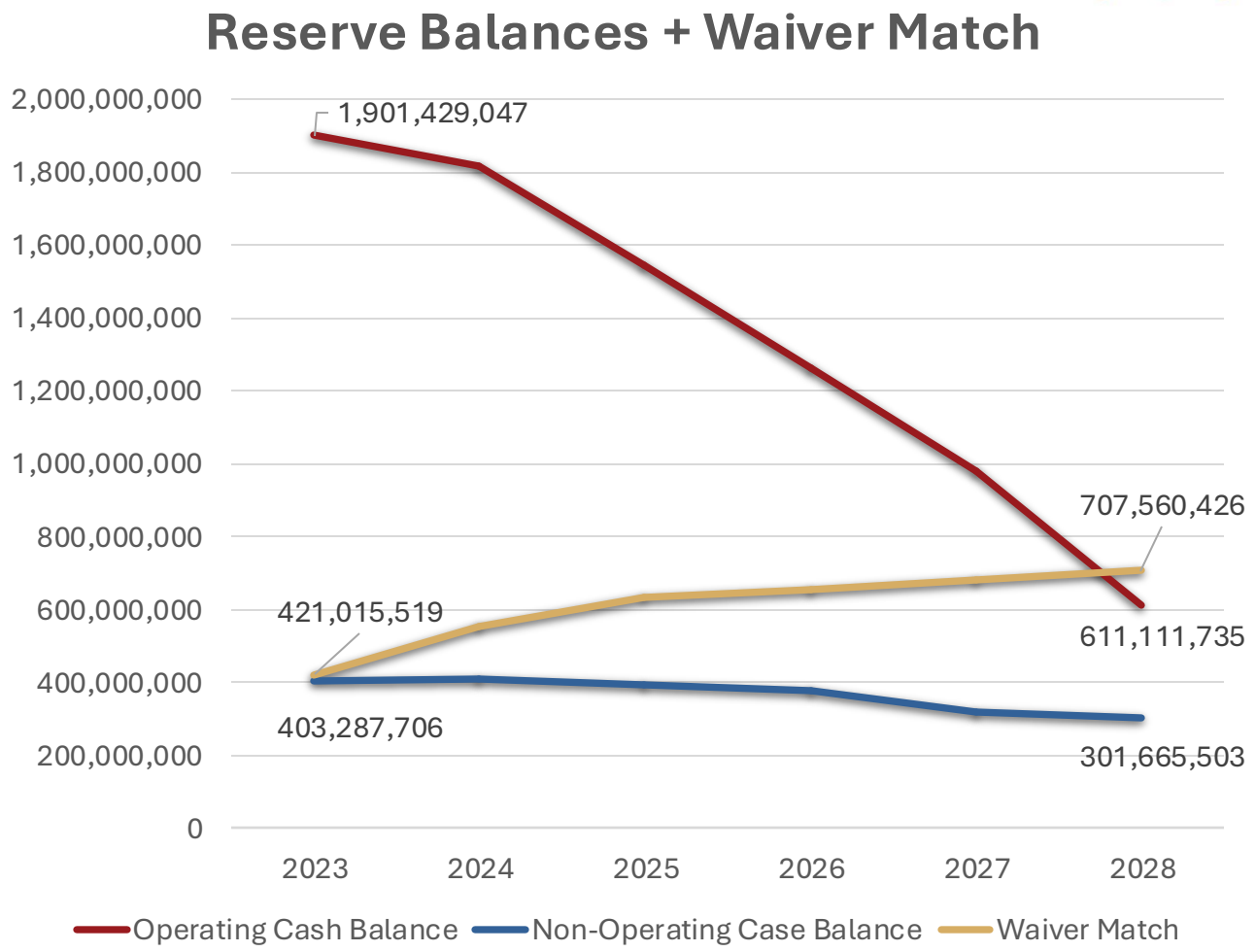
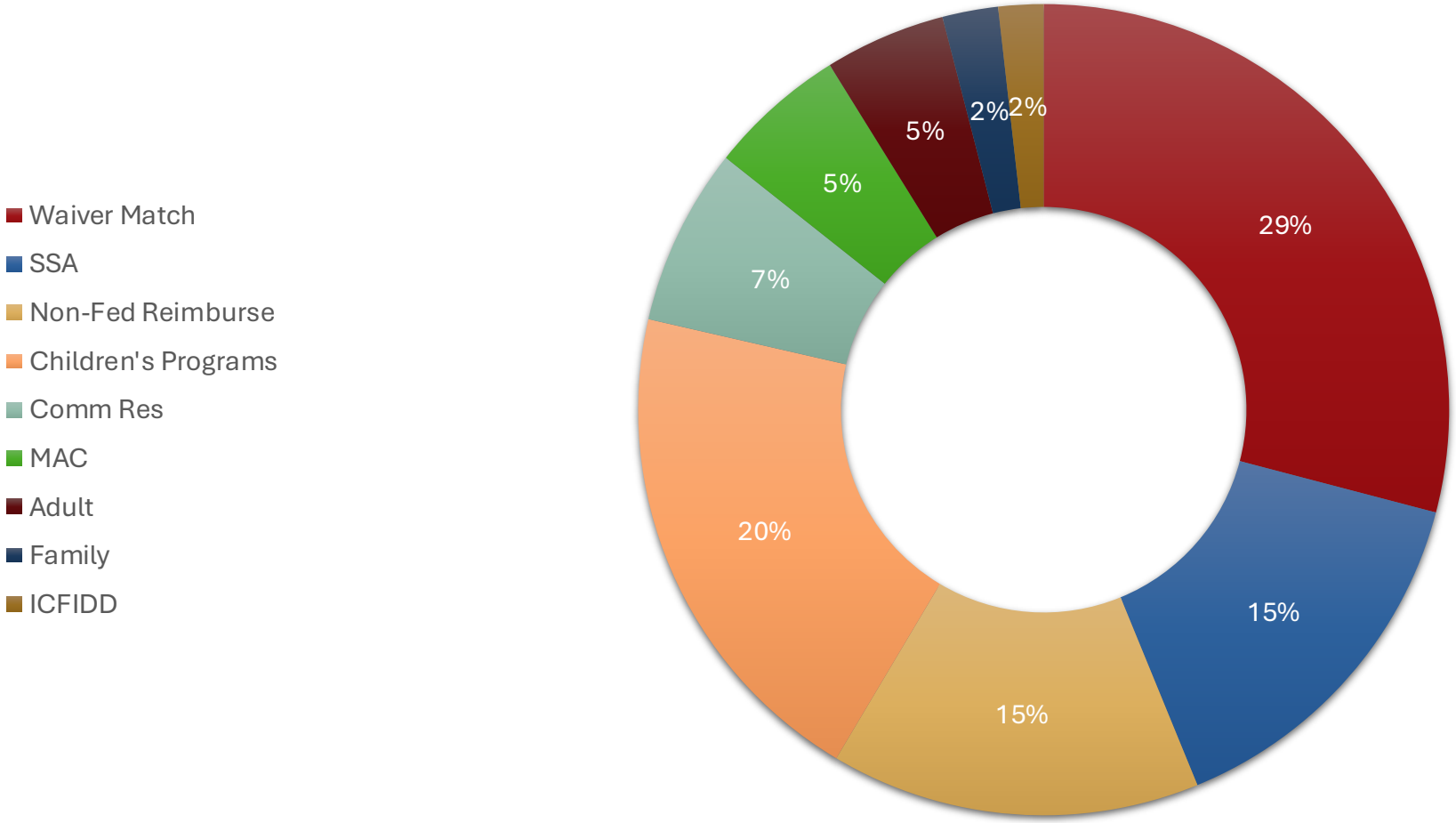
CB Reserves

- **Total cash balances have steadily declined** from ~$2.3B in 2023 to under $1B projected by 2028.
- **If current trends continue**, balances could reach zero by around **2030–2032** and go negative thereafter.
- **This projection assumes current expenditure patterns persist**—without major changes to cost structure, revenue strategy, or service models.



Data Source: DODD County Board Cost Projection database

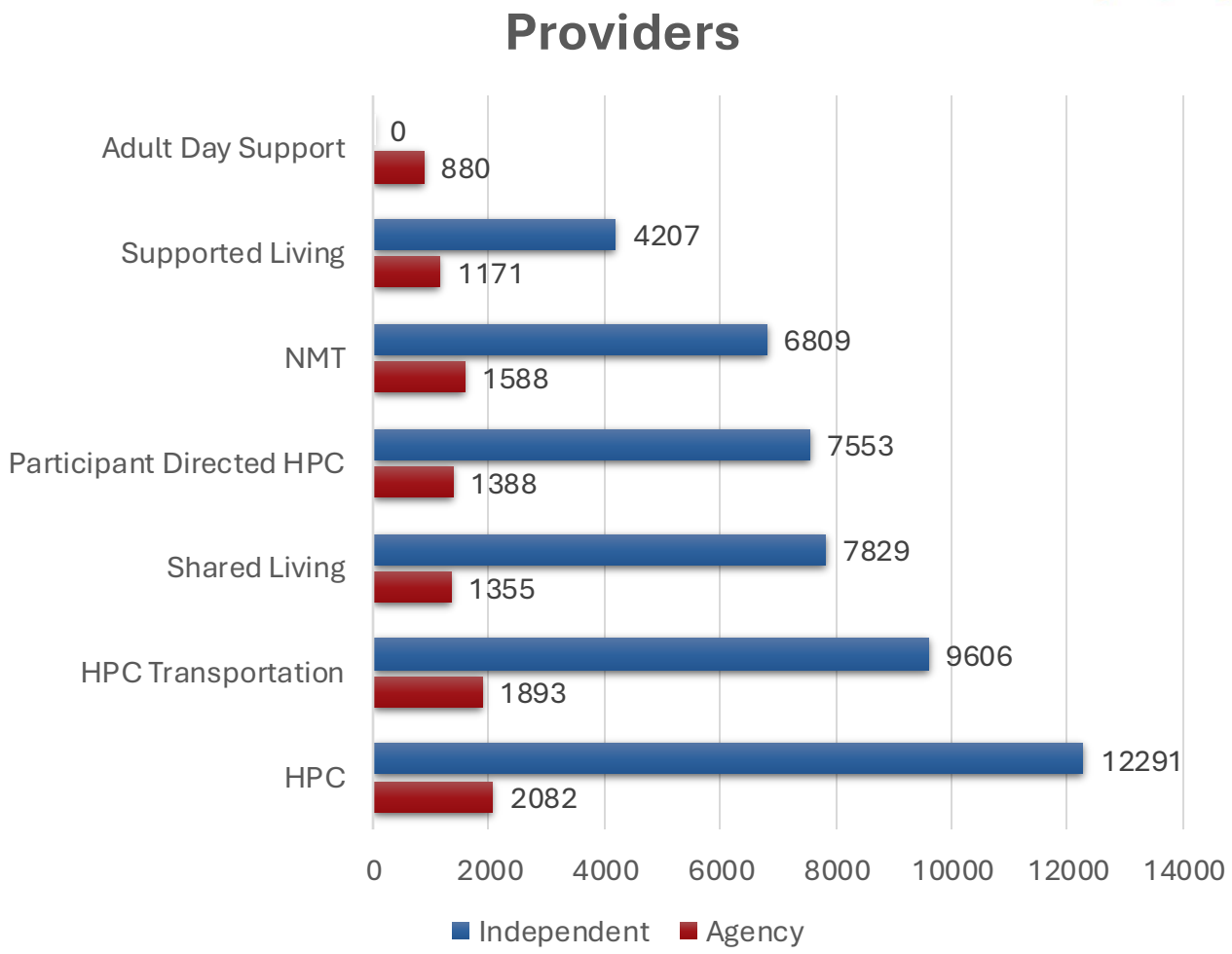
CB program Expenditures - 2023



Data Source: County Board Cost Reports obtained from DODD website

Provider Landscape

- **Nearly 18,000 providers** deliver services — but many support only a few individuals
- **Most are independent providers**, especially in HPC and transportation
- **Wide variation in provider availability** — services like nursing and clinical supports have **few agencies**
- **Low ratio of people served per provider**



Data Source: DODD website – Provider Search Tool download

Data: Breakout Rooms (15 min)

- Based on the data we've just reviewed:
  - What stood out to you?
  - What are the biggest challenges or opportunities this raises?
  - What do you think this data suggests we should be preparing for?

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Policy Survey Results

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Buckets & Priorities

- 44 Responses (as of 7/21)
- All service areas
- Overall agreement with the “buckets” and priorities – ranked in order of importance:
    1. Sustainability
    2. Access
    3. Quality & Accountability
    4. Case management (tied)
    4. Efficiency (tied)

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Sustainability

- **What we mean:**
  - Making sure we can finance the system in a stable, predictable way and sustain the workforce needed to deliver services.
- **Themes:**
  - Concern that current system is not financially sustainable—particularly for small providers
  - Support for rate models that are stable, predictable, and reflect service costs
  - Workforce shortages are worsening, especially for DSPs
  - Calls for changes in provider enrollment and tiered systems
  - Some support for shared services, MSOs, or consolidation as a path to sustainability
- **Quote:**
  - “There will be less funds in the coming years. Collaborations, mergers, and acquisitions will be necessary for survival.”

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Access

- **What we mean:**
  - How people enter and move through the system, and whether they can get the services they need, when they need them—no matter where they live.
- **Themes:**
  - Fragmentation across 88 counties delays access and creates confusion
  - Lack of specialized providers in some regions limits options
  - Transition gaps (especially school to adult services) leave people without support
  - Support for regional or statewide intake/referral models
  - Interest in network adequacy, particularly for complex needs
- **Quote:**
  - “Timely access to services depends on where you live. That shouldn’t be the case.”

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Quality & Accountability

- **What we mean:**
  - Agreeing on shared measures, improving transparency, and demonstrating system performance.
- **Themes:**
  - Strong support for meaningful quality measures and shared accountability
  - Concerns that some providers operate with little oversight or inconsistent rules
  - Desire for transparency in provider performance, authorization practices, and outcomes
  - Some openness to linking payment to value or outcomes—but need clear metrics
  - Suggestions to de-certify low-performing or inactive providers
- **Quote:**
  - “We have way too many providers all in the name of choice… but I don't know if we get what we invested in.”

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Case Management

- **What we mean:**
  - Ensuring planning and coordination work well, are conflict-free, and actually move people through the system.
- **Themes:**
  - SSAs are undertrained, inconsistent, and often overburdened
  - Desire to clarify the SSA role and increase effectiveness (e.g., planning, coordination)
  - Multiple proposals to restructure case management (e.g., embed with providers, shift to COGs)
  - Calls to separate planning from budget authority to reduce conflicts of interest
  - Interest in improving coordination with health, behavioral health, and other systems
- **Quote:**
  - "Take the SSA role out of the CB and put it into something shared across counties."

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Efficiency

- **What we mean:**
  - Reducing unnecessary complexity, duplication, and administrative burden in how our system operates.
- **Themes:**
  - Widespread frustration with “88 ways to do things”
  - Support for streamlining billing, documentation, OISP, and eligibility
  - Support for shared or consolidated administrative functions (e.g., IT, HR, compliance)
  - Desire to reduce duplication between providers and County Boards
  - Interest in reducing compliance burden for high-performing providers
- **Quote:**
  - “We spend so much energy and time on the rat race of 88 different ways to do everything…”

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Non-Negotiables

- **Most Agreed-Upon Non-Negotiables:**
  - **Maintain a cabinet-level Department of Developmental Disabilities** – 78%
  - **Retain some form of local/county-based system** – 69%
    (Not necessarily the same number or functions as today)
- **More Divided:**
  - **Avoid moving to Managed LTSS/Managed Care** – 58%

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MLTSS

- **What is Managed LTSS?**
  - A Medicaid model where **Managed Care Organizations (MCOs)** manage and coordinate **long-term services and supports**
  - States pay MCOs a flat rate to handle **authorizations, care coordination, and provider networks**
- **What It's Not**
  - Not just about acute care — it includes **waiver services and long-term supports**
  - Not a one-size-fits-all model — **states design it differently**
- **Why Do States Use It?**
  - To **control costs**, increase **accountability**, and improve **care coordination**
  - To create **one accountable entity** for managing both medical and long-term care
- **Ohio's Current Landscape**
  - Ohio **does not have full Managed LTSS**
  - But does have:
    - **OhioRISE** (children/youth with complex BH needs)
    - **MyCare Ohio** (Medicare-Medicaid enrollees)
    - 7 MCOs manage **acute care** for all Medicaid enrollees

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Poll Question - MLTSS

“Which of the following best reflects your current position on Managed LTSS (Managed Care for Long-Term Services and Supports)?”

- **I strongly oppose a shift to Managed LTSS** and believe we should resist it completely.
- **I’m concerned about Managed LTSS**, but I think we need to prepare for it just in case.
- **I’m open to Managed LTSS** if it addresses long-standing system issues (e.g., consistency, funding, outcomes).
- **I believe Managed LTSS is coming**, and we need to shape it—not resist it.
- **I’m unsure** or need to learn more before forming an opinion.

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Scope: Breakout Rooms (15 min)

- As we think about a modernization plan for Ohio's DD system:
  - Should we focus primarily on **provider-side reforms**, or
  - Should we also address the broader system — including **County Boards, funding structures, case management, and oversight**?
- In your group, discuss:
  - What are the **risks or tradeoffs** of focusing too narrowly — or too broadly?
  - What kind of plan would be most useful to **hand to the next administration**?

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