

# The Future of Our System

OPRA Board Meeting  
August 13, 2025

# Goals for Today

- 1. Review background and context**  
Reflect on the feedback and insights gathered through conferences, stakeholder conversations, and strategic discussions — including input from past and present system leaders.
- 2. Reaffirm alignment with our strategic foundation**  
Ensure our work remains grounded in OPRA’s mission, vision, guiding principles, and the characteristics of a great provider.
- 3. Recap recent Policy Committee input**  
Summarize key themes and perspectives shared across the last three Policy Committee meetings that have informed our direction.
- 4. Present and discuss current planning framework**  
Share the proposed components of the plan and invite your input on outstanding questions and areas requiring further refinement.
- 5. Outline next steps**  
Clarify the process for finalizing the plan and identifying opportunities for Board engagement and alignment going forward.

# Laying the Foundation

- “SSA’s are the biggest barrier to our work...”
- Toledo
- Meetings w/families...we have to do better
- Strategic Plan: **Develop a proactive strategy for leadership transitions**...ensuring that OPRA’s priorities are communicated early and that new leaders understand the critical needs and challenges within the DD system...
- Budget Amendment
- Great Provider Summit

# Critical Conversations

- **C.W.**

- We've passed **the \$1B mark**, now we're on the radar
- Someone needs to layout all the data and say, **"This is what we're trying to solve for."**
- **"They don't project their needs very well..."**

- **J.M.**

- **"You don't have time for partnership"**
- The **new administration is already working on their plan...**they may already have it developed

- **G.M.**

- **"What hits the biggest campaign contributors?"**
- Give them **3-4 big ideas** and let it run
- Focus on **care coordination (conflict-free case management), eligibility/access, capacity** (provider network), **sustainability/financing**

- **N.R.**

- **"There are too many people worrying** about the future of the system and not enough people **pushing** for change."
- **"If providers suggest it, they'll always think it's about the money..."**

# Current Environment

- “After careful consideration, we will not be able to move forward with the request...exceptions based on existing provider operations would prioritize **provider convenience** over the needs and rights of Medicaid recipients.”

# OPRA Mission, Vision, GPs

- **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.
- **Great Providers**
  - Deliver Person-Centered, Outcome-Focused Services.
  - Invest in and Support Qualified Staff.
  - Cultivate Strong Leadership and Partnerships.
  - Establish Strong Operational Foundations.
  - Advocate and Innovate Continuously.

# Why Great Providers Matter

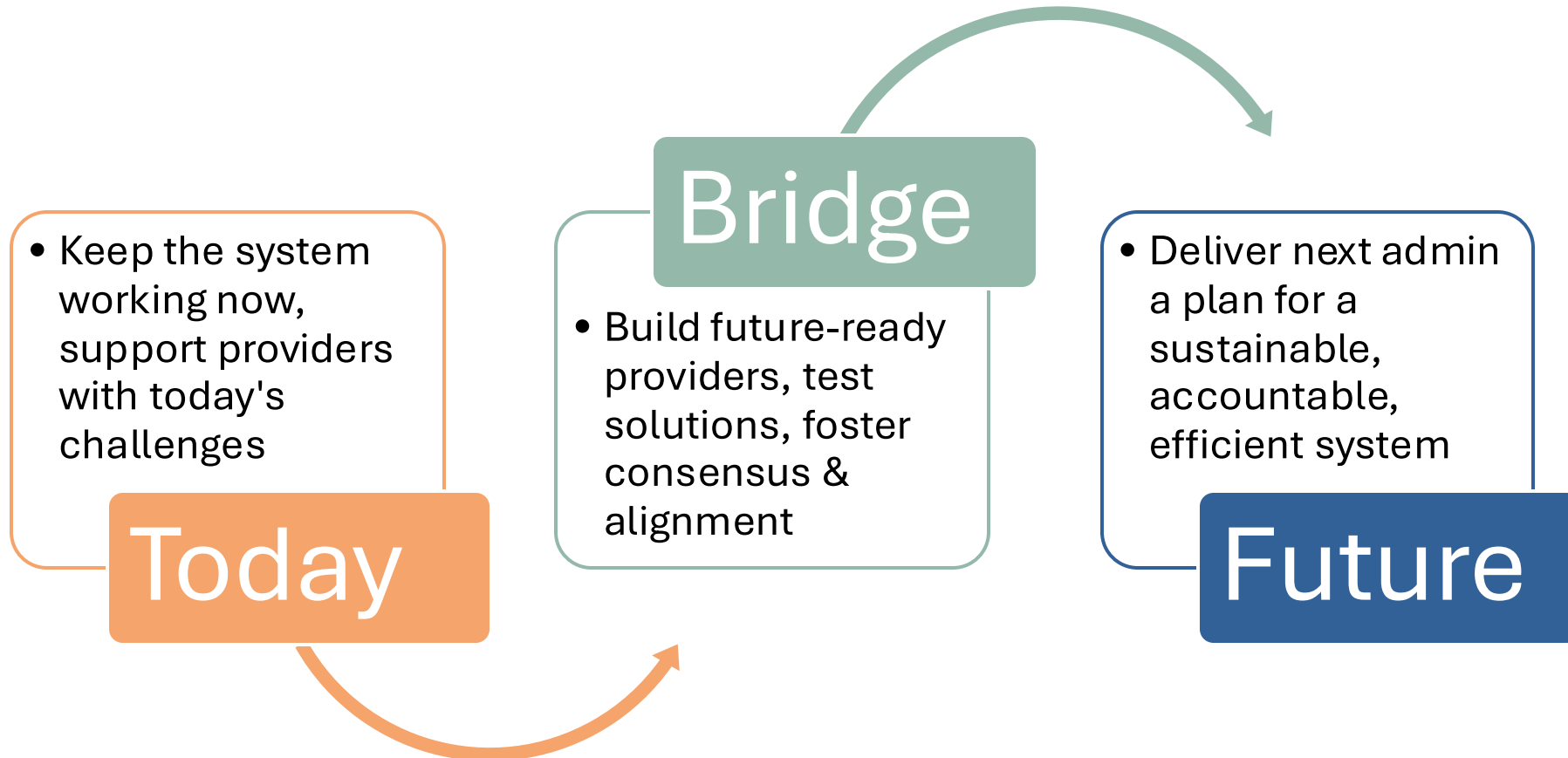
- When people and their families are supported by great providers, they experience:
  - **Services aligned with their goals, preferences, and what truly matters to them** – not just what’s available or fundable.
  - **Consistent, compassionate, skilled support** from professionals who know and care about them.
  - **Teams that collaborate** with families, case managers, and communities to support the whole person.
  - A **dependable, high-quality experience** – no matter where they live or who they choose.
  - A **system that evolves** to meet their needs, addresses gaps, and strives for better outcomes every day.

# What We've Been Asking Ourselves

- What kind of system does it take to realize this future – where great providers thrive and people get what they need?
- Can provider changes alone accomplish this – or does it require real change across the system?
- If we want to shape the future of our system—rather than have it shaped for us—are provider-side efficiencies enough? Or do we need to lead with a broader, system-wide vision for how quality is defined, how services are delivered, and how funding structures evolve (including but not limited to managed care)?
- Are we willing to say: this system isn't working – and we have a better vision for what it could be?

# Our Goal

A strong, sustainable system — powered by great providers, grounded in data, and designed around what matters most to people.



# Policy Committee: May 2024

- Guest Speaker: Mary Lou Bourne (*see notebook*)
- Discussion included:
  - Risks of losing person-centeredness in funding shifts—and how to safeguard against that.
  - Early signals at the federal and state levels providers need to track.
  - How providers can lead on quality rather than wait for mandates.
  - Opportunities for collaboration, innovation, and policy influence before changes happen.
  - The role of data and outcome measurement in securing sustainable funding.

# Key Points from Mary Lou

- Seek to be the **provider of choice**, and understand qualifications, administrative functions.
- Set **performance standards** internally for efficiency and effectiveness, so that you can show your value.
- Propose **alternatives to absorbing Medicaid cuts** impacting state budgets– be prepared now with alternative scenarios.
- Identify and propose **administrative streamlining**- areas of waste that are relics of old systems.
- Is the **current payment model the only model that would work?** What are the limitations caused by the current payment model?
- One **core set of data elements** collected by everyone, with the same operational definitions.

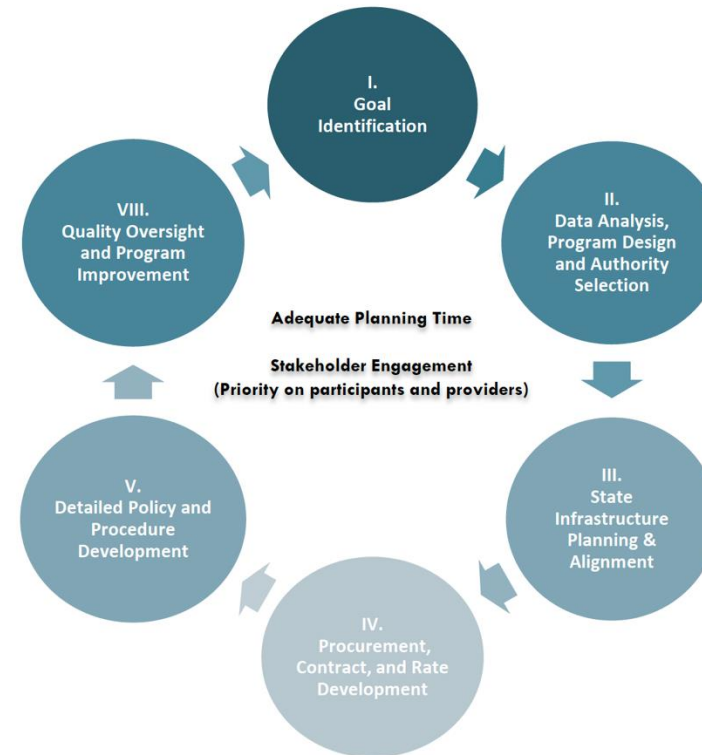
# Policy Committee: June 2024

- Organized nine areas of amendment into a few clear buckets
- ADvancing States: Typical State Goals for MLTSS (*see notebook*)
  - Improved **access** to preventive and specialty care
  - Comprehensive **care/service coordination**
  - **Budget predictability and stability**
- Discussion on Managed Care:
  - “Looking at all this, I get why legislators would think Managed Care is the obvious answer.” – Cmte Member
  - “If we want to avoid Managed Care, we need to understand why it’s appealing—and make the case that we’re already efficient enough to make it unnecessary.” - Cmte Member

# MLTSS Program Life Cycle

## MLTSS

1. If MLTSS happens, it does not happen overnight. It would likely take years.
2. What actions can we take that strengthen the system, move us toward our vision, and prepare us for the possibility of MLTSS — not out of fear, but because they're the right steps either way?



Slide shared by ADvancing States – demonstrating typical process for bringing up MLTSS.

# Policy Committee: July 2024

- Surveyed members on buckets, priorities, non-negotiables
- Presented System Level Data (*see notebook*):
  - Medicaid
  - System Growth (people, waivers, ICFs, dollars)
  - Workforce
  - Local Funding
  - Provider Network
- Policy Survey Results & Committee Discussion:
  - Consensus on Buckets & Priorities
  - Differing opinions on Managed Care & Scope of Plan

Data Source: DODD Data Portal + OPRA Projections

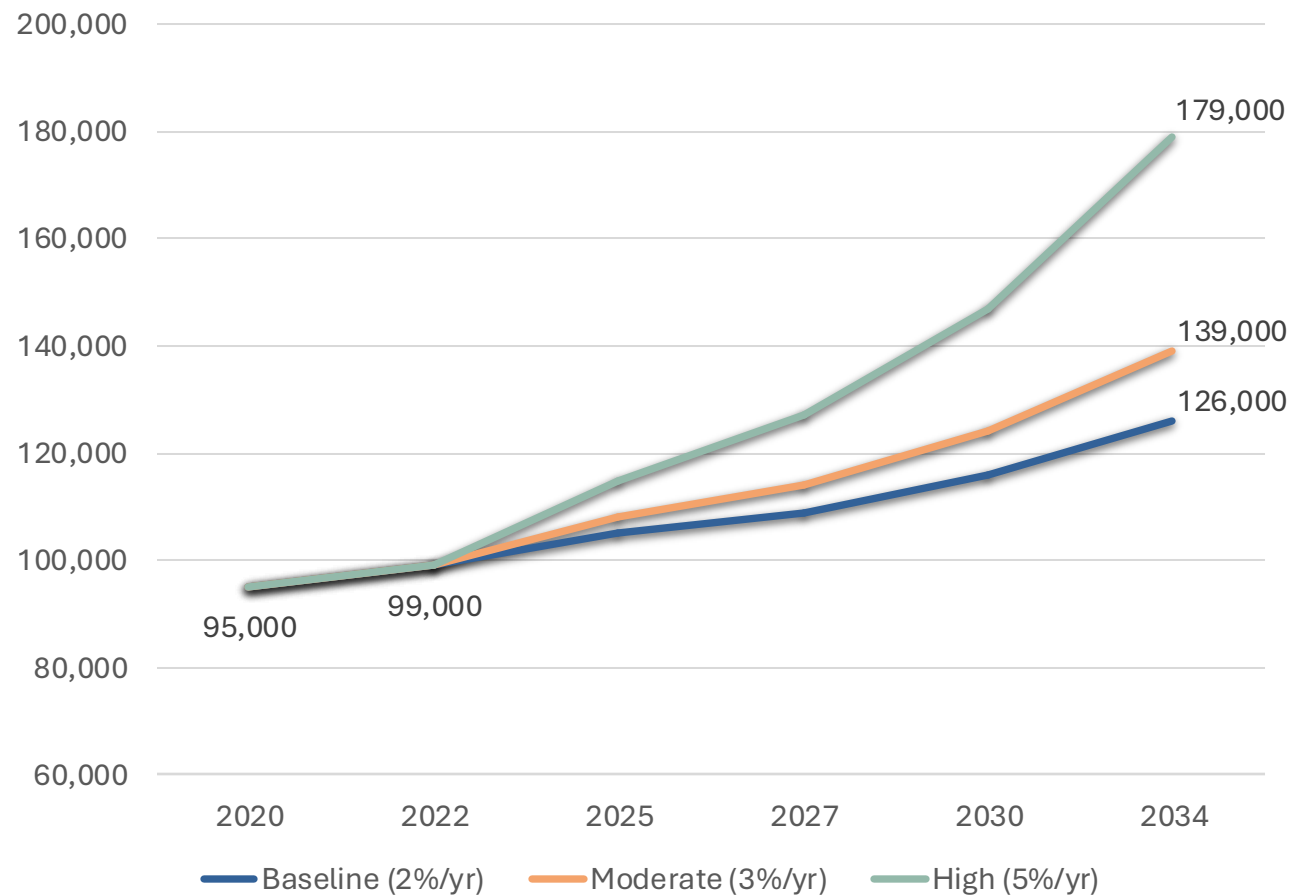


# Growing Demand

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

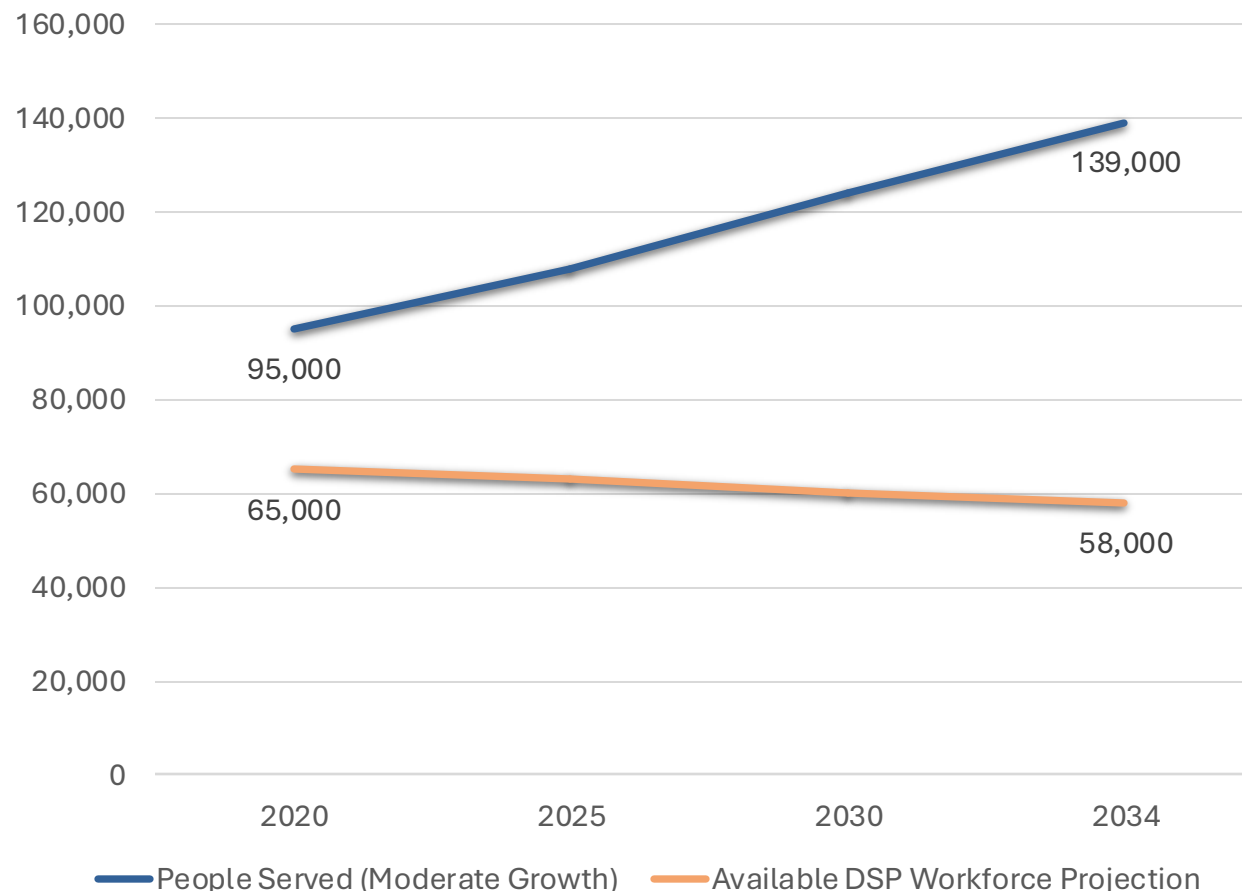
- **Baseline growth alone adds tens of thousands** of people to the system.
- **High-growth scenario** driven by medical complexity, autism, co-occurring BH/IDD, and improved longevity.
- This will likely **double demand on a workforce**.

## People Served



Data Source: DODD Data Portal + OPRA Projections

## People Served v. Workforce



## 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.

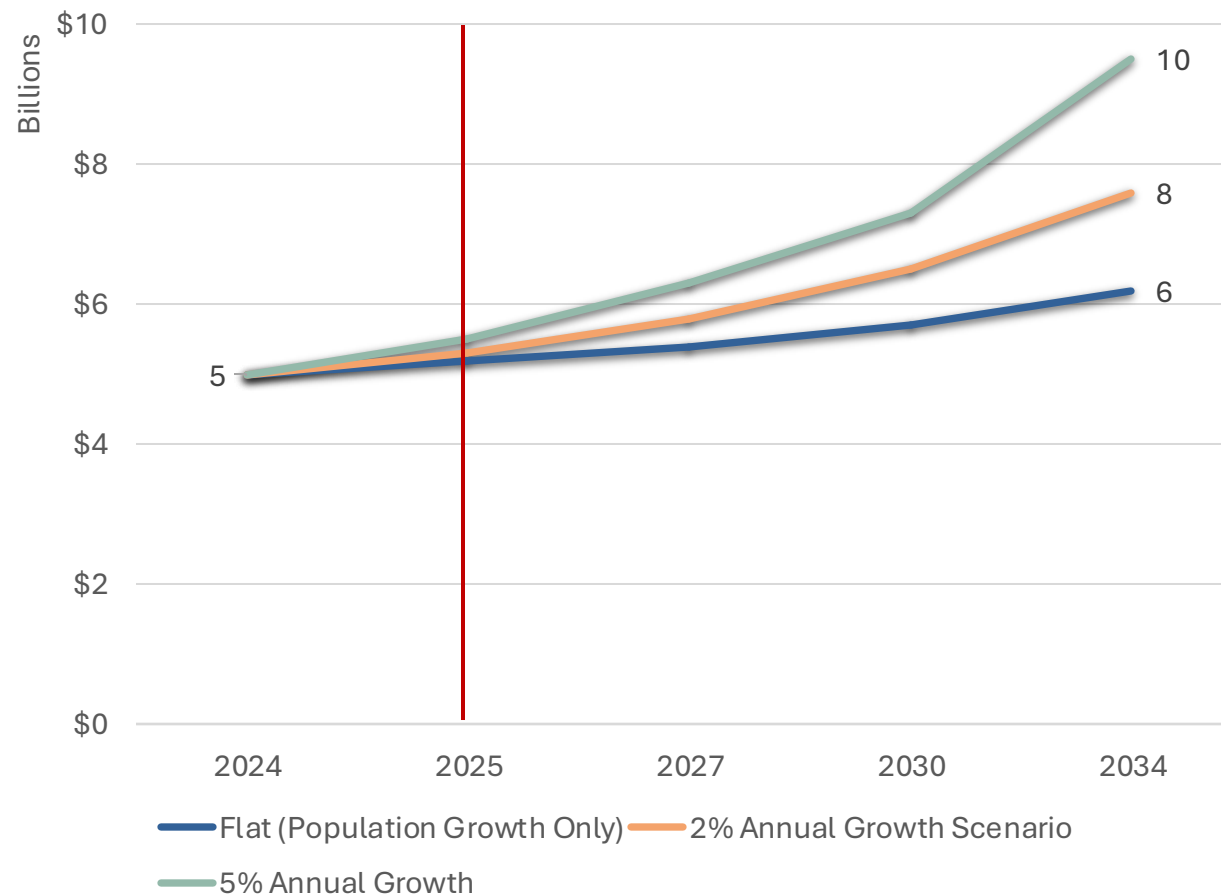
Data Source: DODD + OPRA Projections

## System costs – All funds

# 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.

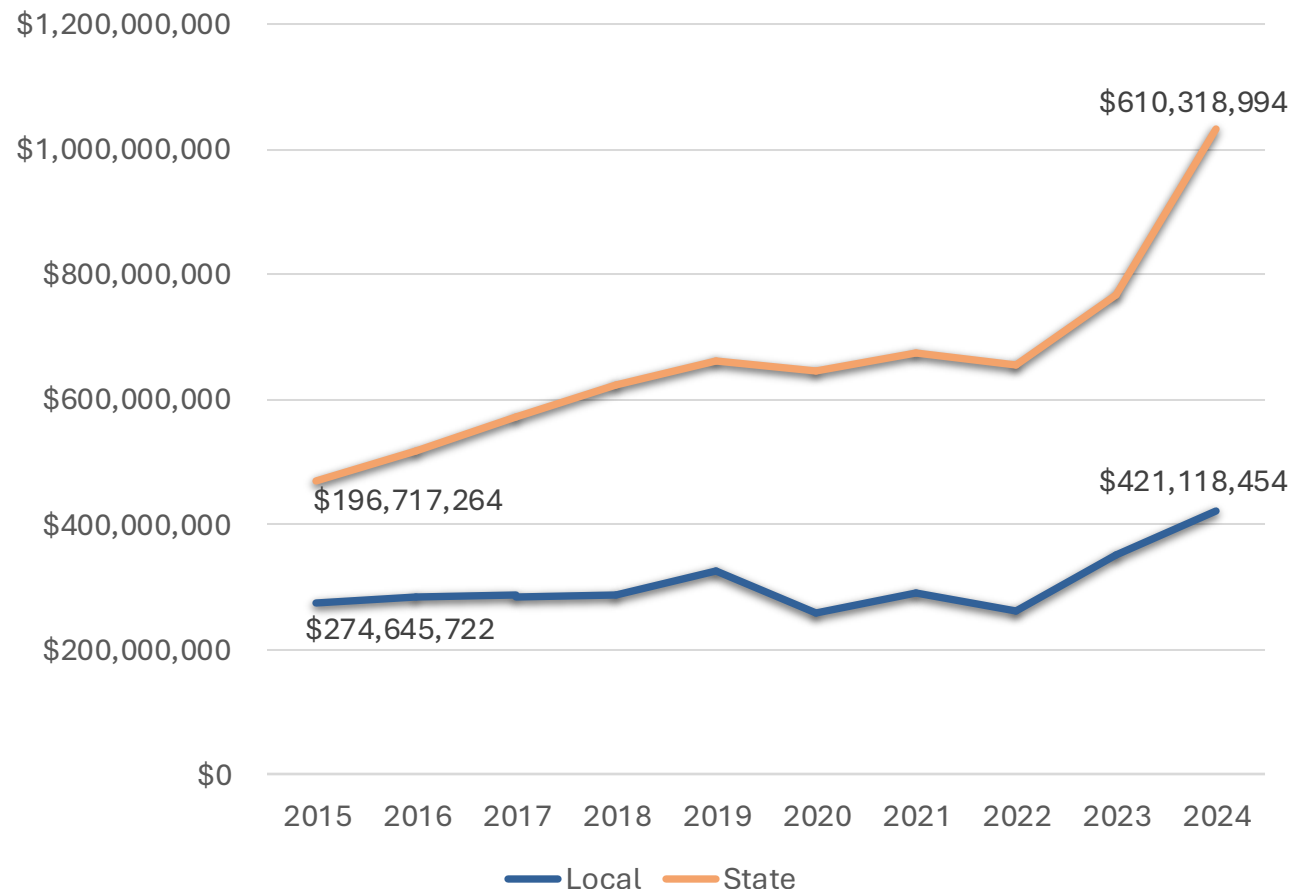
- Even with no inflation, **population growth alone drives spending up 25%.**
- With **normal health cost growth (2–5%), spending could double by 2034.**
- Without reform, local match obligations and state budgets will face unsustainable pressures.



Data Source: DODD provided  
**State v. Local Match**

# 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.



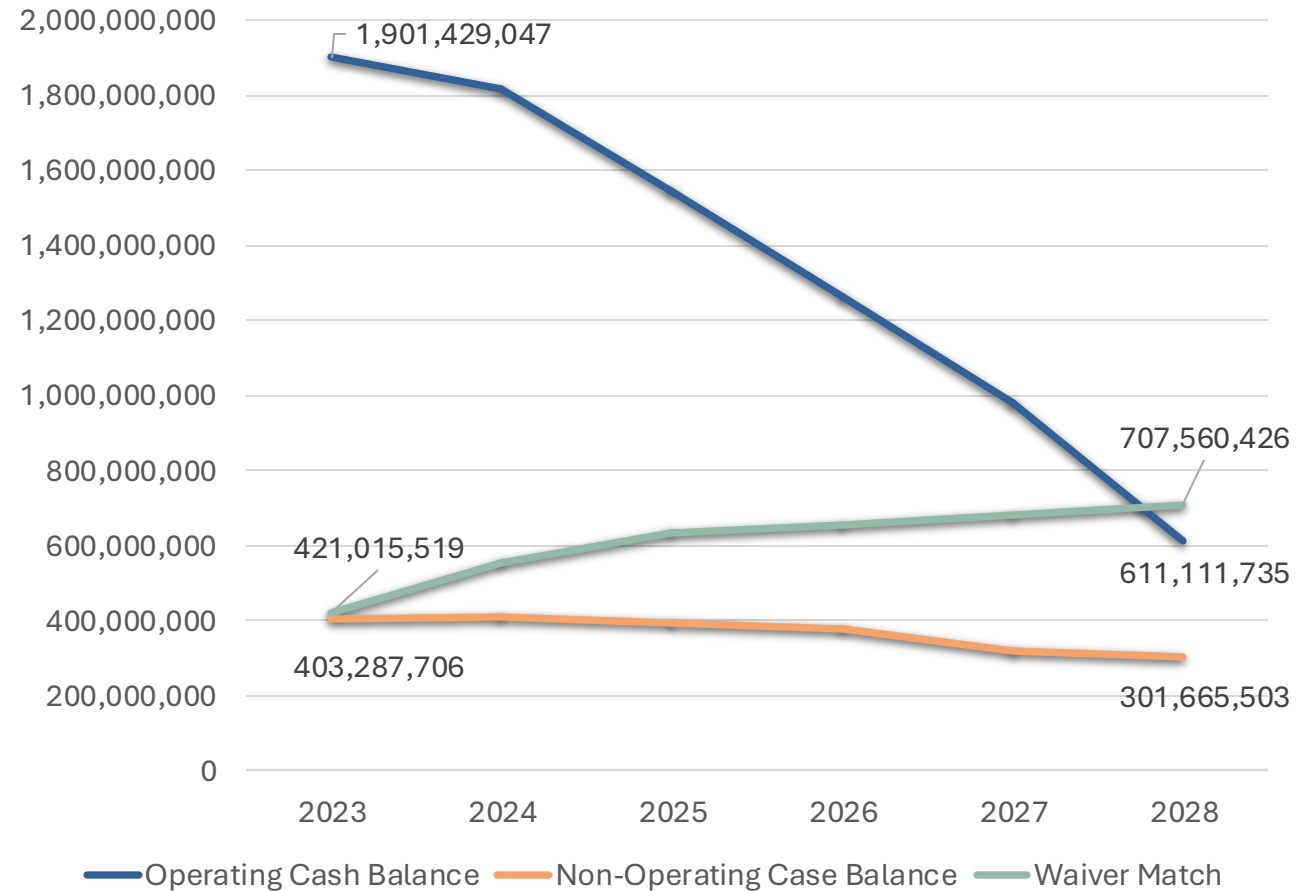
# Match Variation

Data Source: County Board Cost Reports obtained from DODD website

- **% 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: DODD County Board Cost Projection database

## Reserve Balances + Waiver Match



## 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.

# A System that Supports Great Providers

System Reform Bucket	What Needs to Happen	Characteristic
<b>Access</b>	Ensure people can get services when and where they need them, regardless of location or provider shortages. Build capacity across all service types, including ICFs and specialties.	<ul style="list-style-type: none"> <li>✓ Person-Centered Services</li> <li>✓ Strong Operations</li> <li>✓ Advocate &amp; Innovate</li> </ul>
<b>Case Management</b>	Achieve conflict-free case management. Make planning consistent and collaborative, so people move forward with the right supports.	<ul style="list-style-type: none"> <li>✓ Person-Centered Services</li> <li>✓ Leadership &amp; Partnerships</li> <li>✓ Advocate &amp; Innovate</li> </ul>
<b>Sustainability</b>	Fund the system predictably. Align local and state responsibilities. Raise and stabilize provider rates so they can pay and retain qualified staff.	<ul style="list-style-type: none"> <li>✓ Qualified Staff</li> <li>✓ Strong Operations</li> <li>✓ Advocate &amp; Innovate</li> </ul>
<b>Efficiency</b>	Streamline paperwork, processes, and requirements so providers can focus on people, not red tape.	<ul style="list-style-type: none"> <li>✓ Strong Operations</li> <li>✓ Advocate &amp; Innovate</li> </ul>
<b>Quality</b>	Define and measure what “good” looks like. Track performance across providers, SSAs, and systems. Make data transparent and use it to reward quality.	<ul style="list-style-type: none"> <li>✓ Person-Centered Services</li> <li>✓ Leadership &amp; Partnership</li> <li>✓ Advocate &amp; Innovate</li> </ul>

# Policy Levers to Include

Policy Lever	Core Role	How it Interacts w/Others
<b>Rate Rebase with Predictable Adjustments</b>	<b>Financial foundation</b> – aligns base rates with actual costs and supports long-term sustainability.	Creates a baseline for other payment models to build on (e.g., acuity tiers, value-based bundles). Increases provider confidence and stability.
<b>Selective Contracting</b>	<b>Gatekeeper and standard-setter</b> – enables the state to contract with providers who meet specific access, quality, or innovation goals.	Creates the structure for implementing bundled payments, incentive models, and quality-linked contracts. Helps direct investment to providers best equipped to meet system needs.
<b>Acuity-Based Rates*</b>	<b>Aligns funding with individual need</b> – ensures providers are compensated fairly for serving people with more complex needs.	Supports fairness in value-based payments and selective contracting. Helps stabilize providers serving high-acuity populations.
<b>Bundled or Value-Based Payments</b>	<b>Simplifier and outcomes-driver</b> – shifts focus from volume to outcomes, reduces admin burden.	Integrates easily with acuity rates and selective contracts. Encourages innovation and flexibility in service delivery.
<b>Targeted Provider Incentives (i.e., rural, crisis, innovation bonuses)</b>	<b>Gap-filler and capacity-builder</b> – drives investment toward underserved needs and populations.	Can be embedded in selective contracts or used to help providers prepare for value-based models. Strengthens access and equity.

# Policy Levers to Include

Policy Lever	Core Role	How it Interacts w/Others
<b>Statewide Quality Metrics &amp; Reporting</b>	<b>System accountability engine</b> – defines and measures performance across SSAs, providers, and state agencies.	Underpins selective contracting, incentive payments, and transparency efforts. Drives continuous improvement.
<b>Streamlined Service Authorization Processes</b>	<b>Access accelerator</b> – enables quicker implementation of plans and service changes. Standardized, simplified approval timelines across all counties; clear criteria for approvals; automated/expedited authorizations; etc.	Helps people receive supports faster. Reduces wait times and planning delays.
<b>Modernized Technology &amp; Shared Infrastructure*</b>	<b>Digital backbone for the system</b> — enables real-time data sharing and interoperability to streamline eligibility, planning, service delivery, and quality tracking.	Connects and supports nearly all reforms. Interoperability reduces duplication, shortens delays, and ensures shared access to accurate information.
<b>Risk-Based Monitoring &amp; Oversight</b>	<b>Oversight that matches risk</b> — tailors review intensity based on provider performance, past findings, and service complexity.	Focuses resources where they're needed most. Allows the system to invest more time in providers who need support or correction.

# Policy Levers to Consider

Policy Lever	Core Role	How it Interacts w/Others
<b>Readiness Framework for New Providers (Agency + Independent)</b>	<b>Structured entry for new providers</b> — ensures providers meet baseline expectations before delivering services, while offering support pathways for success.	Provides on-ramp for IP/smaller providers. Reduces oversight burden and pairs with TA and performance monitoring.

# Areas For Further Discussion

## Conflict-Free Case Management (Eligibility & Planning)

Examples:

- **Centralize eligibility determination** for DD and HCBS services to ensure consistent, unbiased decisions separate from planning and funding pressures.
- **Prohibit dual roles** at the local level by requiring separation between eligibility determination and service planning/authorization functions.
- **Redesign TCM delivery** through approaches such as:
  - **Selective contracting for TCM** to ensure quality, neutrality, and readiness;
  - **Minimum regional/service area standards** to ensure sustainability and scale;
  - **Free choice of TCM providers** to give people access to truly independent planning support.

## Public Funding Responsibilities (Match)

Examples:

- Establishing **minimum local match expectations** (e.g., waivers must be funded before local initiatives).
- **Redirecting or prioritizing local levy use** to required services before optional ones.
- Creating **incentives or penalties** tied to local participation in waiver match or system improvements.
- Developing a **state-local cost sharing framework** for growth areas (e.g., new waivers, shared investments).
- Exploring a **“funding floor” model**, where the state ensures a baseline level of funding per person, regardless of county.

# Areas For Further Discussion

- Other?

# Next Steps

- **Educating** Board & Membership on Policy Levers
  - Policy Committee
  - Conference, Summit
- **On-going discussions** with:
  - Thought leaders (i.e., J.M., G.M.)
  - Success Group
  - Coalition
  - Advocacy Organizations
- **Draft “plan”** for Board review in October
- **“One-pagers”** for campaigns leading up to and following primaries (May)
- Meetings with **Gubernatorial Candidates/policy teams** May-October
- Meetings w/**transition teams** beginning November