Ohio at a Crossroads: The Developmental Disabilities System

Rose Frech, Fellow
Jon Honeck, Ph.D., Director of Public Policy and Advocacy
Kate Warren, Graduate Assistant

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Executive Summary

Ohio’s Developmental Disabilities System Faces Transformational Change

Ohio relies heavily on institutional care and sheltered workshops for individuals with developmental disabilities, which many advocates argue are isolating, restrictive, and don’t promote independence. The system will undergo profound change in the coming years, and additional measures are needed to strengthen its ability to adapt to change. This study explains the developmental disabilities system in Ohio, and analyzes these recent important changes, including the impact of new federal Medicaid rules and changes proposed in the governor’s budget. We outline a series of recommendations that will help the system to increase access to integrated, community-based services and fully realize the rights of individuals with developmental disabilities. Recommendations include:

- Improve the availability of Medicaid Waiver services & identify a plan to eliminate the waiting list
- Examine funding inequity among counties and improve funding for the tax-equity line item in the state budget
- Enhance funding for community employment supports and streamline access to services
- Accelerate ICF downsizing and conversion
- Address wage issues of the direct care workforce, and monitor employee turnover and provider quality
- Develop additional housing supports which are necessary to fully support community integration

An Overview of the Developmental Disabilities System in Ohio

The Ohio Department of Developmental Disabilities (DODD) provides general oversight to the state’s system of supports and services for individuals with developmental disabilities. Locally, county boards of DD are responsible for facilitating these services. County boards serve nearly 90,000 individuals each year; about half are adults. While historically service provision has favored institutional settings, the pendulum has swung toward a preference for community-based services and independent living, which decrease isolation and increase integration for individuals with developmental disabilities. Finding the proper balance between settings is an ongoing discussion across the state and country.
ICFs and Developmental Centers
A range of services and supports are available for individuals with developmental disabilities, including various residential options. Intermediate Care Facilities (ICFs) include both privately operated facilities, board-operated facilities, and 10 state-run Developmental Centers (DCs). In 2014, these residential options accounted for about 6,700 beds. The size of these facilities varies; while many are smaller and more “home-like,” others are large and deemed by many to be “institution-like.” In total in 2014, almost 3,000 individuals lived in facilities with more than 16 beds, while only 529 were living in six-bed or smaller facilities.

The advocacy group Disability Rights Ohio recently called into question the state’s heavy reliance on ICFs, which many believe promote segregation, impede the rights of those with developmental disabilities, and may violate federal law. The state is currently working to convert ICF beds to Medicaid Waivers, which allow individuals to waive their right to institutional care in favor of receiving services in a home or community-based setting. Relatedly, efforts are underway to decrease the size of large-bed facilities. To date, these efforts have been slow. And, because the state pays the nonfederal Medicaid match for ICFs, boards may have a financial incentive to direct individuals into ICFs rather than onto waivers, where county boards are responsible for the nonfederal Medicaid match.

Medicaid Waivers
Waiver programs include services such as nonmedical transportation, employment and day services, nutrition assistance, respite for caregivers, certain therapies, accessibility modifications, and personal care assistance. Ohio currently has four DD waiver programs that serve people with different types and levels of need, including the Individual Options (IO) Waiver, the SELF (Self Empowered Life Funding) Waiver, Transitions (TDD) Waiver, and the Level One Waiver. As of February, 2015, over 35,000 people were receiving services through DD waivers across the state. Since 2002, waiver growth has quadrupled. DD waiver reimbursement in Ohio totaled approximately $1.5 billion in 2014.

As of October, 2014, there were over 45,000 people on county waiver waiting lists across the state. The median wait time is about 6.4 years. A 2014 study suggests that approximately 22,000 individuals on waiting lists had current unmet needs for services. The number of individuals on waiting lists varies significantly by county, but overall, DODD reports that the statewide list grows by 100 to 200 individuals each month. Several counties only remove individuals from the waiting list on an emergency basis or as other individuals with waivers no longer require these services, due to death or relocation.

Many factors contribute to long waiver waiting lists, including a lack of adequate local funds to make the match. However, data demonstrate that funding alone does not determine waiver accessibility. County boards may elect to divert available funds to other programming. Given the many restrictions and requirements tied to waiver services, counties may be reluctant to expand their waiver programs for fear of losing local control. The IO Waiver, the most
frequently utilized waiver, has no monetary cap, and boards may be cautious to offer new waivers without knowing what their contribution will be in future years.

**Day and Employment Services**
Ohio’s developmental disability system also includes services that offer support for social and employment needs. Medicaid is the primary payer for most day and employment supports, though county boards often heavily supplement this funding. Adult day programs engage individuals, teach life skills, help with social interaction, and provide opportunities for community integration. Adult programs may also be vocational in nature, including facility-based sheltered workshops. Another more independent and integrated option is community employment, with support services such as job coaching or aides as needed.

Many advocates argue that sheltered workshops and adult day programs segregate individuals with developmental disabilities from the community, do not provide adequate employment training, and often pay less than a minimum wage. Others praise the benefits of sheltered work, maintaining that many individuals with developmental disabilities cannot fully adjust to community employment and will face harassment or bullying, and that local communities are not ready and willing to accept integrated employment.

Ohio’s Employment First Initiative emphasizes the importance of integrated employment for all persons with developmental disabilities and consequently is working to design a funding system to shift resources to accommodate that vision. However, since its inception, Employment First has not led to significant change in the employment landscape throughout the state.

**The Governor’s Budget**
In February, 2015, Governor John Kasich announced his 2016-2017 biennial budget, which requires approval by the Ohio legislature. The budget included substantial investments in developmental disability services: $112 million above 2015 levels over the course of the two years. DODD has announced that, if approved, spending would target ICF downsizing efforts, increased funding for community employment, and most notably, the addition of 3,000 HCBS Waivers.

**System Funding**
Ohio’s funding structure is unique in that a large portion of its funding for services for persons with developmental disabilities comes from local revenue streams, primarily property tax levies. Due to this reliance on local money, discrepancies in funding across the state are vast. In some cases, this means that Ohioans with developmental disabilities can’t access equitable services. However, increased funding doesn’t always lead to increased access to community-based services. Counties may elect to spend money on less-integrated services.
CMS Rule Change
Ohio is preparing to implement changes to Medicaid rules that have narrowed the types of settings in which Medicaid reimbursable services can take place, with a greater emphasis on integrated, community-based settings and outcomes. This will have a significant impact on services.

- Sheltered work and day services, as they have traditionally been delivered in Ohio, will no longer meet the requirements outlined in the new rules, as these settings largely isolate individuals and don’t allow for full access to the community.
- The Centers for Medicare and Medicaid Services (CMS) rule calls for “conflict-free” case management. Boards directly employ Service and Support Administrators who complete eligibility determinations, develop service plans, and connect people to recommended services. In addition to this case management service, many county boards also provide services directly to individuals, including Medicaid Waiver home and community-based services. According to CMS, there is an inherent conflict of interest in this structure.

States will have as many as five years to come into full compliance on the new rule; Ohio is requesting 10 years for certain provisions, including changes to sheltered work settings. Transition plans were submitted to CMS in mid-March, 2015.

Key Recommendations for System Change
As a result of our research, we recommend the following changes to improve the Ohio developmental disabilities system.

- Develop a long-term solution to the state’s complex waiver problem. The current system is not sustainable. This should include examining options to increase the financial capacity of counties and additional state-funded waivers.
- Increase funding for Employment First. Improve the partnership with Opportunities for Ohioans with Disabilities (OOD) and streamline access to employment services.
- Implement changes to accelerate ICF downsizing and conversion, including decreasing rates for beds serving those with lesser levels of acuity.
- Add additional housing supports to fully support community integration.
- Undertake an examination of the SELF Waiver to remediate barriers to use.
- Assess waiting lists to identify who has the greatest levels of unmet need and assure that these individuals are targeted for enrollment in the most appropriate waiver.
- Increase collaboration among boards to lead to cost savings and increased efficiency.
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Authors
Rose Frech, Fellow, Applied Research
Jon Honeck, Ph.D, Director of Public Policy and Advocacy
Kate Warren, Graduate Assistant, Cleveland State University, Maxine Goodman Levin College of Urban Affairs
An Overview of the Developmental Disabilities System in Ohio

Background
Ohio is at a turning point in establishing best practices for serving persons with developmental disabilities, as philosophies of best practice are evolving. Due to the changing landscape, it is an opportune time to examine how these services are provided and funded, and explore the significant variations in funding and administration that occur across the state. Key stakeholders believe that impending changes are likely to be the most significant transformation the system has experienced in decades. Ohio remains reliant on certain services that are no longer considered to be best practices (including sheltered-work and large institutional facilities), and while system reform is undoubtedly necessary, promises of large-scale change have led to much uncertainty on the part of individuals with developmental disabilities, family members, and providers alike. In this report, we explain the service system in Ohio, review recent or forthcoming changes, and explore in-depth the complex funding structure that complicates the delivery of services and projected system change.

For centuries, developmental disabilities were misunderstood by educators, doctors, family members of individuals with developmental disabilities, and society at large. Until as recently as the late 1800s, many believed the misconceptions that disabilities were the result of the moral failure of parents, that they could be “cured” through training and education programs, that they were hereditary disorders, and that individuals with disabilities were the cause of many of society’s moral ills. These fallacies often resulted in the development of paternalistic programs and policies that isolated individuals with disabilities and limited their ability to live fully integrated into the community. A system of public and private institutions emerged, and while they were often founded with the intentions to protect individuals, scarce funding, a lack of properly trained staff, overcrowding, and a perception of individuals as burdens on society led to often terrible conditions inside the facilities. Abuse and neglect were common.1

By the 1970s, much of the stigma surrounding people with disabilities had dissipated. People with disabilities were increasingly being empowered to make decisions for themselves, and a

How Does Having a Disability Affect Someone’s Life?

“The effects of intellectual disabilities vary considerably among people who have them, just as the range of abilities varies considerably among all people. Children may take longer to learn to speak, walk and take care of their personal needs, such as dressing or eating. It may take students with intellectual disabilities longer to learn in school. As adults, some will be able to lead independent lives in the community without paid supports, while others will need significant support throughout their lives. In fact, a small percentage of those with intellectual disabilities will have serious, lifelong limitations in functioning. However, with early intervention, appropriate education and supports as an adult, every person with an intellectual disability can lead a satisfying, meaningful life in the community.”

Source: The Arc
http://www.thearc.org/what-we-do/resources/fact-sheets/introduction-to-intellectual-disabilities
movement began to end the institutional system in favor of independent, community living. Parents and caregivers, who sought better, fuller, lives for their loved ones, were at the crux of the movement. The changing language used to refer to people with disabilities also signaled changing societal attitudes toward them. At the turn of the century and up until the 1950s, people with disabilities were often referred to as “idiots,” “morons,” “feebleminded,” and even “almosts,” signaling their social status as not entirely human. In more recent decades, accepted terminology included “mentally retarded,” “handicapped,” and “disabled.” Today, in contrast, we refer to “individuals” or “persons with developmental disabilities” (DD) as a way to emphasize their personhood, as opposed to focusing on their limitations. Both the Americans with Disabilities Act (1990), which prohibits discrimination against individuals with disabilities, and the Olmsted Decision (1999), were key turning points in advancing the perception and treatment of individuals with developmental disabilities. And while significant strides have been made, continued work is necessary by policy makers, providers, and family members to fully recognize their civil rights.

“Developmental disability” is an umbrella term that includes a wide range of specific conditions, including intellectual (cognitive) disabilities, Down Syndrome, Cerebral Palsy, Autism Spectrum disorders, language and learning disorders, and others. However, due to eligibility criteria, outlined below, not everyone with a developmental disability will qualify for services and supports.

The Ohio Revised Code (5126.01) provides the following definition of “developmental disability.” It is this definition that primarily guides eligibility assessment and determination in the state; however, federal definitions vary from program to program, complicating eligibility and resulting in inconsistency in benefit determination:

"Developmental disability” means a severe, chronic disability that is characterized by all of the following:

1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code; (2) It is manifested before age twenty-two;
2. It is likely to continue indefinitely;
3. It results in one of the following:
   a. In the case of a person under age three, at least one developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay;
   b. In the case of a person at least age three but under age six, at least two developmental delays;
   c. In the case of a person age six or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person’s age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least age sixteen, capacity for economic self-sufficiency.
4. It causes the person to need a combination and sequence of special, interdisciplinary, or other type of

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1 U.S. Supreme Court case addressing discrimination of individuals with developmental disabilities
care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

Prevalence
For a variety of reasons, it is difficult to know exactly how many people there are with developmental disabilities. Diagnoses can be unreliable, not all individuals with developmental disabilities are enrolled in or receive services, and definitions of DD can be inconsistent. Furthermore, increased early identification and intervention and the explosion in autism diagnoses mean that estimates are changing rapidly. General population estimates range from 1 to 2 percent. However, there may be geographic variations in prevalence due to environmental factors, service availability, local screening procedures, or variable rates of preterm birth.

Nonetheless, it is useful to make informed estimates about the prevalence of developmental disabilities in order to make helpful observations and recommendations about the DD system. For the purposes of this report, we are using prevalence estimates provided by the Scripps Gerontology Center at Miami University. The Scripps Center provides figures at the county level for people with severe and moderate intellectual or developmental disabilities. Estimates are generated using 2010 population data from the American Community Survey. Scripps’ methodology relies on two sources. Rates for individuals living with severe developmental disabilities are based on the number of individuals who meet the Intermediate Care Facilities (ICF) level of care, provided from the Ohio Department of Developmental Disabilities (DODD) data system. ICF level of care assessments are typically conducted by county boards of developmental disabilities, and those eligible must have a diagnosed developmental disability and be determined to require assistance in areas such as economic independence, communication, independent living, personal care, or daily life activities. Estimated prevalence rates for individuals with moderate disabilities are based on data from the 2004-2005 Survey of Income and Program Participation (SIPP), a household survey of community residents. This report combines these figures to generate one prevalence number for each county, as services are often made available to both populations. To emphasize that figures are only estimates, numbers were then rounded to the nearest 50. Overall, these data estimate a prevalence rate for individuals with developmental disabilities of about 1 percent of the total population, or approximately 113,000 people in Ohio.

Notably, some sources estimate a much higher rate of individuals with intellectual or developmental disabilities, as high as 2.5 percent or upward of 250,000 individuals in Ohio. These inconsistencies can be attributed in part to changes in definition over time, challenges with U.S. Census categorization, and disputes over the accuracy of increases in diagnoses such as attention deficit hyperactivity disorder (ADHD) and autism. And while data on the prevalence of developmental disabilities among children are more readily available, studies specific to adult prevalence rates are limited. Such variances in prevalence estimates are cause for concern, as potential “undercounts” may impact the state’s ability to effectively plan and monitor services.
The aging population is anticipated to have a significant impact on this demographic. Life expectancies are increasing for both disabled and nondisabled individuals. As a result of medical advancements and more evolved support services, even people with severe disabilities can expect to live longer than they may have 50 years ago. Therefore, individuals will require care for a longer period of time, leading to increased costs. Similarly, adult caregivers are living longer, creating complex family dynamics that will certainly have serious implications for the DD system. However, data suggest that more than 1,000 developmentally disabled individuals in Ohio waiting for community supports will lose their primary caregiver each year, requiring a need for increased external supports. 6

Figure 1. Estimated Number of Individuals with Developmental Disabilities by County

Source: The Center for Community Solutions; Miami University Scripps Gerontology Center
Service Delivery

The Ohio Department of Developmental Disabilities (DODD) provides general oversight to the state’s system of supports and services for individuals with developmental disabilities. Locally, county boards of DD are responsible for facilitating these services. Ohio’s Developmental Disabilities system is a prime example of the state’s “home rule” governing structure, as government-sponsored services are administered and provided at the local level. Every county is served by a local board, responsible for coordinating services for children and adults with developmental disabilities. Boards, established in 1967 through a legislative act, are made up of members who are appointed by local probate judges and county commissioners or executives. Each board is comprised of seven individuals, including no less than three individuals eligible to receive services or family members of persons with developmental disabilities. Very few boards in Ohio currently have representation by members with developmental disabilities. County boards are headed by a Superintendent (the title reflects the board’s historic role as an operator of schools for children with developmental disabilities), who is responsible for overall administration, though many boards also employ a business manager responsible for financial management and annual budget development.

County boards make eligibility determinations for those with an accepted diagnosis using an assessment tool called the Ohio Eligibility Determination Instrument (OEDI), or COEDI (for children), or other approved instruments. Only those who qualify may receive services (see Appendix I for Eligibility Flow). These tools are administered locally, typically by board-employed Service and Support Administrators (SSA). Across the state, county boards serve nearly 90,000 individuals with developmental disabilities, or about 80 percent of the population with developmental disabilities in Ohio, based on prevalence estimates. This differs widely by county, with some counties, such as Jackson, Portage and Green, serving fewer than 50 percent of their estimated population with developmental disabilities, and others serving over 100 percent of their prevalence estimate.

Depending on the county’s needs and resources, boards often elect to provide a large number of services directly, through board-employed staff, or to contract with local private agencies to provide the needed services. Currently, according to stakeholder interviews, approximately half of all day services are provided by private providers, while the rest are delivered by county boards. Most counties rely on a combination of both direct services and contracts with providers. In recent years, several local boards have “privatized” almost completely. While there are many similarities in the services and supports offered through local boards, the type, quality, variety, and volume of services offered differ from county to county. Funding for board services comes from a combination of local, state, and federal, sources, which are explored in detail later in this report. Many variables influence the service mix in each county, including local levy millage and property values, proximity to providers and the available provider “pool,” as well as community needs. The personal philosophy of local decision makers, namely

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2 Waivers are a Medicaid program that allows individuals to access home and community-based services as an alternative to institutional care.
board superintendents and membership, can also play a role on issues around quality care, local control, and consumer choice.

In addition to support provided through local boards, individuals with developmental disabilities may also seek or receive services and supports through local education and health systems, county offices of Employment and Family Services, and others. While this report will not address these services in detail, this cross-system involvement is common, and is an important factor to meeting the full-range of needs of individuals.

**Age of Individuals Served**
Children make up the largest percentage of individuals served through county board services. In 2012, children ages 0 to 21 represented 52 percent of those receiving services; 21 percent of individuals served were under the age of 6.

![Figure 2. Number of Individuals Served by Age Group, 2012](image)

Just as service availability and funding vary significantly from county to county, the age demographics of those receiving services are similarly diverse. In several Ohio counties, children make up nearly 70 percent of total individuals served (Delaware, Shelby, Noble, Clermont, Morrow and Union counties). Others- including Marion, Monroe, Mahoning, Putnam, and Highland counties- serve predominately adults (65 percent of individuals served). An aging population is sure to be a significant variable in service provision as life expectancies increase. Additionally, age breakdown can impact funding, as services for adults are typically more expensive, often including the provision of day services as well as other supports (whereas school-age children are served by local school districts).
Service Overview

Often, individuals with developmental disabilities require some degree of supportive services in order to complete basic tasks of everyday life, like eating, bathing, dressing, and using the restroom (called activities of daily living, or ADLs), and to live healthy, fulfilling lives. However, the level of support necessary varies considerably depending on the level of disability, affecting the range of services available to achieve the needed support.

Services for individuals with developmental disabilities can take place in a variety of settings, including institutions or day facilities, as well as home and community-based locations. While service provision has historically swayed toward institutional settings, the pendulum has swung toward a preference for community-based services and independent living, which are seen to decrease isolation and increase integration for individuals with developmental disabilities. Finding the proper balance between home, community- and facility-based settings is an ongoing discussion across the state and country.

Services for Children

For children (individuals under age 22) with developmental disabilities, common supports and services include Early Intervention, Family Support Services, and Special Education. Early Intervention services are for infants and toddlers (under the age of three) who are known to have a developmental delay or disability, or who have a diagnosed condition with a high probability of resulting in a developmental delay. Primarily federally funded, these services are available through Part C of the Individuals with Disabilities Education Act (IDEA). The Ohio Department of Health’s (ODH) Help Me Grow Program is currently the designated Part C lead in Ohio, and administers the Help Me Grow system, which is available to families in all 88 counties. Children receiving early intervention services have an IFSP, or Individualized Family Service Plan, which details the family priorities, the services needed to support those priorities (outcomes), and the progress in meeting those outcomes. The federal legislation and ODH rules list the many services that may be used to achieve the child and family IFSP outcomes (e.g., therapies, special instruction, vision, or audiological services). These services are provided through a joint effort with local county boards of developmental disabilities, as well as other providers, including those contracting directly with ODH, and include both evaluation of the child and the provision of appropriate services, supports, and therapies to promote healthy development. As children with developmental disabilities transition through the education system, children at age 3 may continue to have a disability and be eligible for special education services through their home school district. These services are provided through an Individualized Education Plan (IEP) which contains information about the student’s disability, as well as individual educational goals and services for that student. Both IFSPs and IEPs are considered legal contracts, and adherence to the services agreed upon in the document (including frequency, intensity and method) is required by law.

Children may be “identified” at any time from birth throughout their school years, which includes the requirement to be evaluated to determine their level of disability and needed supports. Using county assessment data, and dependent on funding availability, county boards
work with local districts to determine what special education services they will provide. As the child’s home school-district ultimately remains responsible for the education of the child with a disability, partnerships between boards and districts are crucial, particularly with regards to vocational training for transition-age youth.

Historically, county boards have operated schools for children with disabilities. Often well-known in the community, these schools provide specialized services specifically for children with disabilities. While some schools welcome “typical” peers to increase inclusion, others do not. This service has diminished over the past several years; however, approximately 42 county boards continue to operate center-based preschools and school-age classrooms. Additionally, public schools may have “collaborative” classrooms, wherein the county board provides a teacher to operate a self-contained classroom for students with developmental disabilities out of a public school building. Yet, as public schools are now increasingly accommodating children with disabilities, and parents are increasingly interested in integrated schooling, support for these facilities is likely to continue to decline.

Family Support Services and funds are available to those who meet income guidelines. These services are designed to help families cope with the challenges they may face in supporting their family member with a developmental disability, and often include such services as respite care, counseling or training services, or summer camp assistance. Family Support dollars may also be used for Medicaid waiver match, and to supplement the cost of services not covered by Medicaid or other revenue sources.

As individuals transition from child services to adult life, they may face a variety of obstacles and may again rely actively on county boards for supports as they develop plans for their futures. All students aged 14 and older with developmental disabilities must have an IEP that includes plans and goals for adult life, such as vocational or postsecondary education goals, plans for independent living, and supportive services that will be needed as the individual reaches adulthood. Extensive planning and discussion should occur among the individual, family members, county board staff, school district representatives, and other team members (such as providers) to map out the best plan, as required by IDEA. Results from the Ohio Longitudinal Transition Study (2005-2012) demonstrate the impact of early planning. Students with cognitive disabilities who were able to apply for employment opportunities before they graduated were 44 percent more likely to be employed full-time after leaving school. It’s widely recognized that there are inconsistencies in how this planning occurs from district to district, and work is being done to improve the process through the Employment First Initiative, as well as other programs and partnerships.

Adult Services
For many adults with developmental disabilities, a multitude of services exists. Individuals who are receiving services from their county board of DD are assigned to a Service and Support Administrator (SSA), who can help eligible individuals to identify their strengths and areas of need, point them toward community resources to best meet those needs, and determine which
services will be needed and how they will be paid for. Individual Service Plans, developed by SSAs with input from the individual, family members and others, dictate what services are provided at what level. SSAs act as case managers, working to coordinate services and facilitate communication among providers. SSA caseloads typically range from 35 to 50 clients, but in some instances are much higher. The primary services available to adults with developmental disabilities are residential supports (institutions or community-based), transportation, and employment or day services; however, boards may provide adaptive equipment and necessary home modifications that meet the needs of the individual with a disability. Behavioral treatments, including psychological supports and counseling, may be provided to assist individuals with mental health problems that hinder them from leading fulfilling lives. Additionally, boards often provide services to assist individuals to access and use assistive technology. Many communities also offer classes or workshops and community groups for individuals and families. A myriad of support services are available, though the types and volume of services offered vary by county. Furthermore, funding sources for these services vary, and some services may be provided directly through board staff, while others are available through private providers.

The remainder of this report will address services that are most commonly used by adult consumers.
Residential Services and Supports

Intermediate Care Facilities and Developmental Centers

Residential options for individuals with disabilities vary greatly, and there is much debate about the ideal distribution of housing options (large or small institutions, and home and community-based services). Currently, Ohio relies more heavily than other states on ICFs, or institutions intended for those with intensive physical, behavioral, or self-care needs. ICFs include both privately owned and operated facilities, board-owned-and-operated facilities, and state-run developmental centers (DCs). In 2014, these residential options (ICFs and state DCs) accounted for about 6,700 slots for individuals, often referred to as “beds.” About 5,700 of these Ohioans live in private ICFs. Figure 3 illustrates the percentage of individuals with developmental disabilities living in private ICFs throughout the state (based on prevalence estimates).

Figure 3. Percentage of Individuals with DD living in Private ICFs, 2015

Source: The Center for Community Solutions; DODD; Miami University Scripps Gerontology Center
DODD operates 10 facilities, in Cambridge, Columbus, Gallipolis, Montgomery, Mount Vernon, Toledo, Batavia, Tiffin, Warrensville, and Youngstown. Gallipolis houses the state’s largest DC, while the smallest is in Cambridge. 10 Despite large scale “de-institutionalization” that took place over the past 30 years, these state developmental centers continue to serve about 950 individuals. Efforts are underway to decrease this service; in early 2015, DODD announced the upcoming closure of the Montgomery and Youngstown centers, slated for July, 2017, and impacting 180 residents. DODD hopes to decrease the number of individuals living in DCs by about 25 percent over the next biennium.11

While there are many similarities between private ICFs and state DCs, developmental centers often are better able to serve individuals with significant behavioral issues, or those required to be institutionalized through court mandates, though many states serve these individuals without the use of state-operated centers. Additionally, many cite the role of DCs in providing brief respite services to individuals in crisis or those in need of stabilization, though the median length of stay is about eight months.12

Figure 4. ICF Locations in Ohio, 2014

Source: The Center for Community Solutions; DODD
The overall institutional rate in Ohio is about 14 percent (the number of ICF beds per total residential options, not including DCs); however, some counties have high concentrations of ICF beds, while twenty-five of Ohio’s counties have no ICF beds.13

**Resident Acuity Levels**
Acuity level is one factor utilized to determine reimbursement rates at private ICFs. Acuity assessments are utilized to determine the level of staffing support and other resources necessary to provide quality services to an individual. In Ohio, this is developed through the Resident Assessment Classification (RAC) methodology. Revised in 2013, the new methodology has six classifications. Data from 2014 demonstrate that only about 8 percent of residents have chronic medical conditions (the highest level of acuity, RAC 1), while 12 percent have typical adaptive needs (the lowest level of acuity, RAC 6).14 Residents with higher acuity levels may find it more difficult to move to community settings.

**From Medicaid.gov:**
“ICFs/MR provides active treatment (AT), a continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping the enrollee function with as much self-determination and independence as possible.”

**Figure 5. Resident Acuity Levels at ICFs, 2014**

<table>
<thead>
<tr>
<th>Acuity Level Description</th>
<th>Number of ICF Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical Adaptive Needs (RAC 6)</td>
<td>675</td>
</tr>
<tr>
<td>Chronic Behaviors and Typical Adaptive Needs (RAC 5)</td>
<td>580</td>
</tr>
<tr>
<td>High Adaptive Needs and Non-significant Behaviors (RAC 4)</td>
<td>1506</td>
</tr>
<tr>
<td>Chronic Behaviors and High Adaptive Needs (RAC 3)</td>
<td>868</td>
</tr>
<tr>
<td>Overriding Behaviors (RAC 2)</td>
<td>1550</td>
</tr>
<tr>
<td>Chronic Medical (RAC 1)</td>
<td>420</td>
</tr>
</tbody>
</table>

**Source:** DODD

**Bed Size and Capacity**
Ohio has made significant progress over the years in rebalancing its long-term care systems for the elderly and the disabled. Waiver services have grown, allowing the state to serve over 25,000 persons in smaller settings with six or fewer persons in 2011.
The size of both private and public ICFs has been heavily scrutinized by advocates, who maintain that facilities with large numbers of beds are more likely to be “institution like” and less likely to mirror independent living situations. Ohio is seventh-highest in the nation for individuals living in residential settings with seven or more beds, and ranks third for the overall number of state-operated facilities. According to data provided by the University of Colorado’s “State of the States in Developmental Disabilities,” in 2013, over 77 percent of people served by the developmental disabilities system in Ohio were in residential settings with six people or fewer (primarily supported living, or home and community-based services), while the remaining 23 percent were in settings with more than six persons. However, the greatest number of individuals in this category lived in 16-bed or larger ICFs. While the number of individuals living in small (six beds or less) settings has increased dramatically over the past years, the number of individuals living in large settings has decreased only marginally. Nevertheless, new ICF beds are not being added; Ohio has had a moratorium on institutional beds for the past several years.

Of the approximately 420 private ICFs in operation in 2014, more than three-fourths were six beds or larger. In total, almost 3,000 individuals lived in facilities with over 16 residents, while only 529 were living in small, six bed or smaller, facilities.
The average cost for a resident at an ICF in Ohio is about $101,000 per year, while the average cost for an individual living in a DC is much higher at about $200,000 per year. Reimbursement rates at private facilities are determined by a cost-based reimbursement
formula. Currently, beds are reimbursed, on average across the state, at the rate of $282.77 per bed per day; though the actual cost of providing services is likely slightly higher. Currently, local funding or outside fundraising may make up the difference. As nearly everyone who is eligible for services at an ICF is also Medicaid-eligible, ICFs are almost exclusively Medicaid-funded, with the state responsible for covering the required nonfederal match. The daily cost of care varies greatly between ICFs and DCs, in part due to variation in wages paid to staff and variations in the needs of the populations served. Average costs per person at DCs have risen in part due to the falling number of DC residents.

**Figure 9. Average Annual Cost per Person, Ohio’s Developmental Centers**

![Bar chart showing average annual cost per person from 2012 to 2014.](image)

Recent action by Disability Rights Ohio called into question the state’s heavy reliance on ICFs, which many believe promote segregation, impede the rights of those with developmental disabilities, and may violate federal law. Additionally, because the state pays the nonfederal Medicaid share, advocates emphasize the monetary incentive boards may have to continue to direct individuals into ICFs rather than more integrated, community-based facilities that are board-funded.

**Home and Community-Based Residential Services**

Despite a heavy reliance on institutions, many adults with developmental disabilities are able to live in a home setting, either alone, or with roommates or family members. Many home and community-based services (HCBS) that are available can be paid for using a Medicaid Waiver. Medicaid HCBS Waivers allow for states to make exceptions to federal Medicaid rules; consumers “waive” their right to institutional care, allowing individuals with disabilities to receive care in their homes instead of in a long-term care facility. Waiver programs include services such as nonmedical transportation, employment and day services, nutrition assistance,
respite for caregivers, certain therapies, accessibility modifications, and personal care assistance. Waivers do not reimburse for room-and-board. Nursing services are a limited benefit available through the regular state Medicaid program.

Waiver services may be provided directly by county board staff or by local private providers. In some cases, these local waiver providers also operate ICFs, in addition to providing waiver services. Initially conceptualized to create cost savings, waiver services are intended to be more cost effective than facility-based residential services. According to the Legislative Service Commission Redbook (2016-2017), in 2014, the average monthly cost of an individual on an Individual Options Waiver was $5,721, while the average monthly cost of an individual in a state developmental center was $16,771.\textsuperscript{18} However, these savings are not always realized. While the average annual per-person waiver cost in 2014 was about $41,000, individual amounts can exceed $100,000 annually in some counties.

County boards are responsible for administering waiver programs, which are funded through Medicaid. However, unlike ICFs, the most commonly used waivers rely on a local match from county boards to cover the nonfederal share. The state requests a fixed number of waiver slots from the Centers for Medicare and Medicaid Services (CMS), which are allocated to counties by DODD. Each quarter, county boards make a request to DODD for the number of waivers they anticipate needing, though this can be amended as needed. Counties must identify those in the community who both want and need waiver services. DODD uses information provided by counties through the Planning and Implementation Component Tracking (PICT) tool to determine waiver distribution. If the state acquires new waivers, DODD makes adjustments using this information.
Each county has an established “floor,” or minimum number of waivers that it must offer (which assures that the waiver is “statewide”). Additional waiver allocation is intended to assure that there is proportionate access; however, this is partially determined by demand for services. The state’s waiver application specifies that “individuals who live in counties with longer waiting lists will be able to access waiver opportunities on a proportionately higher level as opportunities become available.”

Ohio currently has four developmental disability waiver programs that serve people with different types and levels of need, including the Individual Options (IO) Waiver, the SELF (Self Empowered Life Funding) Waiver, Transitions DD(TDD) Waiver, and the Level One Waiver (see chart in Appendix II for details). The Ohio Department of Medicaid (ODM), as well as the Ohio Department of Aging also administer waivers for their consumers. The TDD Waiver is currently state-funded, as well as 1,500 Nancy Martin waivers; county boards are responsible for the majority of the match for the other three waivers. Spending limits vary for each DODD waiver. The Level One Waiver has an annual limit of $5,000, with the possibility of adding small amounts to cover assistive technologies. The SELF Waiver has an annual limit of $25,000 for children and $40,000 for adults. The IO Waiver does not have an individual spending cap.

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3 The Nancy Martin Settlement (2007) was the result of a class-action lawsuit focused on congregate settings. It required Ohio to fund 1,500 IO Waivers to increase access to community-based services.
According to data from DODD, as of February 2015, over 35,000 people were served through DD waivers. IO Waivers make up the largest portion of waiver enrollment across the state, then Level One Waivers, followed by state-funded TDD Waivers. SELF Waiver (the newest waiver) enrollment is currently the lowest, with 387 enrollees.\(^{20}\)

![Figure 11. 2015 Waiver Enrollment, By Type](image)

Source: DODD

While eligibility (level of care) is the same for both ICFs and waiver services, the services covered are not comparable. ICF services are “bundled,” and intended to meet the full range of needs of their consumers, including room and board. However, waiver services are more limited. Nursing services are not currently covered under DODD waivers\(^{21}\) (except for the TDD Waiver, previously administered under ODJFS, and paid for by the state), and as aforementioned, federal requirements prohibit waiver funds from reimbursing for room and board. Therefore, individuals living in the community with waivers typically rely on SSI (Supplemental Security Income)\(^4\), wages from employment, or financial support from families to pay for housing. Boards may also provide housing support in the form of rental assistance, depending on funding availability.

Since 2002, the number of waivers has quadrupled, rising from 7,797 to 35,200 waiver participants in 2015.\(^{22}\) DD waiver service reimbursement in Ohio totaled approximately $1.5 billion in 2014. In that year, the primary services supported through waivers were homemaker/personal care services, adult day services, and nonmedical transportation. Both total waiver spending and total waiver recipients have increased since 2011, however the

\(^4\) The maximum monthly SSI payment amount for 2015 is $733. The average monthly payment for an individual in 2014 was about $550.
average per-person spending has decreased. This is largely to due to only a marginal increase in enrollment for costly uncapped IO Waivers and a greater increase in Level One Waivers (which have cost limitations). Combined IO and Level One per-person waiver spending decreased between 2011 and 2014 by nearly 7 percent, while participation increased by 23 percent. Advocates have expressed concern that, as a result of pressure to decrease waiting lists and an inability or unwillingness to tap local funds to cover the waiver match, individuals will be pushed onto less costly capped waivers, such as the SELF and Level One, which may not meet their full needs. A 2012 letter from Disability Rights Ohio (then Ohio Legal Rights Services) addressed to Department Director Martin at the time the SELF Waiver was introduced states:

"...due to matching-fund obligations, the system creates a perverse disincentive against expanding the availability of HCBS waivers for people with developmental disabilities in Ohio. Specifically, the use of local funding to match the cost of HCBS waivers (except Nancy Martin Waivers) while state funding is used to match the cost of expensive institutional care, encourages county boards of developmental disabilities to support institutional placements, thereby shifting the increased cost to the state. Even in those situations in which county boards support community placement, there is a finite amount of resources available to county boards and therefore individuals will inevitably be induced into enrolling on the capped SELF Waiver rather than the uncapped IO Waiver. This is a frightening prospect for the future of the IO Waiver specifically, and the developmental disabilities community in general. Indeed, many advocates are concerned that unless the state elevates the matching-fund obligation, the SELF Waiver will simply be a method to refinance individuals already enrolled on the IO Waiver, rather than a true effort to increase the total number of HCBS Waiver slots available in Ohio."
Figure 12. Total Waiver Reimbursement, by Waiver Type

Source: The Center for Community Solutions analysis of DODD data
Note: Amount of reimbursement for SELF Waivers is too small to appear in chart.

Figure 13. Individuals Served on Waivers, by Waiver Type

Source: The Center for Community Solutions analysis of DODD data
Note: Amount of reimbursement for SELF Waivers is too small to appear in chart, but is labeled for 2013 and 2014.
Data suggest that while the level of care for both waiver and ICF services is identical, impairment levels differ. According to data from 2007, of those with ID/DD living in ICFs, about 66 percent had profound or severe levels of impairment. In contrast, about 16 percent served on Level One and 23 percent on Individual Options Waivers had similar levels of impairment. And, 13 percent of those living in ICFs had mild levels of impairment, compared with 36 percent on IO Waivers and 35 percent on Level One Waivers. The exclusion of nursing services (except for the limited regular Medicaid benefit) in any current DD waiver surely affects these variances. However, these figures have implications for both the cost, and the delivery of HCBS services.

SELF Waivers, which are consumer-directed waivers, have received criticism from some and have experienced a lower than expected take-up rate, since while they have a higher cap than Level One Waivers, many boards find that they can be difficult to use. Others maintain that the SELF Waiver helps to promote consumer choice and independence, and can provide good middle-ground between Level One and costly uncapped IO Waivers.

**Shared Living**

“Shared living” arrangements, commonly referred to as adult foster care, are another non-institutional housing option for individuals with developmental disabilities. In shared living arrangements, the individual with a disability lives with one or more nondisabled adults, or a family, who are responsible for the individual’s care. Additional supports may also be available, such as community programming, transportation, or respite. Shared living homes are managed by local providers, who provide administration and support. The consumer’s income (typically SSI or earned income from work) covers the costs of room and board; waiver funds cover the
residential support services. The individual typically participates in many activities of the family’s daily life, while also enjoying relative independence. While the concept of community members opening their homes to adults with disabilities or illness is hardly new, currently, this strategy only accounts for about 6 percent of waiver service delivery in Ohio. However, efforts are underway to expand the program and recruit additional families to participate. The Strategic Planning Leadership Group, a workgroup with representatives from DODD and DD stakeholder organizations, proposed to expand shared living to 25 percent of waiver participants over the next 10 years. Proponents feel that for some individuals, shared living offers more stability compared to ICFs or supported living, where high staff turnover can be a factor, and can significantly increase opportunities for community experiences in integrated settings. Additionally, the model is cost efficient and allows for a great deal of independence. The administration is seeking to expand the availability of this option.

Skeptics question whether bringing the program to scale is a plausible solution, and challenge that there is insufficient capacity to provide the necessary oversight to protect an individual’s safety and wellbeing. The chances of social isolation may increase if the foster family is not as inclusive as they should be. Concerns about identifying a sufficient number of appropriate home providers also persist. Some question whether providers will take interest in the service, given the low-reimbursement rate. However, other states have seen significant success with this approach. For example, in Vermont, over 70 percent of individuals with disabilities who receive home support live in shared living arrangements.

Waiver Challenges and Waiver Waiting List
Changes to Ohio’s waiver system are imminent both as a result of recent Medicaid rule change and state efforts to modify the option to increase participation. Waiver administration, funding challenges, and long waiting lists have received significant attention lately, especially as a result of the 2014 report “What Are We Waiting For? Waiver Supported Services Needed by Individuals and their Caregivers,” released by the Ohio Developmental Disabilities Council and completed by the Ohio Colleges of Medicine Government Resource Center for Ohio. There is growing recognition that large scale change is necessary to reform the system.

While there is officially one statewide waiver waiting list, each county administers their own waiting list; as of October, 2014, there were over 45,000 people on waiting lists. According to the abovementioned waiver study, the median wait time across the state is about 6.4 years. This same study, however, concluded that over 45 percent of those waiting reported no current unmet need. According to the study authors, this suggests that many people sign up for waiver services in anticipation of future needs, perhaps as a result of historically long waits. Ultimately, the study reports that there are approximately 22,000 individuals with current needs waiting for services. The number of individuals on waiting lists varies significantly by county, but overall, DODD reports the statewide list grows by 100 to 200 individuals each month. In discussions conducted for this study, several counties indicated that they are only taking individuals off of the waiting list on an emergency basis or as other individuals with waivers no longer require these services, due to death or relocation. Others indicated that some individuals are receiving locally funded non-waiver services and the SSA disagreed with the need to expand their service
offerings.⁵ Therefore, with new people joining the waiting list regularly, it is an uphill battle for boards to make meaningful decreases in the size of their waiting list.

Many factors contribute to long waiver waiting lists, including a lack of adequate local funds to make the match. As waiver costs are incurred throughout the year, boards are responsible on an ongoing basis for making the match for those with existing waivers. Additionally, costs can vary from year to year as an individual’s needs shift, making planning difficult. Declining or stagnant property values may also limit a board’s overall levy returns. Some boards’ levy revenues have been affected by the elimination of the tangible personal property tax and the phase-out of the state’s compensation for this lost revenue source. Limited local funds constrain the number of new waivers that a county can offer, and make significant waitlist reduction a challenge. There is currently a great deal of variability from county to county in the proportion of estimated individuals with developmental disabilities receiving waiver supports. As shown in Figure 15, even counties with aggressive use of waivers are reaching just over 50 percent of the total estimated population with developmental disabilities.

⁵ Individuals have appeal rights if they are denied a Medicaid waiver.
However, the data demonstrate that funding alone does not determine waiver accessibility. County boards may elect to divert available funds to other programming, also a potential contributing factor. Given the many restrictions and requirements tied to waiver services, counties may be reluctant to expand their HCBS programs for fear of losing local control. Because IO Waivers are the most frequently utilized waiver, which are without an individual monetary cap, boards may be overly cautious to offer new waivers without knowing what their contribution will be in future years. Despite these dynamics, waiver growth has been significant in Ohio. Since 2011, Ohio has gained close to 5,000 waiver recipients, in spite of challenging economic times.

On average, in 2013, counties had about 1.5 people with developmental disabilities waiting for waiver services for every person receiving waiver services. Twenty-three counties had fewer people waiting for services than receiving waivers. Carroll County had the lowest ratio, where...
82 people were served by waivers, while only 26 people were actively on the waiting list. This is also one of the shortest lists. In contrast, 65 counties had more individuals waiting for services than receiving services, including 16 counties that had more than twice as many people waiting for services than actually receiving them. Trumbull County, in Northeast Ohio, had four times more people waiting for services than receiving them. And while distribution of waiver slots is meant to be determined in part by demand for services, many counties with sizeable waiting lists, including Franklin, Clark, Licking, and Trumbull, have a much higher proportion of people waiting than receiving services than the state average. These counties also have longer than average wait times.

Figure 16. Ratio of Individuals on Waiting List to Individuals Receiving Waiver Services by County, 2013

Source: The Center for Community Solutions analysis of DODD data
Conversions and Downsizing

DODD has recognized that there are many individuals living in ICFs who may be candidates to live in the community with supports and that the current funding mechanism doesn’t provide an adequate number of Medicaid waivers to meet the demand. According to a January, 2015 presentation by DODD Director John Martin to the Joint Medicaid Oversight Committee (JMOC), over 35 percent, or 2,500 individuals currently living in ICFs are waiting for waiver services.

To respond to this growing demand, the state is working to convert ICF beds to waivers. Relatedly, efforts are underway to decrease the size of large-bed facilities. Labeled “rebalancing,” DODD has stated its intent to “increase the number of individuals who have the option to receive services in home and community-based settings,” though emphasizing that ICFs should remain available for short-term arrangements, respite services, or for individuals who may not be able to receive appropriate services in the community. DODD maintains that ICFs could have the potential to net cost savings for those who are able to avoid hospitalization.

Downsizing seeks to reduce the size of large facilities to eight beds or fewer. The process has often involved one facility splitting into two or more smaller facilities, though the total number of beds usually remains the same (the facility names may change). The goal is for settings to more closely replicate a home environment. Additionally, there is an emphasis on community integration, and moving away from campuses that may have multiple smaller structures segregated from other non-ICF buildings.

ICF providers are seeking greater financial incentives to convert and/or downsize, including assistance with the expected monetary loss resulting from closing facilities and already accrued capital debt, as well as a rate increase to offset the loss from conversion of beds or downsizing. Additionally, some providers seek to be more involved in deciding which individuals would benefit most from available waivers. The Executive Budget seeks to address these issues and incentivize downsizing, in part, through increasing rates for people with high acuity (to discourage enrolling individuals with less high needs) and by offering some debt forgiveness. Additionally, the Department seeks to make those in ICFs a priority for new waivers, and to require a recommendation from the county board before an individual enters an ICF to help ensure a proper placement. Bed buy-backs are also proposed, as well as other initiatives to speed up this process (see additional budget details later in the report).

In relation to the total number of ICF beds, the number of conversions and downsizings is very small. From 2013 to 2014, the number of private ICF beds decreased by 1.5 percent to 5,634 beds. Since 2012, 2.8 percent of ICF beds (157) have been approved for conversion; however, only 67 of these have been completed (1.2 percent of beds). In terms of downsizings, 478 beds (8.5 percent of beds) have been approved for downsizing, but only 44 (0.8 percent) have been completed.

Likewise, the number of beds being converted to waivers, or being downsized, at any given facility is small. The median number of beds approved for conversion per facility is two, while
the median number of beds approved for downsizing per facility is seven. Many advocates in the developmental disabilities community feel these efforts have been too slow and inadequate.

Questions remain about the impacts of waiver conversion and downsizing, particularly around the issue of room and board. As waivers do not cover these costs, there is concern about the housing needs of those who transition out of ICFs, without additional dollars being allocated for this expense. The governor’s 2016-2017 budget proposal includes the addition of funds for rental assistance for those leaving ICFs; however, the details were not clear at the time of publication. Additionally, some have questioned the long-term financial implications of downsizing and conversions, as waiver costs for those transitioning out of full-time care could be significant.
Day and Employment Services
In addition to residential supports, Ohio’s developmental disability system includes services that offer support for social and employment needs. Medicaid funds are the primary payer for most day and employment supports, though county boards often heavily supplement this funding. One option often available for adults with developmental disabilities is to attend an adult day program. These centers are often run by private organizations, though they may also be operated by boards themselves. Adult day care programs offer options throughout the day that are designed to engage individuals, teach them life skills, help them with social interaction, and provide some opportunities to integrate them into their community through day trips. Often, participants spend most of their day around others who also have disabilities.

Adult programs may also be vocational in nature, including facility-based sheltered workshops. A sheltered workshop is a supervised work setting that exclusively employs individuals with disabilities. Individuals are most often paid for their work, however, often at rates below the minimum wage.

Subminimum wages are allowed under Department of Labor rules for piece work where the individual is performing at productivity rates below the market rate (established through the Fair Labor Standards Act, section 14(c)). The Workforce Innovation and Opportunity Act, signed into law in 2014 and replacing the Workforce Investment Act (WIA), places increased restrictions on individuals under the age of 24 who qualify for subminimum wage. This includes requiring the opportunity for integrated work before subminimum wage can be an option. The provision was developed to decrease the practice of young people transitioning directly from school into sheltered workshops. Despite these increased limitations, the law continues to allow the practice.

The goal of sheltered work is to prepare individuals for work in the private job market; however, this is frequently not the outcome as the skills acquired through sheltered work are not often transferable to other jobs. According to results of a study of individuals with Autism Spectrum Disorder (ASD), “individuals with ASD achieve better vocational outcomes if they do not participate in sheltered workshops prior to enrolling in supported employment.” Similarly, while often framed as a short-term transitional option, for many, sheltered work placements are long-term or permanent. Research suggests as little as 5 percent of those in sheltered workshops transition to community employment. Proponents of sheltered work argue that for some individuals, the setting provides an opportunity for fulfilling work and social engagement in a safe, supervised, and predictable environment, that they may not be able to find elsewhere. “Enclave” assignments, where individuals perform work-tasks with supervision in a group setting, are another option available in many communities.

Another more independent and integrated option is obtaining community employment. Community employment is competitive and takes place in an integrated setting. According to the National Core Indicators Adult Consumer Survey (2012-2013), 36 percent of Ohio
respondents who did not have a paid job in the community wanted paid community employment. But for some with disabilities, employment is not simple to obtain or maintain; employment supports may be necessary for them to be successful in community workplaces. These supports, either provided by board staff or private providers, may include vocational training, help to search and apply for job openings, assistance with transportation to and from work, training on how to handle issues that may come up in the workplace, and help with understanding salary and benefits. Other individuals may require a full- or part-time aide to provide support and assistance as they complete their daily work functions. To assure opportunities are available, efforts may also be directed toward developing partnerships with community employers to encourage employment for people with developmental disabilities, and offering training for how best to integrate individuals with developmental disabilities into their workplaces. In addition to supports through local boards, Opportunities for Ohioans with Disabilities (OOD) provides employment services, available for individuals with developmental as well as physical disabilities, which may include evaluation, information and referral services, vocational counseling and training, job search and job placement assistance, educational guidance (tuition resources and other support), transportation services, occupational tools and equipment, and personal attendant services (reader, interpreter, etc.).

Ohio ranks sixteenth in the nation for integrated employment (percentage in supported or competitive employment). Currently, approximately 25 percent of Ohioans with developmental disabilities work in integrated community employment settings.

Figure 18. Day Service, by Type, October, 2014

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day</td>
<td>6,280</td>
<td>20%</td>
</tr>
<tr>
<td>Integrated Employment</td>
<td>8,124</td>
<td>26%</td>
</tr>
<tr>
<td>Sheltered Work</td>
<td>16,886</td>
<td>54%</td>
</tr>
</tbody>
</table>

Source: DODD
Note: Unduplicated count (individuals could receive services from more than one category)
Funding for integrated employment services at the board level increased very little between 2007 and 2012 (most recent available—see county board financial data below).

There is growing recognition that many current day programs for individuals with disabilities are often needlessly restrictive and isolating. Many advocates argue that sheltered workshops and adult day programs segregate individuals with developmental disabilities from the community at large and do not provide adequate training for community employment, while often paying individuals less than a minimum wage.

Some challenge that they are in violation of the Integration Mandate of the Americans with Disabilities Act. But as Disability Rights Ohio recently pointed out in their letter to the state, Ohio is still relying heavily on sheltered workshops, with 93 percent of its employment dollars going toward them. Additionally, as new HCBS Medicaid rules apply not only to residential settings, but to any setting where HCBS Waiver recipients may be receiving services, sheltered workshops and adult day programs, as they currently exist, are not likely to comply with the changes. In spite of the controversy, some individuals with developmental disabilities, advocates, and family members continue to praise their benefits. They maintain that many individuals with developmental disabilities cannot fully adjust to community employment and will face harassment or bullying, and that the community at-large is not ready and willing to accept integrated employment. A vocal group of individuals with developmental disabilities, family members, and providers, has worked to highlight this issue across the state. According to one consumer (quoted in Ohio Schools magazine):

“I’ve had my share of issues with work in the community,” Nicole says. “I was harassed—told that I couldn’t do my work fast enough, that I wasn’t getting enough done, that my transportation issues were a problem.”

“I love it at the workshop. I have a lot of friends here. I don’t feel that I am being pushed to do stuff and I can take my time. But the best benefit is the extra support that you get. It makes the difference. I look forward to coming to work each day. It’s my

Sheltered Work and Wages

Average wages in Ohio’s integrated employment programs surpass those of the nation as a whole, at over $265 per two-week period compared with about $185. And, with regards to sheltered work pay, according to analysis of wages paid to disabled workers completed by The Columbus Dispatch,

“At least 14,600 developmentally disabled Ohioans earn less than the minimum wage for the work they are doing. The number is likely much higher, but wage information is not public in 18 of Ohio’s 88 counties…Statewide, there are about 21,000 disabled Ohioans who receive services through their counties and are employed. About 70 percent work in sheltered workshops, quasi-industrial settings that resemble factories. The counties that run sheltered workshops bid on jobs with government agencies and private companies for contract work, such as assembling Christmas packages for prison inmates, bagging stuffed animals and inspecting baby-food jar lids.

Worker pay is based on productivity. A disabled worker who can perform a task at 30 percent the rate of a nondisabled worker would earn about a third of minimum wage—$2.22 an hour. More than 80 percent of the low-wage work force earns an hourly wage of $3.70 or less. More than 35 percent, or 5,200 workers, make less than $1 an hour. Nearly 1,000 make less than a quarter an hour.”

Source:
http://www.dispatch.com/content/stories/local/2011/05/22/far-below-minimum-wage.html
choice to be here and if they take away that choice, I’m screwed.”38

Currently, reimbursement rates for agencies providing employment services are determined in part by “cost of doing business” regions. Counties fall into different categories based on cost of living. For sheltered work, or vocational habilitation, rates vary based on acuity and group size. Rates range from a daily rate of about $30 per day for lower acuity consumers in the counties with the lowest cost of living, to as high as $126 per day for higher acuity consumers in the counties with the highest cost of living. As sheltered workshops are able to serve multiple consumers at one time, their ability to bill for services may be greater. While staffing ratios are greater for higher acuity consumers (1:3 to 1:6), at the lower range the ratio is as high as 16 consumers to one staff person. The current rates and staff ratios allows for providers to bill for as much as $450 a day per staff person. Rates for supported community employment are not based on acuity; they are determined in 15-minute increments, ranging from $6.21 for independent providers to $14 for agency providers. These rates would also allow for a staff person to reimburse for a maximum of about $450 per day. However, given the restrictions on what services can be reimbursed, the total number of individuals a provider may serve in a day, and the likelihood that consumers are not receiving a full day of support, these providers are unlikely to have comparable earnings to workshop providers.

Employment First
Ohio’s Employment First Initiative was developed in response to growing public sentiment that isolated employment settings, or day programs, impeded people’s ability for personal and professional growth, and that working-age adults with disabilities should have the same opportunities and expectations as working-age adults without disabilities. Employment First emphasizes the importance of integrated employment for all persons with developmental disabilities and consequently is working to design a funding system to shift resources to accommodate that vision. In 2012, the initiative began to be implemented statewide, mandating that the preferred outcome for all working-age adults is community employment, which not only gives them greater financial independence, but also further integrates them into their communities. The philosophy behind the policy is the presumption of employability of all. The goal of the policy is that every individual will be involved with community work and life, recognizing that the time and steps it takes to reach this goal may look different for everyone. Not everyone will want to, or be capable of, independent integrated community employment—a continuum of options are possible (called “pathways”). This includes integrated prevocational training to develop workplace skills; individual integrated work (with or without supports); enclave, or group integrated/community work; and for those who aren’t able to work, community-based day services, such as volunteer work or otherwise spending time in a community setting. Employment First is meant to be flexible in its implementation; each county administers its DD services independently, and barriers and challenges vary significantly from county to county. The 2014-2015 budget included $3 million to fund a series of changes to support the initiative, operated through a partnership with the Opportunities for Ohioans with Disabilities Agency (OOD), reflecting an increase of $2 million since the program’s launch in 2012. The governor’s 2016-2017 budget proposal includes an additional $2.8 million for each year to bolster community employment efforts.
While boards play an integral role in coordinating and, in some cases, providing employment services, if an individual with a disability expresses a desire to work, he or she may first be directed to services through OOD. The relationship with OOD is considered key to the success of Employment First, and provides an opportunity to tap into federal funds. Through the partnership, OOD has Employment First counselors working out of regional offices across the state who are meant to work in cooperation with the county boards to address barriers to community employment. According to some boards interviewed for the report, however, an overlap in services, discrepancies around agency role and eligibility, and reports of poor management have resulted in some challenges among DD boards and Bureau of Vocational Rehabilitation (BVR) offices.

Since its inception, Employment First has not led to significant change in the employment landscape throughout the state. As of October, 2014, 16,886 individuals were active in program facility-based work (sheltered work). An additional 6,280 individuals were participating in adult day programs. 8,124 were employed through integrated work programs—representing just 26 percent of all activities. According to the National Core Indicators Adult Consumer Project, in 2012 and 2013, of those involved with integrated employment, half were in a group supported employment position (enclave), and just 1 percent was working for pay without supports in competitive environments. Since 2012, the increase in integrated employment programs has been about 10 percent, while the decrease in sheltered work placements has been only about 4 percent.

![Figure 19. Employment and Day Services, 2012-2014](image)

While advocates continue to push for higher levels of integrated employment, Ohio’s rates remain higher than the national average (about 18 percent in 2012). Will community employers engage fully to provide sufficient employment opportunities for individuals with disabilities? Will providers successfully adapt from administering sheltered work and adult day programming to a new model of supported employment? Is integrated
employment realistic for all individuals? Most importantly, how will family members and consumers adjust to the changes? There are still many unknowns as the policy begins to be more aggressively implemented. Many support a “close the front door” strategy that would gradually phase out sheltered work, by no longer expanding less integrated forms of employment, but still allowing individuals to stay in these environments if they chose. The CMS rule change, and the outcome of the consequent Transition Plan (see details later in report), will largely determine the pace of these changes.

Work will need to be done to educate community members and employers on the benefits of integrated employment. There is currently a marketing campaign being developed, targeted at community employers and employees, seeking to reduce the stigma around work and individuals with developmental disabilities. And while reimbursement adjustments have already taken place to support the plan, additional funding changes are also necessary and underway. Ohio’s administration is pursuing a comprehensive funding system redesign to align with the Employment First policy, and is examining approaches utilized by other states, including the use of outcome-based reimbursement models. Additional program changes include a new employment data collection system, enhanced training and technical assistance, and an online portal with resources and easy-to-understand information.
System Funding
Ohio’s funding structure is unique in that a large percentage of its funding for services for persons with developmental disabilities comes from local tax revenue streams, primarily from levies. This is the exception across the country, where overall, only about 3 percent of total revenue is from local sources. Declining property values and state support have had significant impacts on some communities, while others continue to operate with reserves and unspent funds. Due to a high reliance on local money, as well as variations in service delivery, discrepancies in funding across the state are vast. Examining these variances is of vital importance as Ohio seeks to redesign the system to better serve individuals with developmental disabilities.

State Spending and Revenue
Ohio Department of Development Disabilities
Nearly 60 percent of DODD’s budget comes from federal sources, primarily the federal Medicaid share for spending on home and community-based waivers and ICFs. State general revenue funds (GRF) account for about 20 percent of all funding. GRF is used mostly to make up the state’s share of the Medicaid match for ICFs and Developmental Centers (as well as waivers, to a lesser extent). The final 20 percent are dedicated purpose funds, which according to the Legislative Service Commission includes, “funds from county DD boards to pay a portion of the nonfederal share for waiver services and targeted case management services; dollars that ODODD returns to the boards for targeted case management after the federal share is received; Developmental Center residents’ unearned incomes, which are received by the state and used toward residents ‘cost of care; and revenue from a fee that county DD boards pay to ODODD based on the value of Medicaid Waiver claims paid by the board. “ Internal Service Activity funds account for a negligible portion (less than 1 percent) of the remainder.
Figure 20. FY 2014 DODD Revenue

Note: There is a "Internal Service Activity" fund group that equals less than 0.1% of the total revenue.

Source: DODD

Figure 21. FY 2015 DODD Revenue, estimate

Note: There is a "Internal Service Activity" fund group that equals less than 0.1% of the total appropriations.

Source: DODD
State Spending

Overall DODD appropriations totaled $2.4 billion in 2014 and an estimated $2.5 billion in 2015. Over 90 percent of expenditures are for Medicaid services. However, Ohio ranks 47th in Medicaid spending as a percentage of total DD spending because of the large amount of unmatched local funds.

Sixty percent of Medicaid spending was for HCBS Waivers in 2014. Medicaid expenditures for community-based services totaled $1.37 billion in 2014 and an estimated $1.5 billion in 2015.

In 2014, the department provided $560 million to support ICFs, and about $196 million to support the state’s 10 Developmental Centers. While Medicaid largely supports residential services, this funding stream also supports day services, in the amount of about $66 million.

In addition, the department also provides county subsidies and grants, totaling about $85 million. More specifically, this accounts for funding for early intervention services, family support services, tax equity funds, community employment services, and others.

Of significant importance to local boards, the state subsidy line item for boards has decreased over the past several years. Initially intended to support community services and assist with Medicaid Waiver match, the 501 subsidy funds have decreased from nearly $67 million in 2010 to $44.4 million in 2015.

Funding for administrative costs totaled $52 million in 2014 and $54 million in 2015. This includes rental payments, central office administration, protective service expenses (for granting guardianship, etc.) and Medicaid support and oversight. The increase from 2014 to 2015 is mostly attributable to a nearly 10 percent increase in Medicaid administration and oversight.

Figure 22. Total DODD Funding, 2014 & 2015 Budgets
County Board Revenue and Expenditures

Comprehensive data on revenue and expenditures for each county board in Ohio are compiled annually by DODD. These reports detail spending and revenue only for services provided directly by boards, and do not include costs for Medicaid services provided by private providers through contracts with boards. The most recently available public data are for 2012. In that year, Ohio boards served about 88,000 individuals with disabilities, a 2 percent decrease from 2011. Total spending in 2012 was about $1.3 billion dollars. This includes both the nonfederal match and the federal portion of Medicaid spending. On average, boards spent about $14,500 per individual served. However, this ranged from less than $5,000 in several Ohio counties to over $20,000 in many others. (See Appendix III and Figure 23 for details.)

Figure 23. Annual Spending per Person Served by County, 2012

Source: The Center for Community Solutions analysis of DODD data
**Board Expenditures**

Allocation of funds towards board services varies somewhat across the state. The greatest share of county board funding directly supports programs for adults, accounting for 46 percent of program expenses and $589 million in spending. The majority of that spending (about 85 percent, or $499.5 million) was directed toward adult facility-based (segregated) services. Services for children account for the next largest portion of spending; followed by Service and Support Administration (SSA) costs, and community residential services.

**Figure 24. County Board Program Expenditures, 2012**

Source: DODD

Note: These are expenditures for board-operated services only and do not include expenditures for private provider Medicaid services.

**Revenue**

In 2012, over 70 percent of revenue supporting services provided by county boards of developmental disabilities was local, mostly from property tax levies. Total revenue was about $1.5 billion in 2012; over $1 billion was local. Twenty percent of revenue in 2012 was federal, while just 10 percent came from the state.
Federal Revenue
Ohio county boards received $300 million dollars in federal revenue in 2012. Federal revenue primarily supports Medicaid services, including waiver services, targeted case management, and ICFs.

State Revenue
State revenue to county boards of developmental disabilities in 2012 totaled $151 million, a slight decrease from 2011 (about 2 percent). The largest percentage of that revenue (about $53 million) comes from the Ohio Department of Education, a “pass through” to the boards for special education services. About 20 percent of revenue results from subsidy payments from the DODD, to provide support to people in community settings. In 2012, 15 percent of state revenue came in the form of Medicaid match payments to county boards operating ICFs (10 county boards were operating these facilities as of 2012). Funding for these operations represented over $20 million dollars in state investment.

An additional 8 percent of state revenue coming to county boards derives from the Tax Equity Fund. This fund was established in 2001 for the purpose of equalizing funding to tax-poor counties, and is intended to subsidize the cost of their non-federal Medicaid match (required for Medicaid Waiver services). Twenty-four counties received varying levels of assistance in 2012. The payouts equaled about $13 million, with county disbursements ranging from as little as $12,000 in Williams County to as much as $1,256,172 in Lucas County. Counties are determined eligible to receive funds based on a formula which examines tax property value and adult...
enrollment, outlined in the Ohio Revised Code, and is intended to assure that all counties’ property tax funding is at least equal to the state’s average millage. Also taken into account is the local board’s tax effort. This line item has been funded at $14 million dollars annually for the past several years. See Appendix IV for county-by-county Tax Equity distributions for 2012.

**Local Revenue**

A large proportion of services for individuals with developmental disabilities are funded locally, primarily through property tax levies. Levies can be used to augment state-funded programs or to provide funds for social service and education supports that the state and federal government do not fund. Property tax levies are measured in “mills” or millage. Every county in Ohio reports some amount of local levy monies for developmental disabilities, most frequently through levies generating funds exclusively for DD services; however DD services receive no inside mills (mills that can be collected as a levy without approval from voters). In fewer cases, DD services may receive support from other broader county levies, such as a general human services levy. Ohio is more reliant on local funds to support DD services than other states in the country.

Local levy revenue totaled $1,073,819,058 in 2012; approximately 89 percent of all local income is collected through local levies. About 35 percent of total levy revenue is raised in Franklin, Cuyahoga, and Hamilton counties. As county levy millage varies considerably across the state, there is also variation in the degree to which local levy funds support their county board services, ranging from less than 35 percent in some counties to over 80 percent in others. Figure 26 illustrates the variation throughout the state.
As a result of variations in property tax valuation and inconsistent levy support, there is a disparity in local levy dollars available for each person with a developmental disability throughout the state. According to 2007 analysis from OACBDD (The Ohio Association of County Boards of Developmental Disabilities), tax-poor counties would need to increase their tax rates by three times to raise the equivalent tax dollars to tax-wealthy counties. In 2012, local levy funds generated were, on average, about $9,800 for each person served. However, the disparities across the state are staggering, ranging from less than $3,000 per person served in Highland, Vinton, and Morrow counties to over $16,000 in Portage, Muskingum, and Lake.
County Board Funding Trends

**Federal**

From 2007 to 2012, federal funding to county boards increased by 22 percent. This can largely be attributed to a gradual increase in waivers and waiver spending, as well as increases to other programs, such as rehabilitation services.

**State**

From 2007 to 2012, state funding decreased by 12 percent. Two state subsidies, the SSA subsidy and the operating subsidy, totaling over $40 million, were terminated after 2009.

**Local**

From 2007 to 2012, local funding increased by 3 percent. Local levies consistently represent the largest portion of local funding for boards.

Figure 27. County Board Revenue, 2007-2012, by Source

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**Overall**

From 2007 to 2011, total revenue increased minimally by 5.6 percent. Funding sources have changed only slightly over time.

**Funding Trends: Facility-Based and Community Adult Services**

Similar to overall funding trends, the allocation of funds for adult services has shifted little over time. While boards have increased funding to supported community employment by about 18 percent, funding for facility-based services only decreased by about 2 percent over the same period (2007-2012).
Figure 28. Annual Adult Services Spending, 2007-2012

Source: The Center for Community Solutions analysis of DODD data
Recent Concerns and Issues

CMS Rule Change
Ohio is preparing to implement changes to Medicaid rules that have narrowed the types of settings in which Medicaid reimbursable services can take place, with a greater emphasis on integrated, community-based settings and outcomes. Final regulations were released in January, 2014, intended to guarantee that individuals served through Medicaid Waiver programs have access to integrated, community services to the same degree as individuals not receiving waiver services. According to CMS, “The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting’s location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law’s intention for Medicaid home and community-based services to provide alternatives to services provided in institutions.” 48

The new rules emphasize that HCBS must not only be provided in a setting that physically meets the criteria for home or community-based, but that they must also “…ensure that individuals receiving services and supports through Medicaid’s HCBS programs have full access to the benefits of community living, and are able to receive services in the most integrated setting.” The new rules emphasize integration, choice, independence, and notably, expanded opportunities for integrated community employment. Of importance are the requirements that new rules must not only be implemented in residential facilities, but in any setting where HCBS services are delivered. Medicaid’s mandates on integration and quality of life variables demonstrate a monumental shift in approach that is sure to have a significant impact on what services CMS will reimburse for, who can be reimbursed, and subsequently, what services are available. Not without controversy, individuals with developmental disabilities, providers, county boards, and family members have all expressed concern about the challenges presented by the new rules.

Residential services are sure to be impacted by the new rule, as they clearly state that home and community-based waiver services cannot be reimbursed for institutional settings (like hospitals or nursing homes) or settings that are determined to be “institution-like,” by sharing qualities of institutional settings, such as segregation and regimentation. Additionally, the rules require providers to assure the right to privacy in residential facilities, as well as open access to food and visitors. Not only will this result in changes to how staff must deliver services, but it may also magnify the differences between ICFs and home and community-based services, as waiver homes will likely become more “home-like.”

Employment and day services will be similarly impacted. Most adult day programs, or “day hab” service settings, as they have traditionally been delivered in Ohio, will no longer meet the requirements outlined in the new rules, as they largely isolate individuals and don’t allow for full access to the community. In the same way, sheltered workshops will ultimately no longer
qualify as a HCBS, as individuals are typically isolated and spend most of the day with other individuals with disabilities.

“Person-centered planning,” is a key tenet of the changes to the rules. New service plans, developed by SSAs, must be individualized and reflective of the individual’s preferences for service type and delivery. Measureable outcomes should be included in planning, which should be facilitated by the individual with the disability, whenever possible. Planning should include any friends, family members, or advocates identified or invited by the individual. Many boards feel that they are already fully compliant with this rule.

Of particular interest, the CMS rule calls for “conflict-free” case management, stating that “providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.” Unlike ADAMHS Boards, as aforementioned, boards directly employ SSAs who act as service brokers for individuals with disabilities, completing eligibility determinations, developing service plans, and connecting people to recommended services. In addition to facilitating services, county boards also provide services directly to individuals, including Medicaid Waiver home and community-based service. Therefore, these changes in Medicaid rules will result in restrictions that may lead to significant changes in how county boards operate.

While interpretations of the new CMS rules vary, once fully implemented, many boards could be forced to privatize a large portion of their service provision. There is significant division among boards on the implications of this rule change. Boards that have already mostly privatized will experience minimal change; however other boards continue to expand day and sheltered work programs. The Cuyahoga County Board of Developmental Disabilities (CCBDD), in response to the rule changes, issued a position statement in August of 2014, outlining its “disagreement” with the new rules. CCBDD argues that limiting the board’s ability to provide a wide range of services decreases client choice, and that solely relying on private providers could diminish the visibility of the DD boards in Ohio, jeopardizing needed levy support. Several other boards have issued similar public comments. Questions have arisen about whether levies that have been approved, including those that are ongoing, will remain...

According to CMS rule, all HCBS settings must be:

- Integrated in and support full access to the greater community
- Selected by the individual from among setting options
- Ensure individuals rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices, and,
- Facilitate choice regarding services and who provides them

Source: DODD Pipeline
valid if the levy language references specific services that the board has historically provided, if this includes services that will no longer be allowable for boards to provide. In the most extreme scenario, county boards would be forced to send levies back to the voters with new language, and risk defeat.

This perceived conflict of interest is not new. A “firewall” document, developed by state stakeholders and last updated in 2009, was developed with the intent of mitigating potential conflicts of interest that could result from this role overlap. This included providing clarity on the roles of DODD and county boards, and requirements around reporting structure and safeguards for individuals to assure all available options for providers are presented equally. Many county board superintendents and the Ohio Association of County Boards of Developmental Disabilities (OACBDD) have advocated that updates to the “firewall” document may be sufficient to protect individuals and comply with HCBS rules. DODD has requested that individuals who are currently receiving board services be able to continue to do so, while a plan is developed to cease these services for future consumers (“grandfathering”). However, recent communication from CMS suggests that these strategies are unlikely to suffice. According to the Department, while the rules around conflict-free case management are effective immediately, the state is in discussion with CMS around how and when Ohio can come into compliance given the state’s service delivery dynamic.

While the rules officially became effective in March, 2014, DODD formed a committee, made up of advocates, provider organizations, and state agencies, that has developed a Transition Plan to address how Ohio will come into compliance with the new rules. The group recognized several areas in which Ohio is meeting the requirements, but the state has identified several other areas that require intervention. According to CMS, states will have as many as five years to come into full compliance on some areas of the new rule; for certain rules compliance is expected immediately. The state has requested 10 years for certain provisions of the rule, including changes to sheltered work. Completed transition plans were submitted to CMS in mid-March 2015, after public comment was fully sought. No state is in full compliance with the rules, and all will be submitting Transition Plans to CMS. Plans can be accepted, or CMS can reject plans and ask for modifications.

The committee in Ohio began by conducting a scan of providers to assess the degree to which they self-reported compliance with the rules. Data were collected via survey (some have questioned the validity of this method). Residential settings where individuals lived alone or with family were presumed to be in compliance. The analysis of congregate residential settings (settings with two or more people sharing services) found that more than half were already meeting the HCBS characteristics, and while others settings did not currently, they could with modifications. Three percent reported having “institution-like” qualities, and are therefore likely to face “heightened scrutiny” from CMS. This includes facilities on disability-specific campus settings or in otherwise isolative settings. A very small number (four settings) reported that they were not in compliance and would likely not be able to meet the requirements.
A similar survey of adult day/waiver service providers was conducted to assess their self-reported alignment with the new rules. Integrated community employment programs, supported individual employment, and supported employment-enclave programs were presumed to be compliant. This survey yielded similar results, with some settings meeting the requirements, and others at various levels of compliance.
The transition process will include further investigation into settings that are in compliance, including site visits, as well as requests for plans from providers addressing how they will comply with the new rules. Technical assistance may be provided by the department to assist providers in adhering to the new rule.

As a result of the committee’s work, the transition plan proposes revisions to existing policies and increased oversight of providers to increase protections for consumers, rate modifications to increase efforts at community employment, and the phase out of the TDD Waiver, as it doesn’t provide employment support. Service and provider definitions will change to reflect the emphasis on community integration and independence. Service plans will be revised to better document that clients had a free choice of provider. The definition of Homemaker/Personal Care (HPC) services will be expanded to better define the actual duties of this work. Also of note, the service currently defined as “adult foster care” will be renamed as “shared living,” as many took offense to the service title, finding it pejorative or paternalistic. Most controversial are the impending changes to adult day/work programs, which will need to be redesigned to meet the goal of promoting community employment and community integration. Adult day services will need to be delivered in integrated settings (like libraries or through volunteer opportunities), as opposed to segregated campus-like settings. And ultimately this will lead to the end of sheltered workshops, as they currently operate. By 2024, if the plan is approved, all individuals receiving waiver services who are participating in facility-based sheltered work will need to transition to integrated employment or community-based day supports. DODD has emphasized that this does not necessarily mean full community, integrated employment for all, but rather that individuals enrolled on waivers will receive services that take place in some form of integrated, community-based, day experiences. This rule change will impact approximately 23,000 Ohioans with developmental disabilities who are currently in sheltered work or otherwise segregated day settings.

Concerns around Quality and Monitoring
Monitoring quality is an ongoing challenge in DD services. With a large and growing number of providers across the state, there is concern that there is inadequate oversight. Currently, DODD is responsible for credentialing and monitoring DD facilities, and some feel that improvements are necessary to assure that only high-quality providers are able to receive approval to operate, and that action against potential “problem” providers is swift. Some have questioned whether county boards would be better equipped to manage oversight and quality assurance, as they are more likely to hear about concerns early, through regular contact with consumers, providers, and families. However, this would require additional local capacity and funding.

Consumers and families currently lack a user-friendly tool to assist with making decisions about providers. This is especially challenging in large urban areas, where the market is crowded with multiple providers. Individuals and their support systems often lack the information necessary to make informed decisions. Currently, DODD hosts Compliance Reports on their website, however navigating the site is challenging, and the reports themselves may be difficult to understand. A more user-friendly rating system has been recommended to
assist families in identifying services that best meet their unique needs and fully comply with the law.

**Advances in Technology**
Across the nation, advances in technology are creating noteworthy changes in services for individuals with developmental disabilities. Ohio is beginning to adopt many of these new technologies to improve the lives of individuals with disabilities, and stakeholders believe these developments will be an important factor in system changes in the years to come. These advances include remote monitoring equipment, in which technology is used to monitor the activity of individuals, with the activity viewed at monitoring stations to provide intervention when necessary. Additionally, smartphones and tablet devices allow individuals to access mobile apps that can assist with self-directed learning of everyday tasks, and videos can demonstrate how to complete household duties. Robotic devices also offer opportunities for people with disabilities. Social media and communication programs like Skype are also tools that can help individuals decrease isolation, find support, and stay connected. All of these advances offer the chance to increase communication and enhance safety while increasing the ability of people to live independently. While upfront costs may be significant, cost savings can be achieved in the long term by reducing or eliminating the need for intensive on-site staff presence. The use of these technologies, while currently limited in Ohio, is certainly on the horizon.

**Service Providers and Wages**
Wages and turnover of Direct Support Providers (DSPs) are important considerations in the conversation about provision of residential services. DSPs support individuals with developmental disabilities by assisting them with ADLs and teaching them basic life skills with the goal of integrating them into community life. They work both in ICFs and waiver-funded supported housing. Despite the role that DSPs play as frontline staff working with individuals with developmental disabilities, as well as the high emotional and physical demands of the work, DSP positions are notoriously underpaid and often have high turnover rates. Depending on the type of work they are doing, DSP annual turnover rates range from 42 to 69 percent, with low wages and limited benefits being the primary reasons for high turnover. Studies have also noted the significant differences in DSP wages at private facilities versus state-operated facilities. In 2009, the national average starting wage at a private facility was $9.37 per hour, compared to the average starting wage of $12.57 at a state-run facility. Similarly, the average wage (overall) at a private facility was $10.14, while the average wage at a state facility was $15.53. Therapeutic Program Workers (TPWs) at Ohio’s Developmental Centers earn, on average, $36,854 annually (though this has decreased by about $5,000 since 2012). One executive director of an Ohio nonprofit serving adults with developmental disabilities testified that their starting wage for DSPs is $8.75, and the top wage of $13.60 is paid to employees of over 20 years. These consistently low wages and high turnover rates make finding and keeping qualified employees an ongoing challenge for service providers.
The Governor’s Budget

In February, 2015, the governor announced his 2016-2017 biennial budget, which requires approval by the Ohio legislature. The budget included substantial investments in developmental disability services: $112 million in state GRF above 2015 levels over the course of the two years. While specific details on spending are not clear, DODD has announced that, if approved, spending would target ICF downsizing efforts, community employment, and most notably, the addition of 3,000 HCBS Waivers. Many of the recommendations derived from a Strategic Planning Workgroup, formed in 2013, led by DODD Director Martin and made up of key advocates and stakeholders (see “Highlights from the Strategic Plan Workgroup Recommendations,” on page 54). According to DODD, the increased budget allocation will support:

- 2,000 additional IO Waivers and 1,000 SELF Waivers, over the biennium
- The conversion of the TDD Waivers to IO Waivers
- The addition of nursing services to the IO Waiver
- A waiver rate increase to support wage increases for direct care staff
- $2.8 million increase for each budget year to support community employment
- Modest increase in funds for ICFs to promote downsizing
- Money for bed buy-backs and rental assistance

These recommendations demonstrate a firm commitment from the administration to increase community inclusion in both employment and residential settings. However, key details of the proposed plan are not available. For example, are the additional waiver supports an ongoing commitment for the department? How will these waivers be allocated? As the TDD Waivers transition to IO, will the state pick up additional costs as the cap is lifted? And, is an increase of $2.8 million in Employment Support sufficient given the large number of individuals moving into the system? Will the ICF rate changes result in meaningful downsizing? These are all important considerations as the state seeks to finalize its budget.

Highlights from the Strategic Plan Workgroup Recommendations:

- Waivers: 90 percent of people who are “newly enrolled” in waiver services will be planned and not emergencies.
- Waivers: Total waivers will increase by 1200 per year (no match funding source specified)
- Waivers: Availability of a comprehensive DD waiver
- Housing: DODD will make subsidies available to support community living.
- Employment: Increase employment for people with disabilities to 50 percent of adults served.
- Shared Living: Increased share living to represent 25 percent of housing for all DD waiver recipients.
- Nursing services: Nursing services will be available through all DD waivers, funded through the state
- Developmental Centers: DCs will close and ICF beds will be reduced by 50 percent
- DSP wages: All DSPs earn a livable wage (200 percent of Federal Poverty Level) for all services provided to people with disabilities.
Other Medicaid budget items may prove to have an impact on the DD system. These include the prospective phase out of independent Medicaid providers, some of whom provide services to individuals with developmental disabilities. Once the phase out is complete, these consumers would need to seek services from an agency providing comparable Medicaid services, with the exception of those on SELF Waivers, who are not affected.

Also of note, President Obama’s budget, released in early February, also calls for increased funds for disability services. This includes the addition of $56.7 million for Vocational Rehabilitation, as well as a proposal for a pilot program intended to move more individuals into home and community-based services.56
Ohio at a Crossroads: Recommendations

Despite a growing acceptance and significant progress, even today, individuals with developmental disabilities continue to face a service system that many argue impedes on their rights as citizens. Advocates in the developmental disabilities community refer to their work as an ongoing “Civil Rights” battle, akin to movements seeking full human rights for African Americans, gay and lesbian people, and women. However, the 1999 *Olmstead* decision, possible Justice Department litigation, concerns from Disability Rights Ohio, and recent rule changes issued by CMS are indicative of significant changes to the environment, focused on a desire to give individuals with disabilities dignity and a higher quality of life. Integration of individuals with developmental disabilities into community workplaces, an emphasis on community-based services, and a push toward independent living are all examples of this shift. The following section outlines nonpartisan recommendations to best address the issues facing the system. See Tables 1-4 below for details.
### Table 1. Employment and Day Services Recommendations

<table>
<thead>
<tr>
<th>Revisit funding for Employment First.</th>
<th>Recommendation</th>
<th>Who can make the change?</th>
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<tbody>
<tr>
<td>Revisit funding for Employment First.</td>
<td>Increased funding will be necessary to provide employment supports and comprehensive wraparound services to all Ohioans with developmental disabilities, not just those lucky enough to receive Waiver supports.</td>
<td>Ohio General Assembly, through budget amendments. Some County Boards of Developmental Disabilities may have the ability to refinance community employment services through waivers.</td>
</tr>
<tr>
<td>Develop meaningful rate changes.</td>
<td>Rate must be both competitive and outcome based, to assure that clients have access to choice in providers and receive the necessary individualized services to meet their unique needs.</td>
<td>Employment First’s Funding Re-alignment Workgroup, which continues to meet to develop a new funding approach. Final changes will be implemented through Ohio Department of Developmental Disabilities staff, and changes will be made to the HCBS Waiver application as needed.</td>
</tr>
<tr>
<td>Improve partnership with Opportunities for Ohioans with Disabilities (OOD) and streamline access to employment services.</td>
<td>Improved collaboration between these two entities is necessary, as an increased number of individuals will need supports seeking integrated, community employment. The department would be wise to explore options to improve the service flow for individuals seeking employment supports.</td>
<td>The Ohio Department of Developmental Disabilities and Opportunities for Ohioans with Disabilities</td>
</tr>
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</table>
Table 2. ICF & Housing Recommendations

<table>
<thead>
<tr>
<th>ICF Downsizing &amp; Housing Needs</th>
<th>Recommendations</th>
<th>Who Can Make the Change?</th>
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| **Changes are necessary to accelerate ICF downsizing and conversion.**  
The data suggest that this process has been sluggish. As the current funding model offers little incentive for ICF providers to downsize or convert to waiver services, increased pressure may be necessary for real change to take place. | The governor’s budget calls for a series of other proposals to promote downsizing and conversion. These should be commended.  
Regressive rate changes are also a tool that DODD could utilize to increase the rate at which ICFs convert beds.  
Decreasing rates for beds serving those with lesser levels of acuity to encourage alternate community-based options for this population is the next step. | Ohio General Assembly, through budget amendments  
Ohio Department of Developmental Disabilities |
### Table 3. Waiver Recommendations

<table>
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<th>Waiver Challenges</th>
<th>Recommendations</th>
<th>Who Can Make the Change?</th>
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| **A long-term solution to the state’s complex waiver problem must be developed.**  
As ICF and Developmental Center beds diminish, the need for HCBS Waivers is sure to only increase in the coming years, potentially leading to a growing waiting list.  
Currently, the number of individuals enrolled in waivers represents only about 44 percent of individuals estimated to have severe developmental disabilities. Boards are reluctant to add IO waivers due to the lack of an individual cost cap.  
Assuming a waiver system that served 70 percent of the state’s total individuals who require an ICF level of care, waiver enrollment would need to grow by over 15,000.  
Additionally, there is too much variation among counties, both in funding and services, to assure that people throughout the state are receiving equitable services.  
A continued reliance on local levy funds as a prime funding source for services assures that tax-poor counties will have less access to services. If local boards have insufficient funds to pay for the required nonfederal share, their ability to offer waiver services is diminished. Additionally, non-waiver services, such as housing assistance, are available to a lesser extent in counties that are less able to raise local money. | While the increase in waivers proposed in the governor’s budget are a good start, this is a problem that is sure to grow. The governor’s call for an additional 3,000 waivers represents only about 15 percent of the estimated 22,000 individuals on wait lists and currently in need of services.  
Options to increase the financial capacity of counties should be examined to assure the long-term security of the HCBS Waiver program. Expansion of IO waivers financed by boards requires greater certainty about financial costs. DODD should take responsibility for IO waivers that are extremely expensive or set an across-the-board limit for boards’ financial obligations in IO waivers.  
The “10 percent Solution,” which proposes 2,200 state-funded waivers each biennium until the waiting list is eliminated, has been endorsed by several advocacy groups. This proposal’s reliance on the SELF waiver may be problematic, but the principle is good: the system should commit to a meaningful timeframe and a plan for eliminating waiting lists.  
A close examination of the Tax Equity Fund is past due. Initially developed to help tax-poor counties offset the cost of Medicaid administration and match, current funding is woefully inadequate to address funding disparities. Exploring opportunities to more fully fund this line item, or revisiting the formula for allocation, is timely and should be pursued.  
An increase in this fund to tax poor counties is an important step in reducing waiting lists for waiver services and assuring that all Ohioans with developmental disabilities receive equitable services. Continuing to expand the use of innovative technologies, such as remote monitoring, is another mechanism that should be explored to both increase independence and reduce long-term costs. | This requires a joint effort of the Ohio Department of Developmental Disabilities, County Boards of Developmental Disabilities, and the General Assembly.  
A workgroup to examine long-term options to assure the security of the program should be developed.  
Increases to the tax-equity line item can be achieved by action of the legislature, through budget amendments. |
<table>
<thead>
<tr>
<th>Waiver Challenges, Continued</th>
<th>Recommendations, Continued</th>
<th>Who Can Make the Change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A close examination of the SELF Waiver is necessary as the state seeks to fund additional waivers. While the governor’s budget calls for an additional 1,000 SELF Waivers represents an important investment in decreasing the waiver list, questions persist about the utility of the SELF Waiver. Since its inception, SELF Waiver growth has been incredibly slow. Numerous stakeholders pointed to challenges and barriers to navigating the requirements of the waiver.</td>
<td>While the cap makes the SELF Waiver an attractive option for local governments, questions remain as to whether the new waivers will be utilized due to the challenges with the waiver. Working with stakeholders to identify and work through challenges related to this waiver is necessary for the increase to be utilized. The aforementioned “10 Percent Solution” proposes additional state-funded SELF waivers to reduce the waiting list. In order for this to be successful, challenges related to this waiver must be remediated, or the “Solution” should entail the use of other types of waivers.</td>
<td>Ohio Department of Developmental Disabilities, County Boards of Developmental Disabilities</td>
</tr>
<tr>
<td>A more vigorous assessment process is necessary to identify who on the waiting list has the greatest level of unmet need, and to assure that these individuals are targeted for enrollment in the most appropriate Waiver. The waiver waiting list is not useful and may be misleading. Years of individuals “pre-emptively” joining the waiting list, as well as consumer confusion about waiver services, have led to a waiting list that does not reflect the real needs of the community.</td>
<td>Given the boards’ responsibility to raise the match for waivers, there may be an inherent conflict with boards managing waiting lists. At least one Ohio county board relies on a “Waiver Committee” to make waiver decisions. This represents one possible mechanism for resolving this conflict. However, while this has been pursued in the past, the current situation calls for revisiting the use of a third-party in waiting list management.</td>
<td>Ohio Department of Developmental Disabilities, County Boards of Developmental Disabilities</td>
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</tbody>
</table>
Table 4. Board Recommendations

<table>
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<th>Board Challenges</th>
<th>Recommendations</th>
<th>Who Can Make the Change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privatizing services is critical to boards operating efficiently and freeing local money to enable citizens to live as independently as they can. While many of Ohio’s boards have successfully privatized, many continue to be resistant to taking this step. While the CMS rule change will likely force this process along in the next decade, a more expeditious transition seems advantageous to both consumers and taxpayers.</td>
<td>Given the potential conflict of interest, as well as high administrative costs in some counties, privatizing is the right thing to do for local communities.</td>
<td>County Boards of Developmental Disabilities</td>
</tr>
<tr>
<td>Increasing DODD oversight of waiver allocation and spending by county boards may be necessary as the state seeks to align with philosophy change occurring in the DD community. Through stakeholder interviews, it became apparent that there are county boards who elect not to take full advantage of Employment First dollars, or neglect to develop a meaningful waiver program, hampering statewide efforts to increase community inclusion.</td>
<td>This may include requiring county boards of developmental disabilities to create and submit annual spending plans, in conjunction with invested partners in the DD community, to assure that boards use their funds to emphasize that integration and community support is the priority. Data collection and reporting should also be enhanced. Cost reports submitted by county boards are difficult for outsiders to navigate and vary greatly from county to county, which decreases the utility of these reports. Regular and timely publicly available reports detailing waivers by county, waiver spending, integrated employment rates, and data on other key indicators would be a noble effort to increase transparency and hold both DODD and county boards accountable for services paid for by taxpayers.</td>
<td>Ohio Department of Developmental Disabilities</td>
</tr>
<tr>
<td>Increased collaboration among boards can lead to cost savings and increased efficiency. Several boards in Ohio share senior staff and administrative service functions; others very effectively share services.</td>
<td>As boards largely move away from service provision, their role will focus more exclusively on facilitating and organizing services for individuals, as well as case management. Given this shift, opportunities may exist to share services and administrative functions, or explore board mergers. State incentives to encourage shared services could provide a mechanism for encouraging this practice.</td>
<td>County Boards of Developmental Disabilities Ohio Department of Developmental Disabilities</td>
</tr>
</tbody>
</table>
Appendices
Appendix I

FLOW CHART OF ELIGIBILITY PROCESS

Request for Services

Send out “Eligibility for County Boards of Developmental Disabilities” flyer along with other county-specific applicant information materials.

Obtain verification of qualifying diagnosis (Pages 11-12) – Start C/FED

YES

Determine if Questions 1, 3, and 4 received a “yes” response (Pages 11-12)

YES

Complete a C/OEDI assessment within 45 days (Page 14)

Eligible

Send letter of eligibility and next steps – Complete C/FED

NO

Individual is ineligible based on absence of qualifying diagnosis

NO

Not Eligible

Send letter of ineligibility, due process, information & referral and complete C/FED

C/OEDI Users Guide
## Appendix II
### Developmental Disability Waivers in Ohio

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Who is Eligible</th>
<th>Year Introduced</th>
<th>Services Covered</th>
<th>Annual Cost Cap</th>
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</table>
| Individual Options (IO)<sup>58</sup> | • Must meet ICF Level of Care  
• Must meet financial criteria for Medicaid services | 1991            | • Homemaker/Personal Care  
• Adult Foster Care  
• Adult Family Living  
• Remote Monitoring  
• Remote Monitoring Equipment  
• Environmental  
• Accessibility  
• Adaptations  
• Transportation  
• Residential Respite  
• Community Respite  
• Social Work  
• Home-delivered meals  
• Nutrition  
• Interpreter Services  
• Adaptive and Assistive Equipment  
• Adult Day  
• Waiver Services (includes Supported Employment Services)  
• Non-Medical  
• Transportation | No individual cap; Contingent on needs |
<table>
<thead>
<tr>
<th>Waiver</th>
<th>Who is Eligible</th>
<th>Year Introduced</th>
<th>Services Covered</th>
<th>Annual Cost Cap</th>
</tr>
</thead>
</table>
| SELF Waiver⁵⁹        | • Children (under 22 and not eligible for adult day support, integrated employment, supported employment-enclave, or vocational habilitation).  
                       • Adults (age 22 or over, or under 22 and eligible for adult day support, integrated employment, supported employment-enclave, or vocational habilitation).  
                       • Medicaid-eligible  
                       • In need of an Intermediate Care Facility (ICF) Level of Care  
                       • Willing and able to perform the duties associated with participant direction through exercising budget authority or employer authority for at least one waiver service. (Determined as part of a pre-screening tool.)  
                       • Able to have their health and welfare needs met through the SELF waiver and other formal and informal supports  
                       • In need of at least one SELF waiver service | 2012            | • Support Brokerage  
                       • Community Inclusion (Personal Assistance, Transportation)  
                       • Integrated Employment  
                       • Functional Behavioral Assessment  
                       • Clinical/Therapeutic Intervention  
                       • Participant-Directed Goods and Services  
                       • Participant/Family Stability Assistance  
                       • Remote Monitoring  
                       • Remote Monitoring Equipment  
                       • Residential Respite  
                       • Community Respite  
                       • Adult Day Supports  
                       • Vocational Habilitation  
                       • Supported Employment – Enclave  
                       • Non-Medical Transportation | $25,000 for children and up to $40,000 for adults |
<table>
<thead>
<tr>
<th>Waiver</th>
<th>Who is Eligible</th>
<th>Year Introduced</th>
<th>Services Covered</th>
<th>Annual Cost Cap</th>
</tr>
</thead>
</table>
| Level One乏力 Waiver | • Require the care given in an Intermediate Care Facility (ICF) but want to live at home.  
• Have a network of families, friends, neighbors and professionals who can safely and effectively provide the needed care. The cost for this help cannot be more than what the Level I Waiver allows. | 2002            | • Homemaker/Personal Care  
• Institutional Respite  
• Informal Respite  
• Transportation  
• Personal Emergency Response Systems  
• Specialized Medical Equipment and Supplies  
• Environmental Accessibility Adaptations  
• Emergency Assistance  
• Supported Employment  
• Day Habilitation | Annual limits range from $5,000-$8,000 annually, depending on the service, and may be increased with prior authorization from the board |
| Transitions Waiver乏力 (TDD) | • Individuals previously served on the Ohio Home Care Waiver  
• Must meet ICF Level of Care | 2002            | • Personal Care Aide  
• Waiver Nursing  
• Home-delivered Meals  
• Home Modification  
• Adaptive/Assistive Devices  
• Adult Day Health Center  
• Supplemental Transportation | Varies. Average annual cost is $25,000. |
### Appendix III
### Per Person Spending, 2012

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<th>County</th>
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www.CommunitySolutions.com
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Source: DODD, Ohio County Board of Developmental Disabilities Revenue and Expenditure Report, 2012; analysis by The Center for Community Solutions
### Appendix IV Tax Equity Amount by County, 2012

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Source: DODD, Ohio County Board of Developmental Disabilities Revenue and Expenditure Report, 2012

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6 The Issue. The 10 Percent Solution Website. http://www.10percentsolution.org/the-issue/
8 The most recent available Comprehensive Revenue and Expenditure Report available from DODD is for 2012. All revenue and expenditure figures are from this report.
11 Blueprint for a New Ohio Detail. Governor’s Office of Health Transformation. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=e0syoWSGQ9k%3d&tabid=252
12 Ohio Department of Developmental Disabilities (DODD)
13 DODD
14 DODD
19 Application for a HCBS Waiver http://dodd.ohio.gov/Documents/IO.pdf
20 DODD
21 DODD currently proposes the addition of nursing services to the IO Waiver.
23 Jane K. Straker, Robert A. Applebaum, and Denise R. Brothers, Ohio Long-Term Services and Supports Factbook, Third Ed. (January 2012). Scripps Gerontology Center, Miami University. Figure 6, Comparison of Impairment Level: HCBS and ICF ID/DD, 2007, p. 18.
34 BVR Core Services. Opportunities for Ohioans with Disabilities. http://www.ood.ohio.gov/Core-Services/BVR
42 Legislative Services Commission (LSC) Greenbook, LSC Redbook
45 Ohio Revised Code. 5126.18 County eligibility to receive tax equity payments. http://codes.ohio.gov/orc/5126.18
54 DODD
55 The Ohio Provider Resource Association, Milliken Testimony
57 U.S. Supreme Court case addressing discrimination of individuals with developmental disabilities
61 Transferred from ODJFS to DODD in July 2011. http://dodd.ohio.gov/medicaid/Pages/TDD.aspx
The Center for Community Solutions extends a sincere “thank you” to those who took the time to speak with us about this important issue.

Director John Martin & Zach Haughawout, The Ohio Department of Developmental Disabilities
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Geoff Collver, Disability Rights Ohio
Carolyn Knight & Paul Jarvis, The Ohio Developmental Disabilities Council
Kathy Foley, Services for Independent Living
Mark Davis, The Ohio Provider Resource Association (OPRA)
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Melanie Hogan, Linking Employment, Abilities and Potential (LEAP)
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Kelly Petty, Cuyahoga County Board of Developmental Disabilities
Steve Oster, Knox/Coshocton County Boards of Developmental Disabilities
David Couch, Hocking/Perry County Boards of Developmental Disabilities
John Trunk & Team, Summit County Board of Developmental Disabilities
Representatives from Ashtabula, Lake and Lorain County Boards of Developmental Disabilities
Bob Morgan & Team, Delaware County Board of Developmental Disabilities
Rick Marriott, Ross County Board of Developmental Disabilities
Steve Williams, Belmont/Harrison/Noble County Boards of Developmental Disabilities
Jed Morrison & Team, Franklin County Board of Developmental Disabilities