The Ability Center

June 5th, 2025

Senate Finance Committee on HB 96 Operating Budget

Testimony of The Ability Center of Greater Toledo

Thank you to Chair Cirino, Vice Chair Chavez, Ranking Member Hicks-Hudson, and members of the Senate Finance committee for the opportunity to testify. My name is Dr. Jules Patalita and I am a Disability Rights Advocate for The Ability Center of Greater Toledo. We are a Center for Independent Living that has worked for the last century towards our mission, to make our community the most disability friendly in the nation by increasing independence for people with disabilities, discovering true passions, and changing the community's perception of disability. In fulfillment of that mission, I come today for two reasons: to oppose the "Trigger Language" mechanic that would end Medicaid Expansion, and to support the amendment to create the legislative Long-term Care Workforce Study Commission.

I would like to start by addressing the fundamental issues with the Trigger Language and the negative impact it would have on Ohioans. A point of misunderstanding about the Medicaid expansion is that it is actually a form of work incentive. It is a recorded fact by many organizations that having health coverage makes one more likely to be working part- or full-time, and this applies to both the disabled and nondisabled population. For many in this category, living under 138% of the FPL, this expansion could be their only means of receiving health insurance while working. If choosing between working without benefits, or applying for unemployment and other social services, many will choose not to work and rely on the state.

Ending Medicaid expansion is nothing short of a work disincentive for hundreds of thousands. The main concern with the end of the federal match is the economic toll it would have on the state, but consider the impact this could have on the employment of almost 800,000 people. Income tax, sales tax, all of the ways that working Ohioans contribute to the state economy

suddenly vanish and are replaced by a large population that will have a greater need than ever, a need that the state of Ohio will then be more responsible for fulfilling. We have always seen Medicaid expansion as an incentive to work, and that is the way that the program functions for millions of Americans. If Ohio truly is an Employment First state, as declared by Gov. DeWine, then the state needs to find ways of extending work incentives like the Medicaid expansion program.

An immediate criticism of the Trigger Law is the sheer number of people impacted by its execution. The Ohio Department of Medicaid's data shows that almost 770,000 people are currently covered under the Medicaid expansion, all of which could immediately lose coverage if the federal match changes.[i] The Center for Community Solutions estimates that by 2029, 858,000 Ohioans will have lost access to health care.[ii] In 2025 alone, more than 25% of Ohioans using Medicaid will immediately have their coverage taken from them.[iii] One out of every four people using the program will suddenly lose their only source of health protection. Almost 7% of our state's citizens could lose their insurance overnight. For more perspective, CCS has mapped out at least 10,000 constituents using Medicaid Expansion in every Senate District in Ohio, with some districts reaching almost 45,000 users in that area alone.[iv] This seismic level shift in coverage and protection will shutter our economy far worse than just the financial cost of the program. I will not be the only person to say this, but it bears repeating until its meaning is fully grasped: Ohioans will be less healthy and independent if Ohio loses Medicaid expansion.[v] It is not an estimate or a prediction, it is the only logical outcome.

Another fundamental problem with the Trigger Law is the manner in which the harm it causes will almost purposely target the most vulnerable citizens of the state. Look at who is using Medicaid expansion today: single mothers, those with disabilities, senior citizens working part-time, students, children. The 138% FPL mark for Medicaid expansion is only $15,000 for a single person, or just under $40,000 for a family of four. These are incomes levels where families are struggling to make ends meet, and often this low-income will be indicative of positions where employers will not be supplying health insurance.

One specific group this will impact greatest are those who provide direct care services for those under Medicaid waivers, those with disabilities who rely on care specialists to be able to live outside of hospitals and institutions. National studied showed that 43% of direct care works utilize Medicaid for health care, many of which utilize Group VIII Medicaid Expansion.[vi] That could mean that two out of every five direct care workers in Ohio would be affected by the Trigger Law, in an industry where the term "direct care crisis" has been used for decades to describe the lack of home-and-community care. Ending the Medicaid expansion will not only harm those relying on its coverage, it will have a ripple effect that threatens to harm the care of those need Medicaid to survive. Medicaid expansion is the only form of protection for many Ohioans, and the three years we lived through a pandemic showed our country how vital these protections are to keeping ourselves and our loved ones safe. As much as the state needs to stay within its budget, and as expensive as it would become for Ohio to take the weight of the Medicaid expansion from the federal government, an immediate end to these benefits will only harm the most vulnerable citizens of our state.

One of the biggest critiques of the Trigger Law is the wording that coverage would end "immediately." What happens to the mother who buys medication for her child hours after the Trigger Law takes effect? She'll be forced to, without any notice, pay the full cost of the prescription, and one can only imagine how this scenario will impact the hundreds of thousands of Ohioans who rely on this coverage. I have heard other agencies suggest a roll-back of coverage, or making it a permissive shift away from the expansion services. Any of these are a better solution than, without warning, completely negating the coverage of close to 1,000,000 of our citizens. I understand the impact that funding Medicaid expansion would have on the state budget, but there must be a more effective, and humane, solution to the problem than to end it immediately.

The entire conversation around the Trigger Law and Medicaid expansion seems to come down to numbers. This many millions of dollars, that many billions of dollars. Here are the numbers that I hope are most important to the House Committee today. One out of every four Ohioans on Medicaid suddenly losing coverage. Seven percent of the state losing their health insurance. Ten thousand constituents of every Senate District in Ohio having their health coverage taken.

Zero, the amount of warning that Ohio citizens could receive before the only way they have to pay for their children's medication is stripped away. Finally, an unknown number, somewhere between one and 800,000. The number of people in Ohio that will lose health coverage if the Trigger Law is pulled in its current form. I pray that the committee can find a way to balance the economic needs of our state against the cost.

Next, I will explain why The Ability Center and other members of the disability community are supportive of the creation of the Long-term Care Workforce Study Commission. I touched on the direct care crisis in my previous point on Medicaid Expansion. This term stems from the fact that, for decades now, this vital industry has been shrinking, losing care providers faster than they can be recruited. Home- and Community-based Services have been proven to be more cost-effective than facility-based care, and exponentially improves the independence and quality of life of Ohioans.[vii]

ODM data from February of this year counts over 106,000 people using Medicaid waivers to receive HCBS, just short of 9% of the total population of the state.[viii] This industry is responsible for the independence of one in every 10 Ohioans, yet the DODD reported a 56% turnover rate among providers at the end of 2022.[ix] In the last budget, Ohio attempted to address this by raising the rate of Medicaid reimbursement, hoping to provider wages and support this workforce. I conducted a study throughout 2024, surveying care agency representatives and sitting for focus groups with direct care providers. The full report has been attached to the end of this testimony for your convenience and to demonstrate the degree of challenge the HCBS industry faces in Northwest Ohio. What we found was that this reimbursement increase failed in impactfully increasing wages, but more important was the realization that wages were only one of several issues these providers face. Wages lower than entry-level positions such as food service and retail, combined with a widespread lack of benefits, see the current care industry in Ohio barely healthier than before the increase.

Wages are a clear contributor to the direct care crisis. In our study, we found that 73% of providers had only received a single wage increase throughout their tenure in the position, with most of those as a result of the Medicaid reimbursement increase. Yet we found this to not be

enough to bring rates to where they eventually need to go, as one national organization found that the median wage for home health and personal care aides in Ohio had only increased $2 from 2014 to 2023.[x] A $2 increase over the course of almost a decade is why most entry level positions in food and retail services have higher pay than the average direct care provider, and why these industries are often one of the main competitors for care agencies looking to solve staff shortages.[xi] Why do the work of a care provider, known for being taxing physically and emotionally, when you could be paid better for less strenuous labor elsewhere?

Another pressing issue is the systematic lack of benefits provided to direct care providers in Ohio. A report by DODD found that most agencies do not provide insurance to their providers, with small, medium, and large agencies answering "No" at 78%, 81%, and 54% respectively.[xii] The size of the agency clearly matters in this case, but most agencies are not giving health benefits to the people responsible for the long-term care of our citizens. A national study found that 43% of care providers must use Medicaid or other public coverage options, with almost 20% being totally uninsured.[xiii] We also found that travel reimbursement is shockingly low, only offered on a consistent basis to 27% of our participants. We spoke to several participants who drive hours a day, at their own cost, to provide care to those in need. There is a great divide in the amount of HCBS available in rural areas compared to urban, and this lack of travel reimbursement is one of the biggest factors in this issue, with Midwest studies confirming that additional steps must be taken to ensure care is accessible for rural communities in our area.[xiv] In our own study, we found that 73% of providers did not receive health insurance from their agencies, 62% had no travel reimbursement, and 49% received no benefits at all for this difficult labor. Unfortunately, while there were signs that the Medicaid Reimbursement rate assisted agencies in increases pay wages, we found no evidence of benefits being offered as a result of this change.

During our study, we found that 50% of care providers had heard about a worker shortage, while a staggering 95% of care agency representatives agreed that a shortage was taking place. From wages that linger behind even fast food and retail positions, to a healthcare workforce where more than 60% of provider agencies do not provide access to health insurance, our findings paint a grim picture for an industry that is so vital to the daily lives of almost one in 10

citizens of our state. This has been a national crisis for decades. Ohio is not alone in our struggles to solve the issue of a skills-based workforce with an average turnover rate of 56%.[xv] The multiple causes of the crisis make it difficult to recommend any one specific action to address it, as a combination of wages, benefits, and an overall lack of tenured workers all see high turnover rates that most negatively impact those relying on home and community care. A bipartisan taskforce would be able to fully explore the causes and solutions to the worker shortage and make recommendations for the state of Ohio to move forward. We firmly believe that this is the best course of action if Ohio wants to make concrete steps towards providing an adequate amount of home care for the 106,000 Ohioans relying on these daily services.

Sincerely,

The Ability Center of Greater Toledo

Jules Patalita

Disability Rights Advocate

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The Ability Center

Direct Care Wages in Northwest Ohio:

A Study on the Impact of Medicaid Reimbursement Increases

> **"I love my job. And each time I am trying to give care to the agents, and they are responding respectfully, I see that I derive some kind of joy…they pray for me. They wish me well and I believe, as a Christian, I believe that these prayers, they're really, really helpful and God will definitely answer them."**
> – A Direct Care Provider during an Ability Center Focus Group

Created by:
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The Ability Center

Table of Contents

About the Ability Center of Greater Toledo 2

Participant Groups and Partners 3

Acronyms to Know 3

Executive Summary 3

Introduction 4

Background on the Direct Care Crisis 5

Legal and Policy Context 6

Our Method and Sample 7

Our Findings 8

Provider Quotes on Provider Shortage 11

High Turnover and Low Tenure of DCPs 13

Provider Quotes on Turnover 17

Lack of Regular Wage Increases Leading to Low Industry Average Wages 17

Provider Quotes on Wages 24

Systematic Lack of Benefits 25

Provider Quotes on Benefits 29

Recommendations 29

Conclusion 31

Data Collected from Focus Groups 32

About the Ability Center of Greater Toledo

The Ability Center of Greater Toledo is a Center for Independent Living located in northwest Ohio serving Allen, Defiance, Fulton, Hancock, Henry, Lucas, Ottawa, Paulding, Putnam,

Sandusky, Seneca, Williams, and Wood counties. The Ability Center advocates, educates, partners, and provides services supporting people with disabilities to thrive within their community. The Ability Center's programs are aimed at creating greater independence and stronger connection to the community. Programs include Advocacy, Assistance Dogs, Community Living, Independent Living, and more.

Participant Groups and Partners

We would like to thank those individuals and partners who participated in this survey. The following organizations partnered with us to promote our survey:

- Ohio Association of Area Agencies on Aging
- Wood County Board of Developmental Disabilities
- Ohio Self Determination Association
- Ohio Council for Home Care and Hospice
- Area Office on Aging of Northwest Ohio

Acronyms to Know

Center of Disease Control and Prevention (CDC)

Direct Care Provider (DCP)

Direct Service Provider (DSP)

Home- and Community-Based Services (HCBS)

Long-Term Services & Support (LTSS)

Ohio Department of Aging (ODA)

Ohio Department of Developmental Disabilities (DoDD)

Ohio Department of Medicaid (ODM)

Executive Summary

From January to the end of August of 2024, The Ability Center of Greater Toledo (The Ability Center) has worked with a statewide coalition of partners to conduct a study on direct care provider (DCP) wages. In 2023, Ohio House Bill 33 (HB 33) provided funding to increase the reimbursement rate for direct care under Ohio State Plan Medicaid and Medicaid HCBS Waivers. The increase was set to go into effect as of January 1st, 2024. While the bill language required that this increased funding be used for DCPs, the bill did not set a specified higher wage for DCPs. In fact, a section in the original version of HB 33 setting a mandatory base wage for DCPs was vetoed.[i]

The Ability Center and our Coalition were interested in determining whether DCPs saw an increase in wages after the passage of HB 33 and, if so, how much of a raise they saw. Our

study contained two separate elements to gauge the impact of this increased funding on wages in NW Ohio: 1) an online survey to be filled out by representatives of direct care agencies and 2) online focus groups with DCPs. Study participants included individuals working under all seven[ii] of the Ohio Department of Medicaid HCBS waiver programs as well as a mix of independent and agency providers in NW Ohio.

The Ability Center identified several themes in analyzing the results. While none were a surprise, our results confirmed that more needs to be done to solve the direct care crisis. Most immediately, there is still a shortage of DCPs within the HCBS field. This was confirmed by agency representatives and the care providers themselves. Consistently, the shortage was linked to three major elements. First, the tenure of DCPs was low, with the average time in the industry for our focus group participants coming at 3.19 years. With turnover this high, few care providers have the experience and skills that many of their clients need to live independently. Second, the hourly wages for DCPs are too low, lower than many entry level positions in retail and food service. While just over 60% of DCPs working under agencies did receive a wage increase in 2024, these were often the first raise the provider had ever received while working at their agency; only 25% of independent providers, on the other hand, saw a raise after the Medicaid increase. Finally, almost half of the DCPs interviewed complained that their agency did not provide them with any consistent benefits or reimbursement besides their earned wages. This failure by agencies to provide benefits adds to the worker shortage and forces those requiring home care to carry the burden of decreased access to care, especially those in rural areas.

From the results of our study, it is clear that raising the Medicaid reimbursement rate for direct care was not the only step needed to solve the Direct Care Crisis. Additional steps beyond a single increase in reimbursement or just raising wages must be taken to end the direct care crisis in Ohio. Based on the results, higher wages and benefits need to be offered to DCPs, but there also needs to be a set methodology for agencies to calculate wages based on the rate of Medicaid reimbursement alongside additional opportunities to receive job training and career advancement. We also recommend that a legislative taskforce be formed to research the scope of the problem and identify solutions. It is only by addressing each of the problem areas of the industry while also providing consistent support that we will see the necessary supply of providers.

Introduction

For decades, the direct care industry has been going through a crisis. Nationally,[iii] and within the state of Ohio,[iv] there are a shortage of qualified care providers. We have seen unusually high turnover rates, low wages that cannot compete even with entry level positions in other fields, and a general lack of support and benefits for the providers. For years, the term “direct care workforce crisis” has been used to describe agencies’ struggle to maintain staff while consumers struggle to find care providers that allow them to live independently.[v]

In 2024, Ohio advocates worked with legislators to increase base payment rates for direct care services as part of Ohio House Bill 33. The final draft of the bill, which passed both the Ohio House of Representatives and Senate, set base payment rates for direct care services to $17/ hour in FY2024 and $18/ hour in FY2025. Unfortunately, Governor DeWine vetoed the base payment rates, stating that he believed that agencies and state departments should have the final say in wages.[vi] Though the payment rates were vetoed, Governor DeWine left the increase in funding with a general legislative directive that the increase should be used for DCPs.[vii] As advocates for the disability community, The Ability Center's focus was to study the impact of this reimbursement increase and gauge if it had noticeable effect for the providers themselves.

The availability of DCPs is a major factor in ensuring the health and independence of those with disabilities in Ohio. A strong network of direct care providers is also necessary to ensure that the state of Ohio meets its legal obligations under the Americans with Disabilities Act and Supreme Court decision of *Olmstead v. L.C.*.[viii] A network of DCPs is the only way to enable those that rely on homecare are able to live outside of institutional settings.

Prioritizing HCBS care also makes ethical, legal, and financial sense for the state of Ohio. Studies have shown that care received in the community costs less federal and state dollars than care within institutions, giving financial incentive to encourage HCBS beyond the ethical stance that Americans should be free to live in the setting of their choosing. In 2023, the Kaizer Family Foundation found that the average cost of home care for an individual was almost 75% of the average cost for institutional care.[ix] As home care is a key part of independence for those with disabilities, the DCP shortage continues to be one of the top priorities for our organization as well as the Ohio disability community as a whole.

Background on the Direct Care Crisis

For years, people with disabilities in Ohio have been warning decision makers about a shortage of DCPs. While advocates have asked for increased funding to DCPs in the last several Ohio budget cycles,[x] the only steps that Ohio has taken to remedy the crisis were increasing funding in a general way for agencies that employ workers and "one-time payments."[xi] In 2022, an Ohio Direct Care Expansion Working Group did meet to listen to the concerns of consumers and make recommendations. However, it is unclear how many, if any, if its recommendations have been followed.[xii] In fact, a survey by the Kaiser Family Foundation published in 2023 states that the only action Ohio reported that it took to remedy the DCP crisis was increasing provider payment rates.[xiii] This falls short of actions taken in at least 42 other U.S. States, which have responded by developing or expanding worker education and training programs, offering incentive payments to recruit workers, establishing a base wage for DCPs, and offering paid sick leave.[xiv] Presumably, the lack of visibility of the Expansion Working Group's Report, and its placement within ODJFS rather than the Ohio General Assembly, made its recommendations both not visible and not mandates. While increased funding is a welcome response to the crisis, many advocates worry that, without specific set

wages, the increased funding provided to agencies went to overhead and administrative profit rather than to the workers, which does little to remedy the issue.

Thus, the 2023 increase in Medicaid funding for DCPs was meant to combat a decades-long shortage of qualified DCPs in Ohio. Ohio has a higher rate of people with disabilities than the US average, with more than 30% of Ohioans having some form of disability according to the CDC.[xv] A statewide Needs Assessment published by The Ability Center in 2021 sought to identify, in part, barriers to healthcare access for those with disabilities in Ohio.[xvi] One of the most prevalent issues in the survey was a shortage of direct care providers, which threatened many people's ability to live outside of institutions and hospital settings. Of those Ohioans surveyed, almost 24% answered "I have trouble finding in-home providers." Further in the study, 54% of respondents said that high turnover caused them to have to change providers often, and 55% stated that they had trouble finding a care provider to meet their needs; the data point of most concern, however, was that 29% answered that "they are sometimes left without in-home providers for weeks at a time."

According to a report by the CDC, more than 111,000 Ohioans have a disability that impacts their ability to perform self-care, the type of disability that often results in hiring DCPs.[xvii] The number of people in Ohio impacted by the crisis in this industry is immense and needing of immediate attention, but the number of people needing DCPs in Ohio will likely only increase in coming years. Global trends are moving towards longer life expectancies, meaning more members of the aging community will also require home care to Age in Place. The Scripps Gerontology Center predicts "24% increase in those age 80 and older over the next two decades will continue to have an impact" on the care industry.[xviii] Ohio must get in front of this trend, rather than run behind it. To truly work on this issue, we must estimate how many DCPs will be needed over the next decade and develop policies to incentivize that enough workers will be available.

Legal and Policy Context

In 1999, the U.S. Supreme Court held in the case of *Olmstead v. L.C.* that "unjustified isolation" of persons with disabilities constitutes discrimination under Title II of the ADA, which states that public entities must, "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified people with disabilities."[xix]

Olmstead involved the state of Georgia's failure to transition two people with developmental disabilities and mental illness from state psychiatric hospitals to the community because of a lack of state-sponsored community services. While the two plaintiffs had both been deemed able to leave the hospital by their doctors, and wished to leave, they were unable to move into the community due to a lack of available services.[xx] Where a state government program, like Medicaid, provides care that forces people with disabilities to live in institutions rather than community-based settings in order to receive services, that program violates the ADA.

Based on the law and spirit of the *Olmstead* decision, states have since expanded services available in the community to ensure that people with disabilities have the ability to live as independently as possible, in the "most integrated setting" appropriate to the needs of the individual[xxi], which in most cases, with the right supports, is a person's own home. Many community, wrap-around services are offered through Home and Community Based Services Waivers, Medicaid programs that offer services meant to remove barriers to independent living for people with disabilities – home modifications, in-home nursing services, transportation services, home-delivered meals services, and in-home aids.[xxii] Other services are offered through direct state funding of non-profit organizations and housing programs that assist developers in creating accessible housing.[xxiii] These services are necessary to support deinstitutionalization and community based living.

Many states have created *Olmstead* plans: plans that lay out how the state intends to ensure that citizens with disabilities are receiving appropriate, wrap-around services in the community rather than in institutions. These plans lay out what independent living goals states have for their communities and how they will accomplish them.[xxiv]

Direct Care is a key component to any state *Olmstead* plan, as independent living for many people with disabilities is impossible without a direct care worker in their home. Ohio has both a legal and moral obligation to gather data on the current direct care crisis and ensure it has a plan to incentivize more direct care workers to prevent people with disabilities from being forced into institutional settings.

Our Method and Sample

We are seeking solutions for this issue. The Ability Center set out to study if the 2024 increased Medicaid funding had any impact on care providers' wages and benefits. We used two methods: a virtual survey completed by representatives of direct care agencies, with an emphasis on how this reimbursement was used and how employees were informed of the increase, and virtual focus groups with direct service providers, with a focus on their benefits and how their wages had changed in the past few years. The virtual survey and focus groups were promoted from May 8th to August 6th, 2024. Data collection was limited to the Northwest Ohio region and the 13 following counties: Allen, Defiance, Fulton, Hancock, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Seneca, Williams, and Wood counties. Data from both methods has been compiled to create this report. This region is a good sample for the state as a whole given the makeup of the area – it is a combination of urban areas (the largest being the greater Toledo area, Lima, and Bowling Green) with stretches of rural area between. While this report is limited by its sample size and the confines of the Northwest Ohio region, it sheds light on the HCBS industry in Ohio as a whole.

As a final note, this note uses the term "direct care provider" (or DCP) as an umbrella term to refer to the participants of our focus groups and the individuals who provide HCBS care. There are several different job titles that fall under DCP including: home health aides, direct service

providers, caregivers, home care workers, personal care aides, direct support professionals, and many more. Some of these differences in name come from the rules language of different waiver programs, while others are differences based on the agency one works for; there are cases where the differences in skills or job duties make two DCP positions fundamentally different and others where the difference is simply in the name. Even within our focus group, many participants were unaware of the exact name of their position or seemed to not know the differences between different job titles within the DCP umbrella. Within the HCBS industry, the distinction between these terms is more an administrative difference than a functional one for many individual providers. As such, this report uses DCP to refer to those providing non-medical HCBS care. Any cases where a specific job title is used (such as home health aide or DSP) is data that is pulled from a report where that exact term is used, with us mirroring the language used for consistency with the original report.

Our Findings

Our survey was meant to examine how the 2023 increase in funding affected the Direct Care Workforce Crisis. Our findings confirmed that the 2023 increase in funding has not impacted the worker shortage and showed the need for a set methodology requiring additional wage increases for DCPs. Additionally, the increase in funding did not affect the three major elements that have caused the shortage of care providers: high turnover rates, low pay rates, and a lack of benefits.

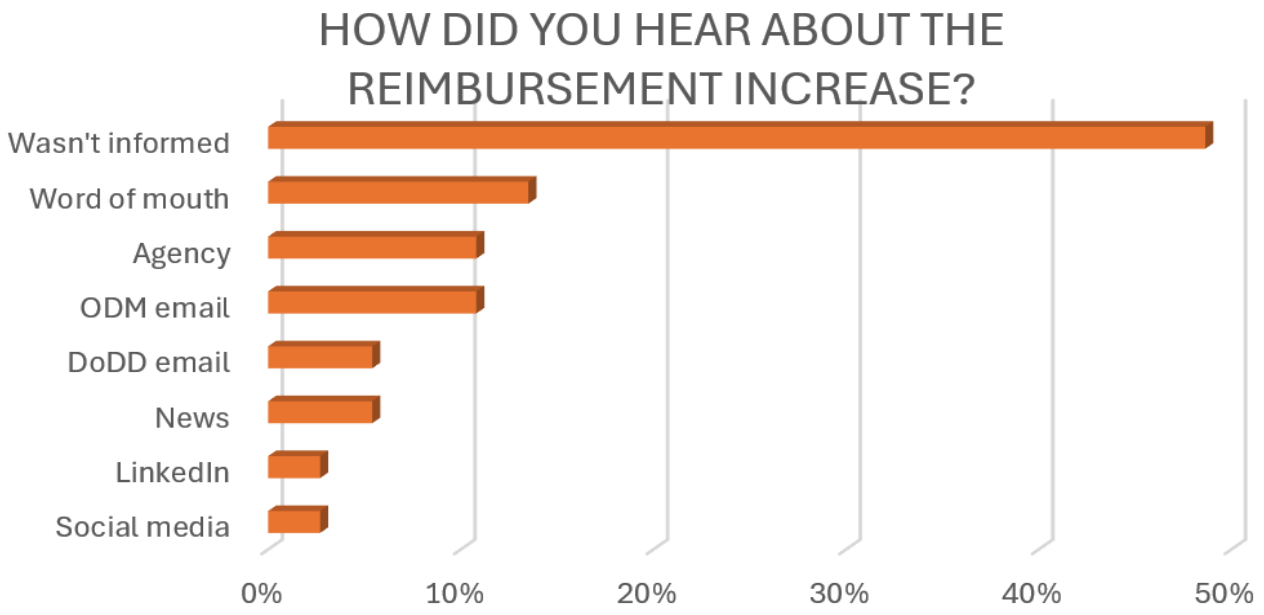
The 2023 Increase resulted in some higher wages, but wage increases were inconsistent and did not resolve the worker shortage

First, when looking at the impacts of the Medicaid increase, we found that most DCPs that we interviewed did receive some form of wage increase, but that the amount of the increase was inconsistent. Most agencies in our study did not report having a methodology for determining provider wages based on Medicaid rates, meaning that a reimbursement increase will not have a consistent impact on wages. Instead, wages depend on the agency. Additionally, not every DCP interviewed saw a pay raise. Over 15% of DCPs interviewed told us that they did not receive any wage increase in the last year. This is likely due to the fact that agencies were not directed on how these increased funds should be spent. Thus, while the Medicaid increase did lead to some increased wages, the amount of the increase and whether or not it happened at all was inconsistent.

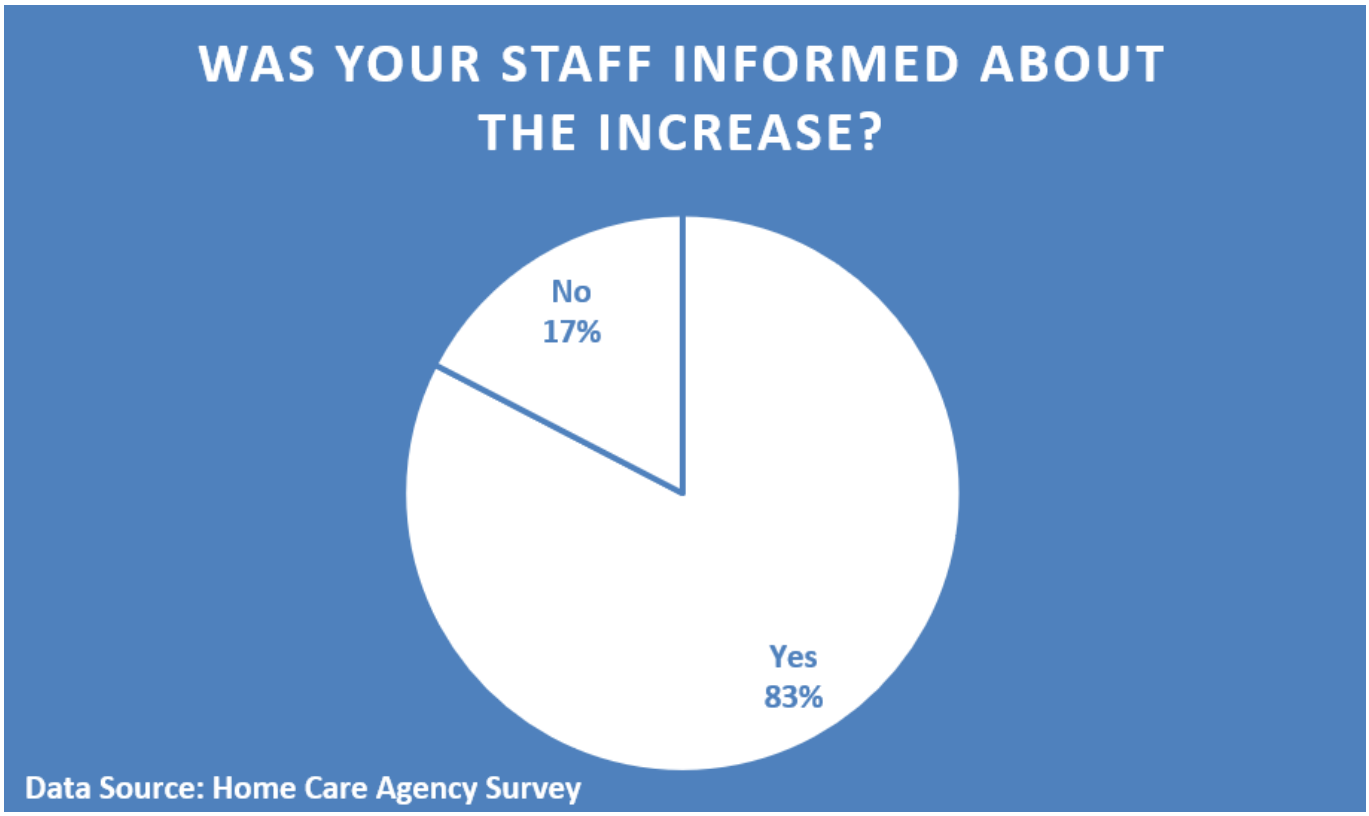
The Medicaid increase was not promoted well, with many providers not knowing it was occurring or what the increase was focused towards

Few DCPs seemed to be aware of the state increase funding, a move that was made to benefit them directly. One care provider reported that, “I do keep myself knowledgeable, but I haven't quite heard of this. I am just hearing it for the first time.” Our study found that only 12.5% of interviewed agency-employed DCPs were informed of this increase to reimbursement by their agency, while 50% of interviewed DCPs learned about this increase during the focus group itself. At the same time, 82% of surveyed agency representatives reported that they informed their staff of the increase. Presumably, this disconnect demonstrates that either the increased funding was not spent on wage increases or that there is a lack of transparency between agency administration and DCPs.

It also appears that ODM did not effectively communicate the increase in funding to DCPs. When discussing the increased Medicaid reimbursement, one provider told us, “I heard it from word of mouth. I heard a couple of colleagues talking about it, I think, about two weeks ago.” This DCP heard about the increased rate, something that should be benefiting them directly, from a coworker and not ODM or their agency. They also learned this news late -- sometime in July, which was half a year after the initial rollout of the benefits. There is a clear weakness in communicating this information to the providers directly impacted by this reimbursement, from both ODM and the care agencies.



Data Source: DCP Focus Group



The 2023 increased funding did not affect the three main causes of the workforce shortage: high turn-over, low pay, and a lack of benefits

In sum, the increased reimbursement rates did, generally, raise wages, but the amount of the raise and whether a DCP received a raise was inconsistent because agencies do not have a set methodology or parameters for worker wages. The increase in funding was also not well communicated, if at all, to DCPs themselves. This increase also failed to address the other historic issues facing DCPs. More direct action needs to be taken by the state of Ohio if the direct care crisis is to eventually end. It is a crisis that must end, as all reports show that this worker shortage will only worsen while more and more Ohioans will require home care, leading to a horrible increase in demand as supply drops further each year.[xxv]

Our study confirmed that the historic problems facing the DCP workforce still exist and that an increase in funding needs to be paired with additional action in order to ensure that Ohio is properly supporting the independence of those with disabilities. Both DCPs and agency representatives stated that more providers continue to leave than enter the field. Increased

funding that does not go to wage increases will benefit provider agencies but will not directly impact the three major elements that have caused the shortage of care providers: high turnover rates that limit the number of experienced providers, low pay rates for providers with rare wage increases, and a systematic lack of benefits that threaten the livelihood of providers and risk the health of care recipients.

The lack of access to DCPs is one of the greatest unmet needs for the state and has been noted not just by the disability community, but outside studies and those working within the care industry.[xxii] More than half of the care providers we spoke to mentioned that they had noticed a shortage. This has been the reason that some current DCPs entered the industry. One independent provider told us that the worker shortage was "why I'm working all of these hours," working 10-16 shifts six days a week while working two jobs. Another provider was actually the parent of an adult with a disability that forced her to provide unpaid care herself when "my child was on a waiver for five years and couldn't find a provider," forcing her to become a provider. Many providers told me that their entry into the industry was providing unpaid care for family members, whether it was children, grandparents, or siblings. An industry that relies on recruiting family members and loved ones because of a lack of trained professionals is not a thriving industry, yet the demand for DCPs continues to grow with few solutions in sight.

The findings of this study confirm all reports of the direct care crisis from the past decade, and that the Medicaid reimbursement increase is not enough by itself to solve the worker shortage. The unfortunate truth is that the issues within the HCBS industry are too complex for a single action to make an impactful change. Rather, multiple efforts taken in tandem are necessary for Ohio's population to have access to the proper supply of DCPs. Before looking at recommendations on how to combat the worker shortage, it is important to understand the key issues that are causing this lack of DCPs: high turnover rates causing a low average tenure of providers, the infrequency of pay raises that cause the low average wages, and the lack of benefits for the majority of workers. By first understanding the nuances of the industry itself, recommendations can be made that are informed about current conditions as reported by those providing care to Ohio.

Provider Quotes on Provider Shortage

> "A lot of issues with agency and as a result, they lost a lot of workers. So that was how I got employed into the agency."

> "Some feel like you're not really satisfied with the job you're doing. Or they feel they're underpaid and are not satisfied. Or maybe they feel the work they're doing is not letting them have enough time for their family. So stuff like that, and various reasons also, do contributes to a shortage in workers in our field."

> "I did a little bit of research and got to find out that they quit the job because they were not happy with the pay. It's something that really bothers me because, you know, a lot of

people are complaining about the pay and quitting the job. And it just doesn't [speak] well, about the agency and industry at large."

> "They really don't treat their workers well. You know, the agency is figuring out a lot of things, and they really don't give us the respect we deserve. They don't give us enough incentives, enough benefits."

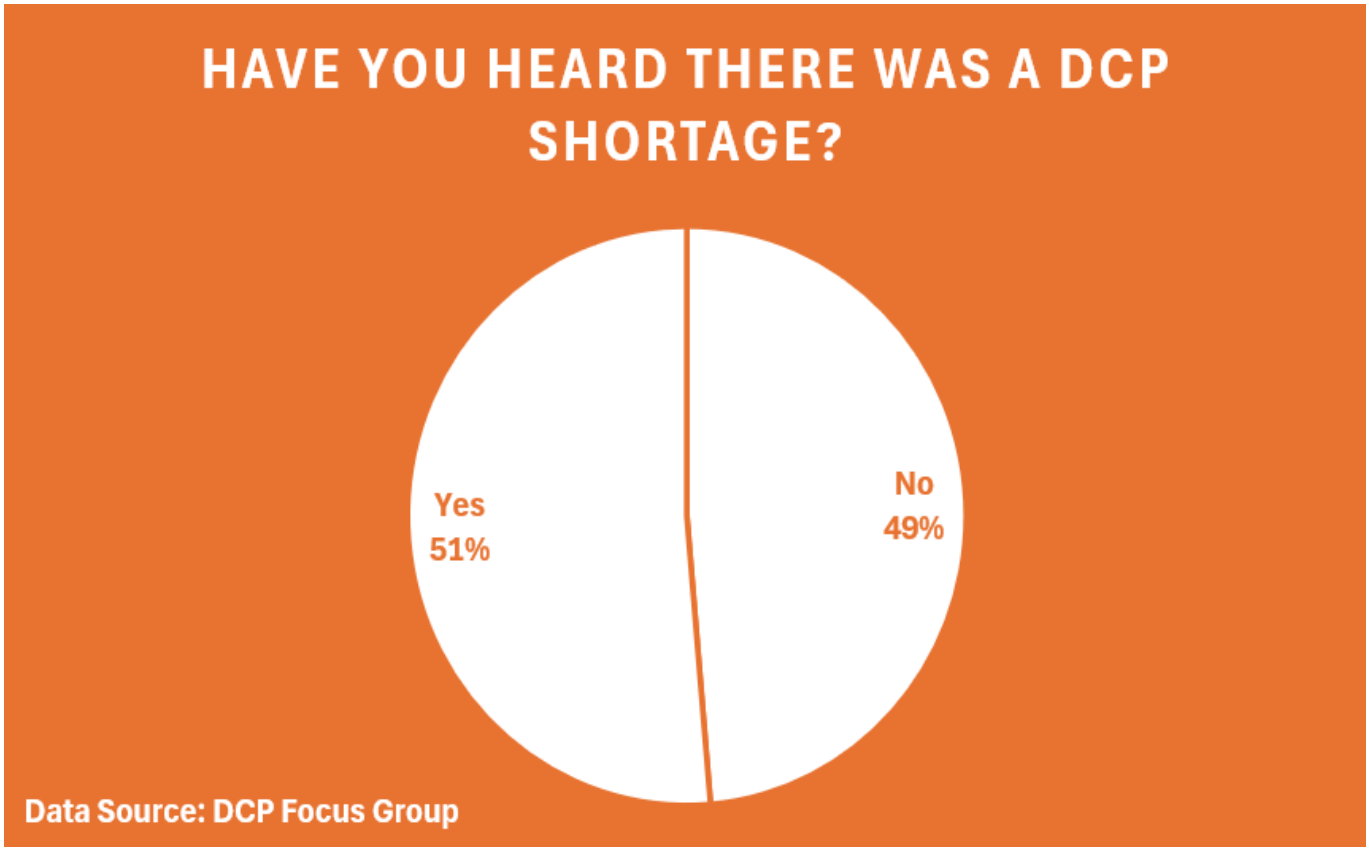
> "You see them taking notes, you see them agreeing with what you say. But at the end of the day, your opinion doesn't count, your opinion doesn't matter. It's still, what the board sees within themselves…that's what they do. And then that which they are doing, just falls short of what you actually brought to the table."

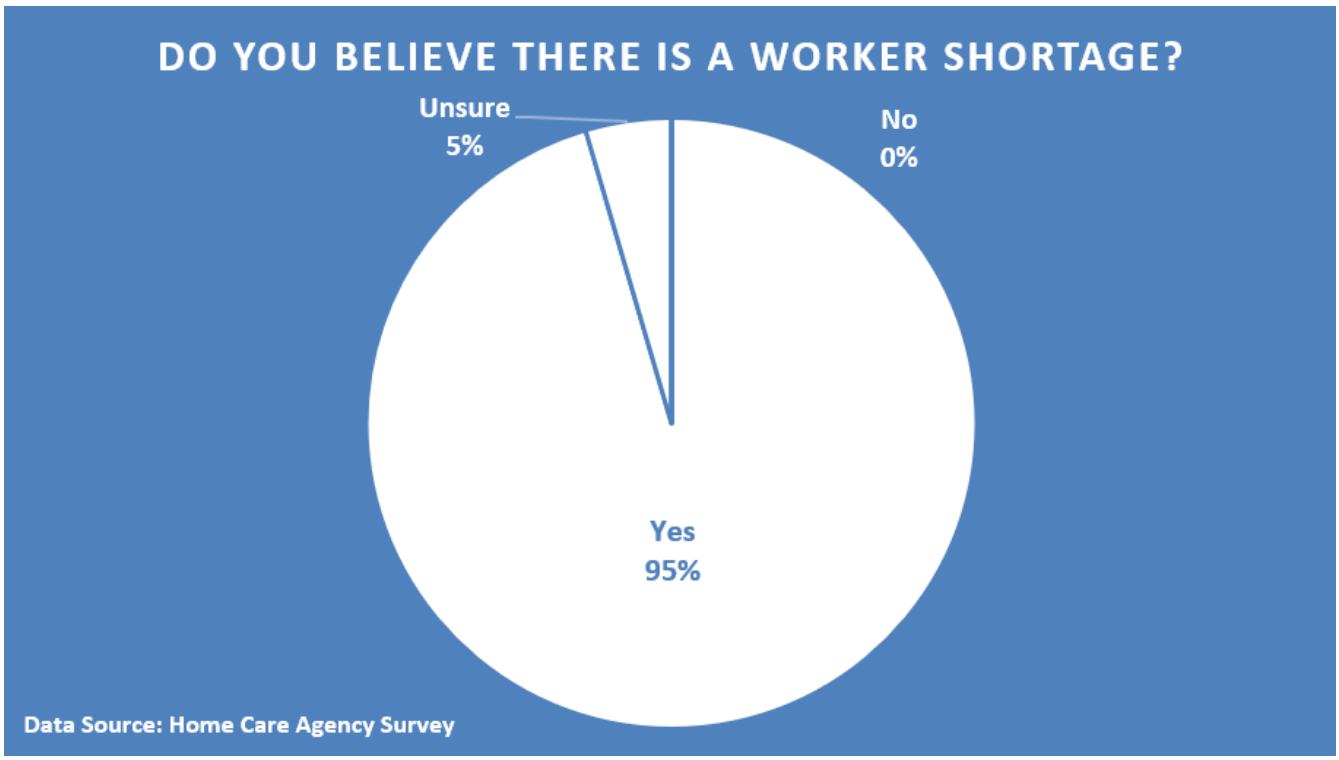
> "There's this particular thing that I don't enjoy about my agency and that's the lack of moral support for employees. When you work with an agency, especially the kind of work that we do, you know, being direct caregivers, sometimes you need this moral support from your employer. Just to do your work well and make sure you have that mental stability, and for everything to just go well and work with topmost efficiency. I think that that's a place that they did lack a lot."

> "There's a huge shortage in the field of DSPs. And I believe one of the main reasons is the agencies. So, people don't know how to find them, how to get the job. What even working with people with disabilities is even like. and when you go to find them… the pay is so low, it's starting off at like $10.50, $11."

High Turnover and Low Tenure of DCPs

This shortage has clearly been noticed, not just by advocates, but by the HCBS industry: the providers and the agencies employing them. While more than 50% of DCPs in our focus groups had heard of a worker shortage, a staggering 95% of agency representatives stated that they believed there was a shortage of care providers. There are few clearer signs of an industry struggling than for the heads of those providing the service and those providers on the front lines coming to such a near-anonymous conclusion. This cannot be seen as a failing of an agency to find DCPs if 95% struggle to fulfill their worker needs; this is evidence that outside intervention is needed to correct a problem that threatens the independence of 30% of Ohioans. Not only is this impacting the access to care for Ohioans, it forces existing providers to fill the gaps in coverage by the shortage. A national study conducted in 2021 by the Kaizer Family Foundation found that "a number of paid caregivers described regularly experiencing uncertainty about whether they would be able to leave work at the end of their shift due to staffing shortages and scheduling challenges."[xxiii] It seems clear to all parties involved, from those receiving care to care providers to those running care agencies, that Ohio is indeed in the middle of a direct care crisis that needs more aggressive steps to combat.





One direct impact caused is that the average tenure of DCPs is far lower than a skills-based position of its kind should be. Our study participants repeatedly discussed the high turnover rates of DCPs, and consequentially, the low tenure of the providers. A workforce highlight report released by the Ohio Department of Developmental Disabilities in November 2022 listed a 56% turnover rate among care providers, with 71% leaving voluntarily.[xxvi] This is higher than the US average at 43.6%, a worrying statistic given the increased percentage of people with disabilities in our state.[xxvii] Just as worrying of a statistic, the DoDD found that 63% of DCPs had a tenure at their agency of less than 3 years.

According to our participants, much of the turnover is due to the duties of being a DCP. There is a high amount of physical labor in having to lift patients and help those with limited mobility as well as an emotional and mental toll of working with clients who range from grateful to aggressive. One provider told us their experience, saying that:

> This work isn't actually as cozy and all glory as it seems and sounds. Because so many people can't actually put up with the type of work agent caregivers give to them. So some of them, even on their first day of work, they just come back and they sign out and we never see them… We lose more staff than we get.

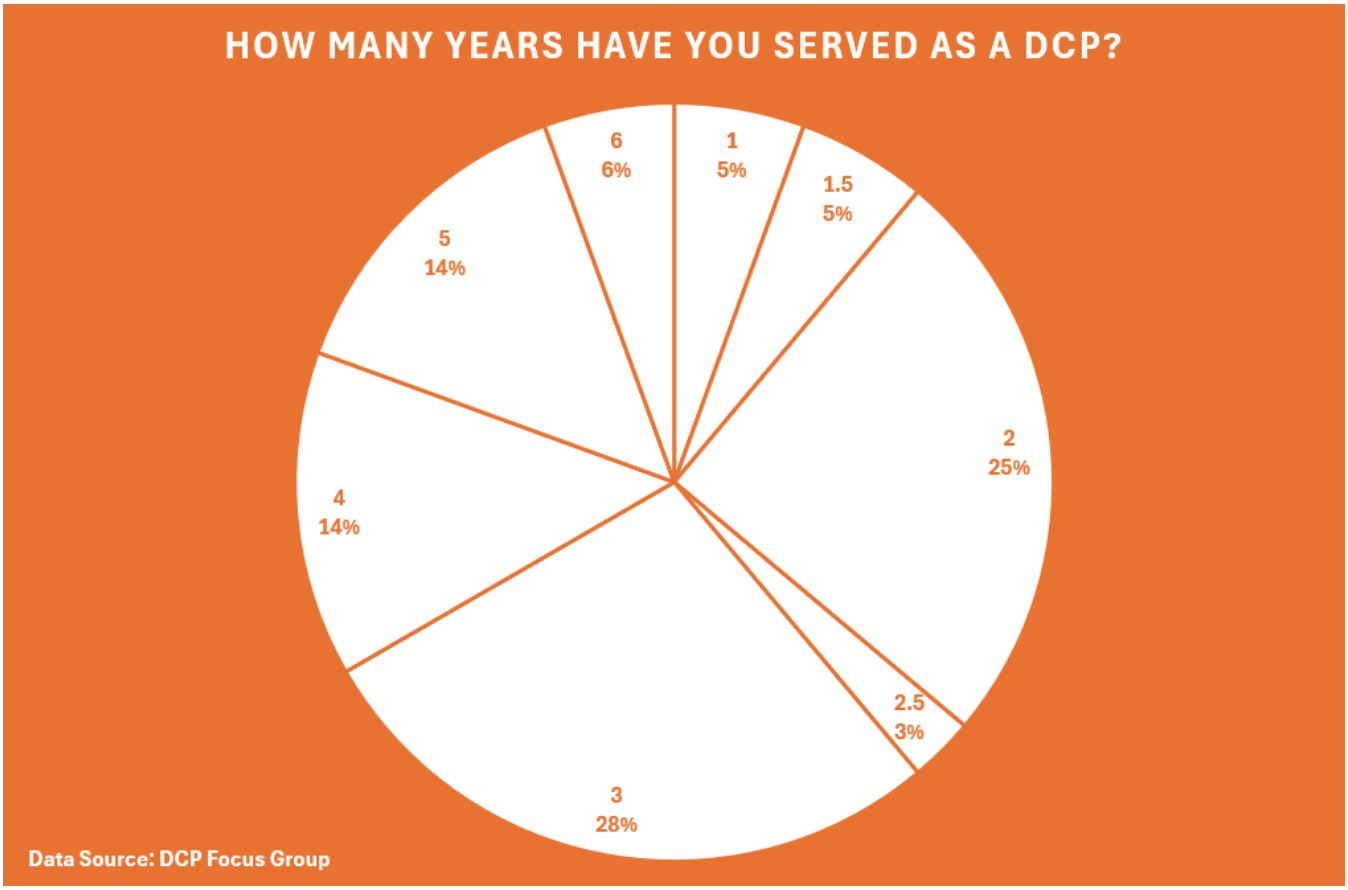
Many DCPs believe that the pay rates for direct care providers “do not reflect the demands of their jobs.”[xxviii] The work is challenging physically and mentally. Many people receiving care need assistance being transferred out of bed, onto mobility equipment, and in and out of restrooms. Many clients can be rude, aggressive, or abusive to their care providers. A report by the Health Affairs publication wrote, “occupational stress related to the pressures of caring

for ill and dying patients, client aggression and other behavioral issues, and violence perpetrated by clients or other family members is a serious challenge for this workforce."[xxix] A special issue released by Oxford University Press described direct care as "physically demanding work, leading to disproportionately high rates of occupational injury and also requires considerable relational skills and emotional labor."[xxx] For the work being provided by these care providers, and the risk of injury and infection associated with the position, it is clear that DCPs are not being properly compensated for their labor.

There is also a lack of respect for the work from clients and from our community. Nearly one in six of the DCPs in our study brought up the fact that there is not enough respect placed on the work done by care providers, sometimes from clients but often from society as a whole.

The low retention rates for direct care agencies greatly impacts the care received by clients relying on DCPs for everyday assistance. For the providers, this can mean taking on the clients of coworkers when they leave. One participant spoke on "this time that a coworker quit his job. And I was asked to take on his role. It was a bit difficult at first and I had to renegotiate with my agency based on the pay." For clients who are used to having services rendered in a specific way, a change in care staff can mean deep impacts on the assistance they receive. Direct care is a skills-based industry, where the quality of care received by the consumer can have enormous effects on their health. This means that the experience of a DCP and the length of their tenure has a direct impact on the health of Ohioans. In any industry, the first year in a position is often one where the worker is learning the basic skills and how to meet the demands of the job. How is a care provider able to properly learn these skills and provide quality care when almost 70% of DCPs in Ohio have less than one year of experience?[xxxi]

Our study shows that this high turnover continues today. The average tenure of our focus group participants was only 3.19 years, which is barely enough time to build all of the skills necessary to be competent in one's field. If 41% of DCPs in Ohio have two years of experience or less, access to experienced care providers is a scarcity in our state that must be addressed by finding ways of lowering this systematically high turnover and creating an environment that encourages providers to have long-term careers in the field.



The main competitors for many care agencies are not other health care agencies, but retail business and fast-food restaurants. These entry-level positions have been noted nationally as a threat to care agencies because they often provide higher pay, better benefits, and a less strenuous workload. One provider was blunt when they said that "people in the caregiving industry, when they get a better job, they move, they leave. So majorly, is because of the low pay and nature of the work, how stressful the work is. That's why there's a worker shortage." Specifically in the state of Ohio, the median wage for a direct care provider in 2019 was reported at being $3.52 lower than the average hourly pay for entry-level positions.[xxxii] Why would someone stay in this field if they can find work that is easier and pays better in industries that are constantly hiring?

When interviewing DCPs, we were repeatedly told that people are entering this field because they have a passion for caring for others, with one participant saying "I love working with people. I love making an impact. You know our kind of work, we leave an indelible mark in the lives of these kids and their parents." Unfortunately, consistent barriers (noncompetitive wages, high workloads, lack of benefits) are causing these workers to quickly look for other employment. One provider told us that workers left because "of the issues I stated previously on the issue of bonuses, issue of not getting gas money, not getting health insurance. So they feel that venturing into other fields will be the best for them." For the high demand of home and community care, there must be a large enough workforce of care providers to ensure that

aging Ohioans and Ohioans with disabilities can live independently. This means that it is paramount that DCPs are provided with a competitive wage and benefits packages that surpass entry-level positions. Providing direct care is not equivalent to an entry-level position. It is a challenging position that is essential to maintaining life in the community for many aging Ohioans and Ohioans with disabilities. It is no wonder that 69% of DCPs are leaving the field after one year or less, especially if more lucrative positions are available at entry-level jobs that require less training and less strenuous work. Having care providers is not enough, there needs to be experienced care providers that have longer tenures and the skills to properly care for Ohioans.

Provider Quotes on Turnover

> "The work is really stressful and difficult and burdensome. Yes, and a lot of people out there in the society that need caregivers. So the hands that are on deck, as the current number of caregivers, I don't think it's enough. So there's such a shortage of workers in the in the field."

> "Considering the hectic nature of the job, so many people have to quit the profession because they believe it's not lucrative enough to meet their ends meet. And I think if there is a general standard, whereby the caregivers are given priority to actually increase the wages…I believe so many people actually venture into it. Though, you have to have the interest of the people at heart."

> "I think all that really caused the shortage is, there's a lack of low wages and benefits, and then lack of recognition and appreciation. And then, limited career advancement opportunity. And it's just a whole lot of needlessness, it's a whole lot of them. And it just takes someone passionate to be able to continue doing the job without quitting. Just for me, I think what drives me is the fact that I am willing to provide care for people and then see, we need to put smiles on people's face. I think that's what drive it for me, but then someone that has bills to pay and other things to do and then a house to run and other things. I don't blame them if they quit the job because of the low wages and benefits that comes with it."

> "I think the work we do is, you know, cannot be understated. And I think even people who would want to do it, who have the passion for it, may not want to venture into it, mainly because of how poor we're being paid per hour, and how caregivers are not really given the amount of value and respect that they should be given."

Lack of Regular Wage Increases Leading to Low Industry Average Wages

The DCP shortage has been documented for years, but the causes and impacts of it seem to go against the common sense understanding of labor markets. In most industries with a low supply of workers with a high demand for their trade, one would expect higher wages and low turn-over as those in the field stay in their positions long-term. Yet we consistently see

throughout our study and those of other agencies that the HCBS industry is defined by its high turnover rate among service providers, with low wages combining with a lack of benefits making these unattractive long-term jobs for those with families to support. Many of the DCPs in our study stated this directly, and accredited both of these factors in seeing coworkers leave their agencies. Federal reports have shown that, throughout the country, DCP wages are lower than those of entry level positions in every other profession, including retail and food service.[xxiv] Worse, these positions often pay better and offer better benefits than many care agencies do, all while requiring a lower workload with more consistent schedules.

Many DCPs in our study reported that they saw fellow care providers leaving the field to go into the food service, with one participant saying,

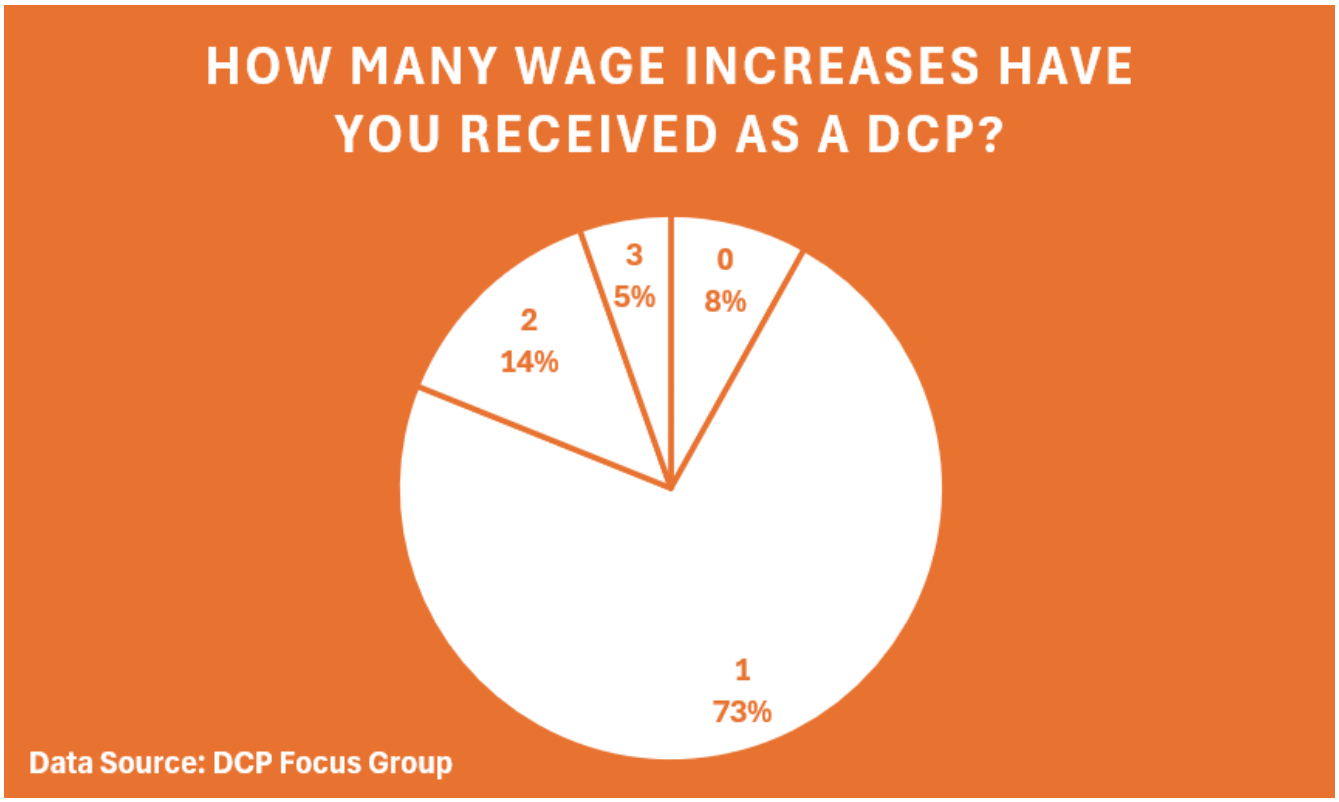
> There's a lack of low wages and benefits, and then a lack of recognition and appreciation. And then just more like limited career advancement opportunity....And it just takes someone passionate to be able to continue doing the job without quitting...But then someone that have bills to pay and other things to do and then house to run and other things. I don't blame them if they quit the job because of the low wages and benefits that comes with it. So I think that's the main reason why there's a shortage.

Almost every single care provider interviewed said that they had a passion for caring for others, that it was the personal satisfaction of helping people that caused them to stay in the industry. Personal satisfaction can only go so far, however, when you are unable to feed your children or provide them with health insurance.

While not the only root cause, pay is certainly a major contributor to the current shortage of care providers in Ohio. Throughout the focus group process, most of the DCP participants brought up wages as one of the main points of contention in their role, or an arguing point between care agencies' administration and staff. It is clear from the data collected in this regional study, alongside studies done on state and federal levels, that low wages are a major weakness of the HCBS industry and a main contributor to the issues seen in finding providers. A study for DSP wages showed that the average hourly pay for this work, characterized by one of participant as "really stressful and demanding," was only $13.36.[xxxiii] One provider told us that, "it's not enough to cater for me and my family. You know, with the current inflation rate and where things are going, it's really not enough...That was why we in the agency, we demanded an increase over time." While the set base wage for care providers in HB33 was vetoed, the increase to the Medicaid reimbursement rate was left to fight the direct care crisis and protect DCPs.

Unfortunately, this increase is not merely there to combat low wages, but to compensate for that fact that many DCPs have received few, if any, wage increases during their tenure. Our study found that 81% of participants had received one or fewer wage increases throughout their career, with less than 20% having had their pay increase two or more times. Given the way that inflation has skyrocketed in recent years, a lack of wage increases means that one's hourly pay quickly becomes a nonviable wage. It is understandable why DCP wages are not

able to compete with those in other fields, even food service and retail. One agency representative wrote that that the way to combat the current worker shortage was to offer support “to allow home health to compete with [the] fast food industry.” Another agency head suggested a further increase in reimbursement rates “so agencies can increase the hourly wage,” and many more agreed that increasing wages and benefits was the best way to attract providers. And yet the DCPs of Ohio are still barely receiving wage increases throughout their tenure.



Some participants recalled past pay raises that occurred due to heated negotiations between the providers and agency administrations. Providers stated that these pay raises were the result of staff petitioning as a group for their agencies to increase wages, or that they were the direct result of filling a worker shortage. One provider told us that an increase from $17 to $20 an hour only happened after complaints from providers. “Some of my colleagues were really bitter about the amount they received, and they decided to take on the agency.” Another provider spoke on the fact that provider scarcity at his agency was “why they increased wages.” Yet another said that “quite a few of my colleagues left the industry...because they weren’t satisfied with the pay. They deserved better.” Still, an alarming 70% of DCPs reported that they had only ever received a single wage increase during their time as care providers, with the majority of those being in the last 12 months.

It is possible that wage increases were not the result of increased reimbursement but were, instead, the result of worker shortages or staff negotiations. None of the providers working for agencies reported that these raises came because of the Medicaid reimbursement increase; it

is probable that many raises were independent of the increase. Even before the increase to reimbursement, it is clear that many agencies were forced to raise the hourly pay of workers to prevent further loss of providers. Yet wage increases were too small and infrequent to correct the worker shortage. A universal effort is needed by the state of Ohio to ensure that these types of increases are happening more regularly and are implemented by every agency.

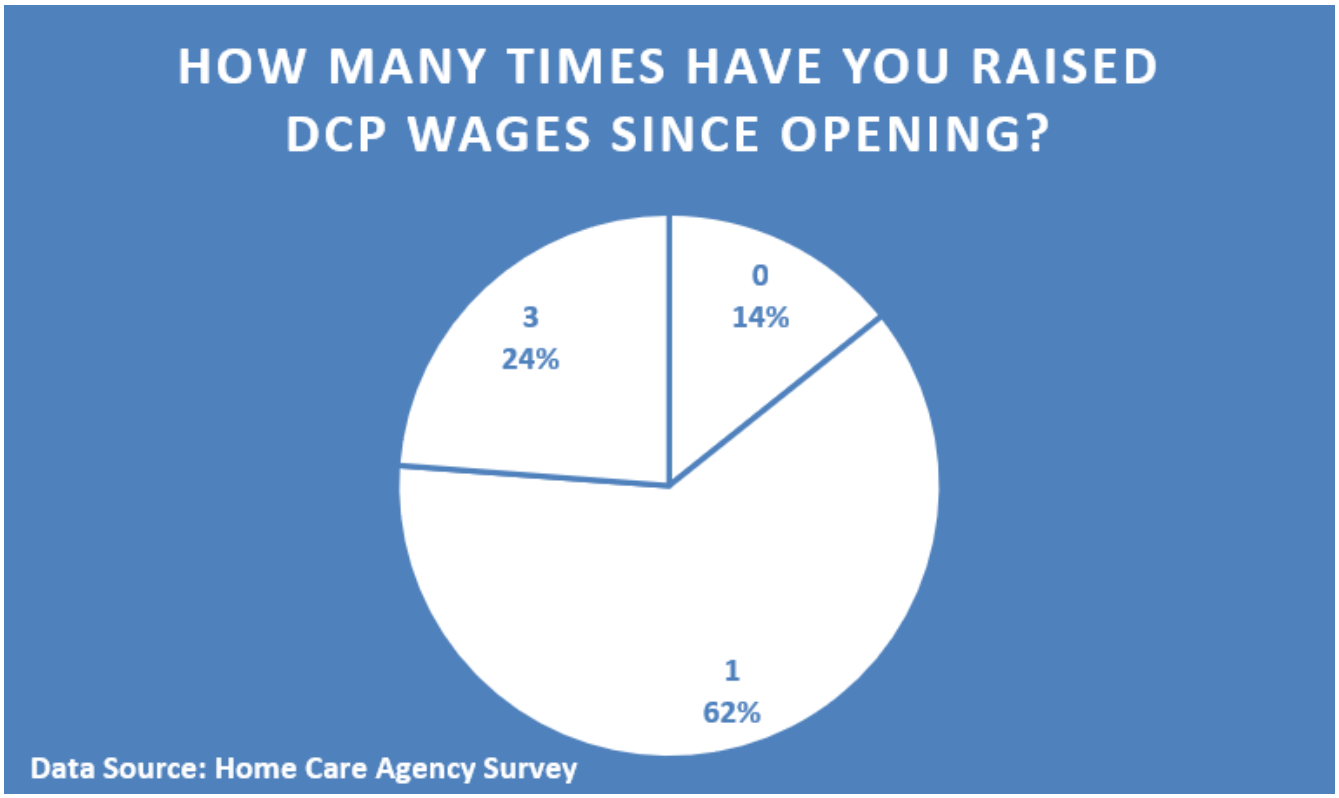
The low wages of direct care providers are a systematic weakness of the HCBS industry, created by the fact that pay raises in this field are staggeringly rare. One provider working under the Level One waiver under the DoDD, which is noted by some in the industry as paying their providers better than the ODA and ODM waivers, had his only wage increase in his six years of service, bumping his pay from $16.45 an hour to $18. An increase of $1.55 over a six-year period does not come close to covering inflation costs in that time, especially as his agency did not provide additional benefits. A second provider explained that the only wage increase they ever received had to be fought for by the entire agency staff. “Some of my colleagues were really bitter about the amount they receive a day, and they decided to take on the agency, and, you know, have their complete complaints submitted to them…That was the only one, that’s the first.”

One agency representative reported in our survey that “we have not had an increase, only been in business five years.” While we are sympathetic to the needs of these businesses to maintain profits, five years is a longer period of operation than the majority of participants have been working as paid care providers. For someone to work in the same position for five years and never see an increase in wages is not sustainable in today’s economic market, so it is no wonder that we are seeing long-term trends of providers leaving the field to find better positions.

During Focus Groups, more than 15% of participants had not received a wage increase in the last 12 months, signaling that the reimbursement increase gave neither a consistent nor universal pay raise. We see a trend that many direct care providers are doubtful that this reimbursement money will actually make its way from ODM to their wages, with mistrust towards agency administration. One experienced provider was honest with their impression of how reimbursement was handled by agencies, stating

> Working under an agency, they get to take all of the money that they get from Medicaid funding and can choose how much they want to pay their DSP workers. So that's why you see some people get paid 12 [dollars], some at 19, some at 23, because they're making up how much they want to pay their DSP workers. And I don't think that that's fair, I think there should at least be a minimum on that, that you should have to pay your DSP workers, but maybe it is, I'm not sure. But it might be just too low. So they kind of just put the money into the agency hands and say, “Here hand it out how you would like.” And that's not the fairest thing to do when all of the work falls on the DSPs, not the agency.

Of the agencies surveyed, when asked specifically about the last three times their staff had received wage increases, more than 60% of respondents stated that there had only been a single wage increase. One agency reported their only wage increase to have occurred in January 2024, the same time as the reimbursement increase, but that it was only a $0.50 increase. Only 23% reported three or more wage increases, while almost 10% did not have any wage increases at all to report on. This data is troubling, but only highlights trends that have been reported by federal agencies and health officials for more than a decade. [xxxiv]



Another issue is that many of the wage increases DCPs have seen in recent years have not been impactful enough to improve their living conditions, especially those with families to provide for. One agency representative reported three increases from 2020-2023, ranging from $10 an hour to $12. While a 20% increase in wage across three years sounds substantial in theory, $12 is not a livable wage in 2024, especially for the difficult labor being done by DCPs. One care provider told us, “on my own end, the raise isn't really meaningful or impactful, just a $2 increase. With the rate of inflation, a $2 hour increase is really not significant.” One agency stated that one wage increase occurred “when we realized excess profit, we increased their wages by 2% just to appreciate them.” A 2% increase does not sound like the demonstration of appreciation this representative seemed to think it was, especially for a field with such a low average pay.

For home health and personal care aides in Ohio (one of the many different positions that fall under the umbrella term “direct care provider”), the median hourly wage from 2012 to 2022, a 10-year period, only increased by $1.47.[xxxv] In our survey, agency representatives were asked

how they determined provider wages based on Medicaid reimbursement rates. The clear trend was that most agencies did not have a set methodology, with most giving nondescript answers about "percentage of reimbursement, taking into account the expenses of cost of doing business." Those specific methodologies that were reported did not convey an optimistic outlook for providers. One agency stated that wages are "approx. 55% of reimbursement," while another answered that wages were "5% of reimbursement pay." This ties in perfectly to the provider quoted as saying that agencies had the power to "hand it out how you like," as there is little to no consistency to what determines these care providers' wages even as they should have their pay increased with state dollars. Even resources made by statewide agencies seem to admit this shortcoming in the system. An official handout created by DoDD told its DCP workforce that

> it is ultimately up to each employer (agency provider) to determine on how they use the increased reimbursement rates. DODD pays a reimbursement rate to a Medicaid provider to deliver a Medicaid service, not a specific wage for specific types of employees.[xxxvi]

While it is clear from Governor DeWine's statements that he believes that giving agencies flexibility with their pay rates "benefits Ohio consumers,"[xxxvii] our findings make it clear that this has not been the result. Instead, there continues to be inconsistencies across different agencies and waivers that confuse consumers and providers, while the wage increases that actually occur are far lower than what is necessary to combat the direct care crisis in Ohio. If this reimbursement increase is meant to benefit DCPs, then there must first be a consistent methodology for determining agency wages to ensure that this increase is universally improving pay rates and bettering the living conditions of providers.

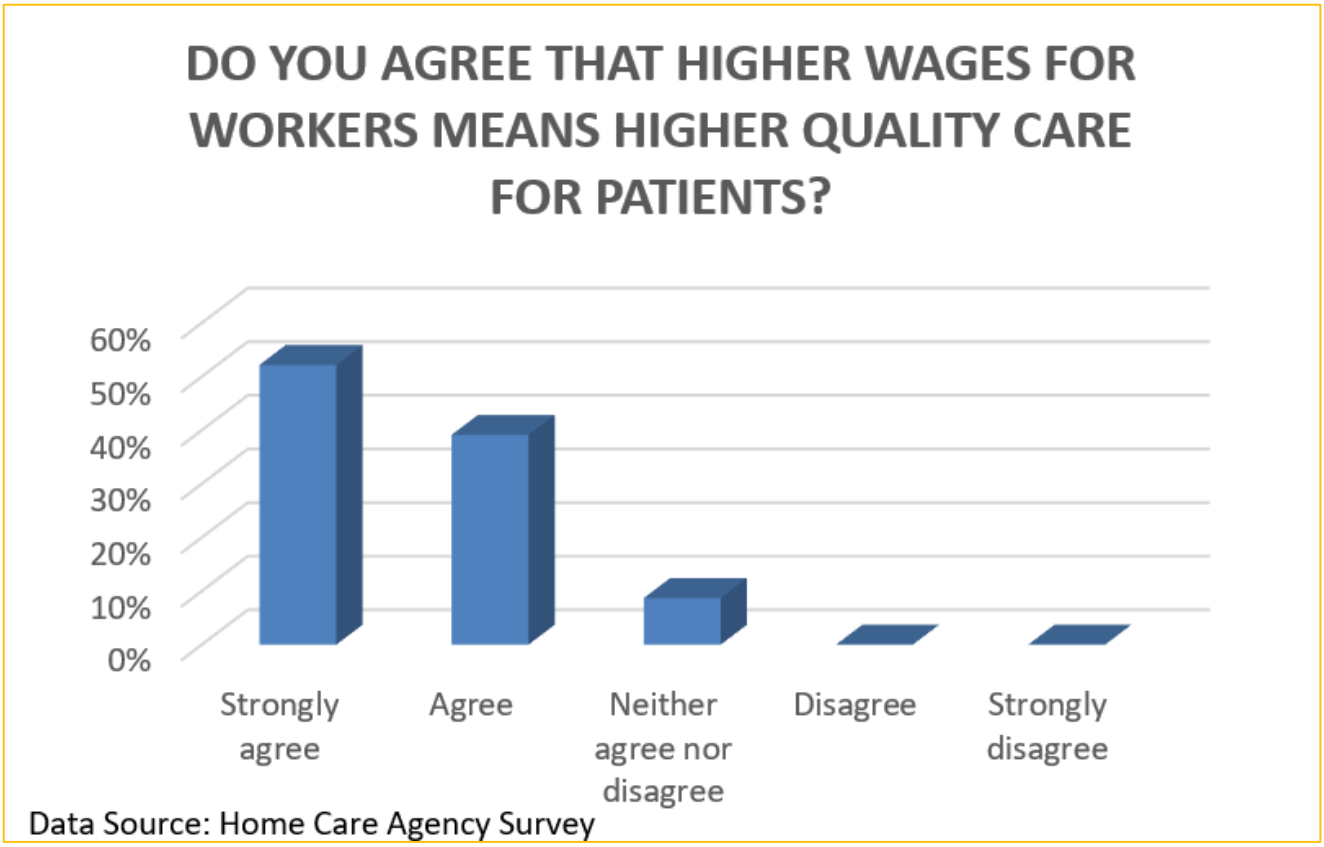
As a result of these low wages, wages that cannot compete with other positions in today's market, many care providers are leaving the field. Others stay but are forced to look in other places to find the money necessary to feed their families. One national study found that personal care providers are 35% more likely than other workers to have a second job, due mainly to low wages.[xxxviii] Almost a third of DCPs in our region reported working more than one job. Providing home care is a tasking occupation, meaning it is disheartening that so many must drain themselves helping Ohioans only to be financially forced to work additional positions to make ends meet. Beyond this, the risk for these workers having second jobs is the increased possibility of infectious disease being carried to those receiving care.[xxxix] The disabled and aging communities may have compromised immune systems and this increased possibility of second-hand infection means that their health is being risked as a result of DCPs being forced into working multiple jobs.

The findings of our regional survey were that the average wage among participants in 2023 was $17.38 an hour, with 2024 average wages being $18.96 an hour. This is a positive finding, as The Ability Center's stance is that DCPs should be better compensated for the difficult, vital labor they provide. Looking at this increase in a vacuum, a $1.58 increase is a significant raise

at 9.09%. When looking at the context of this pay within the current labor market, however, this is somewhat misleading. This increase was the first that most participants have seen throughout their tenure as a provider, meaning that this increase needs to correct years of wage loss while also serving as a yearly increase to combat inflation. This figure of $18.96 is also lower than most other average pay within the medical or care fields,[xl] in spite of the fact that DCPs are in incredible demand throughout the state and will continue to become more demanded as Ohioans life expectancy means more aging adults.

The final factor to consider is the number of hours most DCPs are working. Throughout this study, we found that less than 19% of participants worked 40 hours or more a week as a provider; many DCPs had a wide range of hours they worked on average, due mainly to changing needs and emergencies by their clients, but more than 80% worked 10-39 hours a week. If the average DCP works for 30 hours a week, this increase only sees them earning an extra $47.40 a week before taxes. For those with families to provide for, that level of wage increase does nothing to impact their yearly expenses or quality of life; at best, it allows a family to order pizza once a week. This is the type of systematic wage increase that the HCBS industry should be providing each year if they wish to keep up with the wages offered by retail and fast-food restaurants. It is clear that most providers did receive a wage increase in 2024; but wages are only one of the causes of the care crisis, and the impact of that reimbursement was not enough to remove low wages as a cause for the worker shortage.

Perhaps the best summary of the solution came from the head of the second largest agency in the study, who stated, “to solve the shortage of workers in home care, it's important to pay better, offer flexible schedules, and provide training for caregivers.” Some may balk at these recommendations, not wanting to see agencies or the state covering the cost of increased wages or benefits but failing to change the system is not an option. Done properly, a strong DCP workforce can also contribute to Ohio’s economy. A Yale Law Journal article reported that “the care economy generated 74% of low-wage job growth in the 2000s, and this trend is likely to continue given demographic pressures and the difficulty of outsourcing or automating.”[xxi] We see that this field is greatly contributing to the economy, but the note of “low-wage job growth” does demonstrate the issue with subpar pay. One provider described their work as “one of the key aspects that keeps America moving,” and it is hard to disagree given the enormous demand for home care. Many of the tasks done by DCPs protect the dignity of the individual receiving care, but many others are necessities for a healthy independent life and to go without such a provider for an extended period is a great risk to one’s physical health. It is disheartening to see such a passionate workforce, one that provides such a necessary service to their community, pushed out of the industry for years because pay cannot keep pace with the quantity and caliber of labor they provide.



Data Source: Home Care Agency Survey

Provider Quotes on Wages

> "The only raise that we were ever notified on was years ago when they were going to give us a 13-cent raise. And we had it for one or two weeks. I can't remember exactly what it was. And then they took it away."

> "I'm not really being compensated for the work I do, you know, the care and the amount of time I invest the commitment, the dedication I give isn't being compensated for by my agency."

> "It's not well respected. And I feel like it's not. I mean, yes, the wage increases were nice. But when you can walk down the street and make more money at McDonald's than you can taking care of humans, I think we have a societal problem. And I think it goes towards McDonald's and, you know, Meijer, and everywhere else will pay benefits. We have no benefits, which I think is a huge problem. Because there's no holiday pay, there's no vacation time. If our caregivers, or we as caregivers, take a break, then that's on us. We have to front all of that. There's really nothing beyond now a halfway decent wage. But sadly, a 30% increase? Yes, it was nice. But it's only been because the industry has been ignored for so long without an increase."

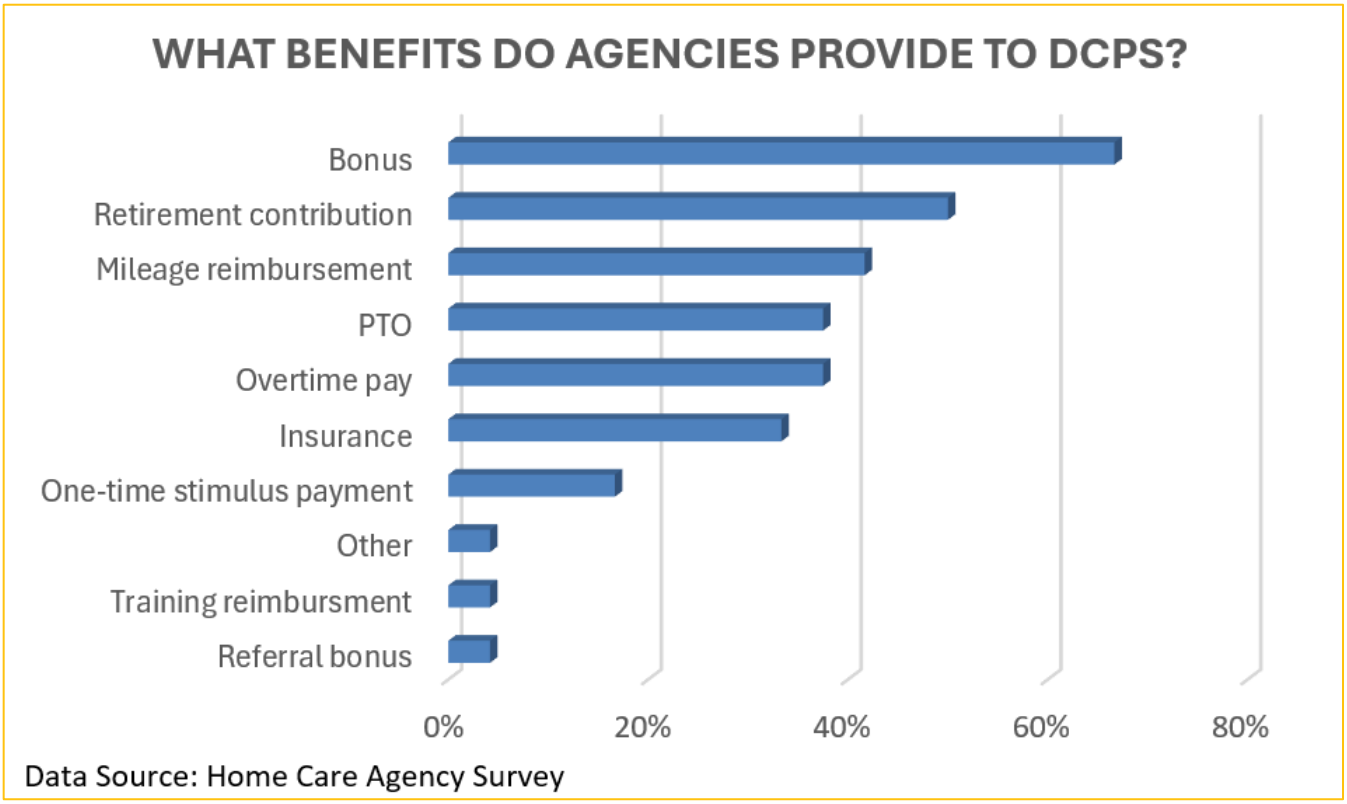
> "I don't feel so good about the industry generally, because I hear a lot of people complaining about the wages. It's low…It pains me. I don't feel happy at all about the industry, and I think they need to do something about this particular problem."

> "But the only issue is that I feel we as caregivers should be appreciated more. I feel like our wages are, like, compared to the work we're doing, we are not being paid enough like we are supposed to… I hope the relevant authorities will check this matter and ensure that we caregivers are being paid properly"

> "Not only the DoDD raise the rates for independent providers, they raised them for agencies, too. But the agencies are not giving the DSPs the money, they're pocketing most of the money."

Systematic Lack of Benefits

Beyond wages, one of the most important elements of a position for an employee is the benefits provided. Especially after the COVID-19 pandemic, it is essential for working Americans to have access to health care, with working parents having even greater need to provide protections for their children. Yet half of the DCPs interviewed stated they did not receive any regular benefits from their agency. It is paramount that those providing HCBS have access to health insurance to protect their own long-term health. In our study, 25% of agencies reported using the increase to reimbursement to increase non-wage compensation but not a single provider told us about providing new benefits in the last year. In a 2022 report by DoDD, they found that 54% of large agencies do not provide insurance, with small and medium agencies reporting 78% and 81% respectively offer no insurance to employees.[xli] This is clearly a widespread issue in the HCBS industry and seems to be a leading contributor to the unhappiness of the providers. Looking at the graph below, only 1/3 of agencies in this study reported that they offered insurance to their DCPs, and with most benefits falling below 50%.

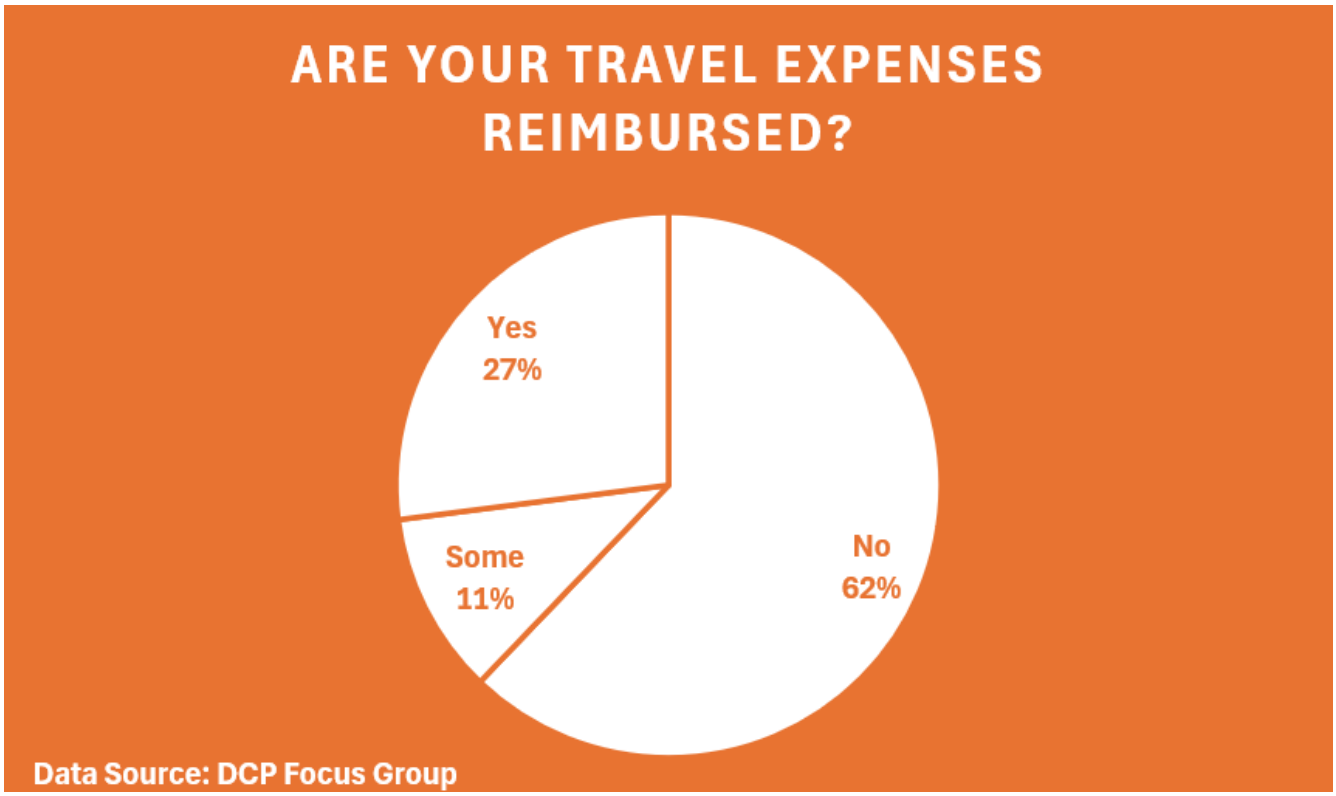


The average wage for these care providers is already far too low for the work being performed, so for many of these providers, being able to support their families while also paying high premium rates for benefits plans is impossible with their monthly financial budgets. Placing the burden of paying for health care onto the DCPs after understanding the low level of pay makes this even worse. One provider told us that "if my husband didn't carry the benefits in our household, I couldn't be able to do what I do. If I were a single parent or, you know, if I were doing this as a full-time gig, I wouldn't be able to survive." This provider's passion for the industry was obvious when speaking with her, but a lack of health insurance would have been the deciding factor for determining whether or not she could continue to provide care.

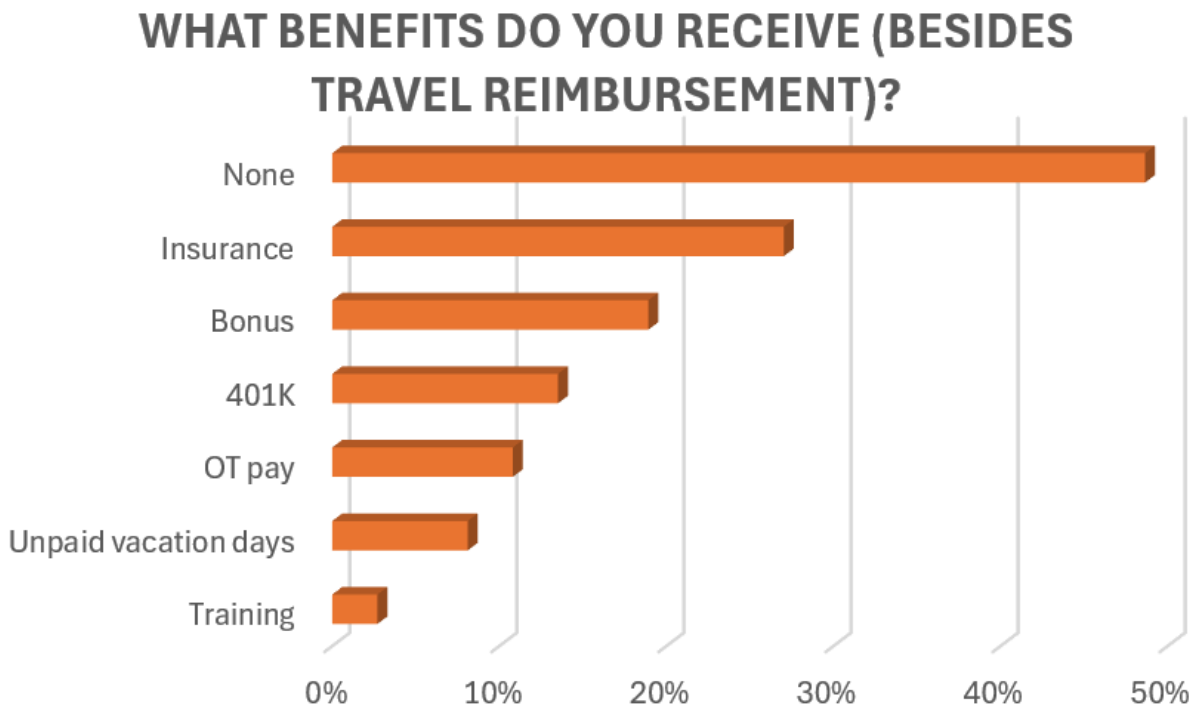
The lack of health insurance for DCPs has been documented for years on a national level. According to PHI, a national research group focusing on long-term care, 17% of care providers do not have health insurance, while 43% have to receive their insurance through Medicaid or other public coverage options.[xlii] That means that six out of every 10 DCPs are working without health care, or must have their care subsidized by the state due to a lack of agency benefits, while they themselves are providing care to populations that often have compromised immune systems and higher health care needs. It is a recipe for disaster and those most impacted by it will be those most vulnerable.

Another benefit that many DCPs in our study requested was compensation for their commute to clients' homes. Less than 1/3 of study participants had their mileage reimbursed by their agency in spite of the extended travel times for many providers. One care provider we spoke with drove an average of "three to four hours" daily to reach clients. Another provider was

driving 90 minutes a day without compensation to reach clients and would then work a three-hour shift before returning home. A study conducted by DoDD quoted one provider as saying, "I am often scheduled to work at different sites that are far away from each other. I have to use my own car to go between sites, and most of the time I am running on empty, literally and figuratively."[xliii] The wages of these providers have already been noted as being too low for many to be financially stable, but a lack of reimbursement for miles traveled will lead to providers only choosing clients within shorter distances from their homes.



The lack of mileage reimbursement contributes to another long-standing issue within the HCBS industry: the lack of care providers in rural areas, of which there are many throughout the state of Ohio. Studies focused on the Midwest have found that rural areas receive less funding and less overall support for care providers when compared to urban areas.[xliv] For many, to receive home care in these rural communities, a DCP often must drive from where they live in more urban areas to meet their clients' needs. If the daily commute of the provider becomes a limiting factor in one's wages and in the selection of clients they serve, we will only see these already underserved rural areas of the state further left behind. In fact, a brief by the University of Minnesota concluded that "access to home and community-based care will not be an option for all rural older adults unless policies are put into place to support LTSS in rural areas and the direct care workforce."[xlv] We cannot allow Ohioans with disabilities to be denied the home care they need to live independently because DCPs cannot afford the cost of travel to provide the services they require. The manner that this impacts those in rural areas only intensifies the need to find ways of ensuring travel compensation for DCPs.



Data Source: DCP Focus Group

The experiences of the DCP participants in our survey are consistent with national reports that, for years, have pointed to a lack of benefits as a major weakness of the HCBS industry. Looking at the data collected, it is clear that Northwest Ohio providers suffer under these same conditions. Half of DCPs have zero benefits from their agency and instead have to pull from their limited income to pay for insurance and travel costs. This practice may save the agencies money, but providers cannot make ends meet with their current wages. Providers can barely afford to pay their own insurance, which is why national studies have found that 43% of providers receive government assistance.[xlvi] A lack of travel compensation not only cuts into the earnings of providers, it creates a greater shortage for those needing care in rural areas. Benefits, alongside wages, must be considered as areas that must be addressed to combat the direct care crisis.

After the COVID-19 pandemic, the need for Americans to have health insurance is paramount, especially for those with families. Yet, looking at Northwest Ohio, 73% of DCPs interviewed stated that their agency did not give them access to health insurance, 62% did not have their travel expenses reimbursed, and a shocking 49% did not receive any benefits at all. This is only looking at those working for care agencies. Independent providers were forced to pay for private insurance, a difficult task given their low pay. PHI reported that 43% of personal care aides are already receiving their health insurance through government-funded programs, like Medicaid, so having their benefits subsidized by the state or federal government would be significantly smaller of a financial burden for Ohio than this appears at first glance.[xlvii] We found that more than 1/3 of providers were driving an hour or more a day, with one provider stating

they did “hundreds of miles of driving" daily without compensation. This further financially hinders this group of already underpaid providers, but then also creates additional barriers for those in rural communities from receiving care. One national study made the specific recommendation that “payment for travel expenses and travel time is especially important for rural personal care aides, given the long distances they need to travel to clients’ homes.”[xlviii] Thus, while last budget’s increase in reimbursement may have had a small, inconsistent impact on wages, it cannot solve the crisis unless direct care providers also receive compensation for mileage. It must be remembered that care provided in the home or community has been found to be less expensive than care provided in institutional settings.[xlix] It is clear that if benefits cannot be provided for DCPs, the worker shortage will only worsen and more people needing care will be forced to live in institutions, and the state of Ohio will be responsible for covering these increased costs. For the sake of those needing care providers, and in the economic interests of Ohio, action must be taken to ensure health insurance and travel reimbursement for providers.

Provider Quotes on Benefits

> “Yeah, it’s really bad health insurance. So I really don't tend to [see] that as a benefit because I'm not really actively using insurance provided by my agency… I really don't even count that as a part of my benefits.”

> “We provide care for others, but then who's going to take care of us, you know? We've got a lot of bills to take care of, got a lot of things to pay for our own selves, get ourselves taken care of. But then we didn't get the better treatment and incentive that will cover all of that. And a good number of us don't even have an insurance, that would really be of benefit to us, that would be encouraging us even to put more effort in our work.”

> “Honestly, I don't think there's anything like that [benefits] at this place, it has just been frustrating, and I've really wanted them to do something about it, but nobody's working on it, and I'm just so disappointed.”

> “I've got mixed feelings because, like I said, last year my wage was increased, and we were happy for that, but I'm not happy with the fact that they don't have that incentive for us. And regardless of the number of times we've complained to the management about that, they seem not to do anything about it, and just makes us feel, feel really bad.”

> “The only negative stuff I don't like about my agency is the fact that we are not given extra bonuses for working overtime, and we do not also receive the health insurance.”

Recommendations

The goal of this report was to document our study on the impacts that the Medicaid reimbursement rate increases had on direct care provider wages in an attempt to combat the direct care crisis in Ohio. Not only has this reimbursement increase not effectively raised the

wages of all DCPs, it has not properly targeted the many systematic causes of the crisis. Studies on the HCBS industry, from federal perspectives to medical academics to advocates, have been making the same recommendations for years as to how to increase tenure and the overall supply of care providers. The following are suggestions made by The Ability Center to Ohio legislators on how to support this industry and the Ohioans who rely on this care to live independently.

Setting a Higher Base Wage

The most apparent fix to this crisis is to set a base wage for DCPs in the state of Ohio. The overwhelming consensus of this study showed that only raising reimbursement rates did not lead to substantial or consistent growth in wages. Not all DCPs received increased wages as a result of the reimbursement increase, and many who had their pay increased noted it was “not impactful.” It must be remembered that this is the only wage increase that many DCPs have ever had; the increase has to not only keep ahead of rising inflation costs but also a decade of the industry not raising wages. While increasing Medicaid reimbursement rates is a positive step to assist direct care agencies, this has failed to trickle down substantially to the pay of its workers. If the state of Ohio wishes to take steps towards ending the shortage of care providers and increase access to home care, setting a base wage for DCPs is the most logical course of action.

Creating a Set Methodology for Agency Pay Rates

An alternative to setting a higher base pay for DCPs, while still ensuring that that these providers are compensated fairly for their labor, would be to create a set methodology for agencies providing HCBS under Medicaid. Our survey showed that most care agencies have different means of determining how to calculate the pay of their DCPs, leading to inconsistent wages within the industry. Even within our own study, there were providers making $9.50 more than another who was working under the same Medicaid waiver system. If Ohio legislators want to assist DCPs and see consistent wage increases, creating a set formula to determine pay based on Medicaid reimbursement is a solution worth investigating.

Guaranteeing Benefits for DCPs

Just as vital to ensuring that historically high turnover rates end is finding ways of guaranteeing benefits for direct care providers. Providers fighting with agency administration for benefits was a common thread throughout the focus groups held during this study, yet it appears that few (if any) agencies have begun to offer benefits as a result of the increased Medicaid reimbursement. This is one of the biggest reasons that workers are leaving the field, but little has been done to fix the issue. Care agencies, or the state of Ohio itself, must provide benefits to these care providers to ensure their health and the health of the clients they serve.

Offering Job Training and Career Advancement

Another way that Ohio could strengthen its HCBS industry would be to offer forms of job training and job advancement for DCPs, whether that be the state offering it directly or

reimbursing agencies who provide this service to its workers. One participant said that a chief complaint of the position is “limited career advancement opportunity,” and another believed that a way to combat the worker shortage is “providing training, enhancing skills, or advancing career advancement.” For years, national reports have called out the lack of training available to DCPs,[l] while many advocates agree that training and job advancement are essential to improving the conditions for providers and seeing an end to the high turnover rates we see.[li] Professionals in the field, advocates, and industry experts alike agree that training would encourage individuals to enter the home care industry and help retain current DCPs, and it is time that Ohio listen to this unanimous recommendation.

Create a Legislative Taskforce to Investigate the Crisis

The direct care crisis is a complex problem, one that the United States as a nation is still analyzing how to best solve. The multiple causes of the worker shortage make recommending specific actions difficult. Therefore, we recommend that Ohio legislators create an official Direct Care Taskforce with the sole purpose of creating a plan to address the Direct Care crisis. A bipartisan taskforce would be able to fully explore the causes and solutions to the worker shortage and make recommendations for the state of Ohio to move forward. There is a bill currently in the works in the House of Representatives that would create a Long-term Care Workforce Study Commission, and The Ability Center believes that this is the best course of action if Ohio wants to make concrete steps towards providing an adequate amount of home care for the thousands of Ohioans relying on these daily services.

Conclusion

When we began this study, our organization was shocked at how difficult it was to gather data on the wages of DCPs. Though the state of Ohio was paying for this service, no one was monitoring DCP wages, and they were inconsistent across providers. The Ability Center saw this information gap and began its task of interviewing providers and surveying agency representatives on how the Medicaid reimbursement impacted the industry. While the increased reimbursement rates for care agencies is a strong step towards strengthening the HCBS industry, experts and advocates have been saying for years that it will not increase wages adequately or for all providers. Unfortunately, the findings of our study confirm this viewpoint. Despite increased reimbursement, wages have not increased to a point where it properly compensates DCPs for their labor. The inconsistency with which agencies did and did not increase pay was just as concerning. This inconsistency is partially due to agencies having no standard methodology for determining wages based on reimbursement rates, meaning that raising reimbursement can never be a systematic method of addressing low pay. Furthermore, the lack of benefits offered to Ohio care providers is only more evidence that the criticisms of advocates and national reports are just as accurate today as they were when they were first voices a decade ago, while a lack of job training ensures that many struggle to advance within the HCBS industry rather than leaving for food service and retail positions.

Experts in the field agree that "without a strong community support system, we can expect inadequately supported older adults to continue to cycle through illness, repeated unnecessary hospitalizations, and potentially unwanted nursing home admissions."[lii] We have seen the disability community list a lack of home care providers as a major barrier to independence, alongside countless statistics showing that the current direct care crisis will only worsen as the number of Americans requiring HCBS is rising each year. It is such a tragedy that an industry providing care for others, a workforce characterized by its passion and the selflessness of their labor, is one that has been undercompensated and neglected for so long. It is The Ability Center's stance that direct service providers of Ohio deserve better, and that the state of Ohio must take steps to attract and retain direct care workers in our state.

Data Collected from Focus Groups

Age	Zip Code	Years Served	Agency vs Independent Provider (IP)	2023 Wages (hourly unless otherwise noted)	2024 Wages (hourly unless otherwise noted)	Benefits	Heard of Worker Shortage	Heard of Reimbursement Increase
64	45875	35	IP	$21	$27	None	Yes	Yes, heard from ODM emails
27	45807	3	IP	$19-20	$20-35	None	No	No
59	45867	4	IP	$22-23	Went from $6.91 a unit to $7.29	None	Yes	Yes, heard from ODM newsletter
41	45801	4	Agency	$12.50	$12.50	Health insurance, unpaid vacation	No	No
37	43512	1.5	Agency	$13	$16	Travel costs, rare performance bonuses	Yes	Yes, heard through word of mouth
34	43512	2	Agency	$18.50	$18.50	Health insurance	No	No
33	45229	5	Agency	$12.50 (higher for dementia patients)	$15	Health insurance, travel costs	Yes	Yes, heard through Facebook post
29	45807	2	Agency	$12 for one client, $18 for the other	$18	Health insurance	No	No

27	43608	3	Agency	$15-17	$15-17	Travel costs	Yes	No
28	43004	5	Agency	$20	$20	Health insurance	No	No
32	45840	3	Agency	$14	$14	Health insurance, retirement, unpaid vacation	Yes	Yes, heard rumors from coworkers
24	"02124"	1-2	Agency	X	$19	None	No	No
27	43614	2	Agency	$12	$15	Travel costs, monthly bonus	No	No
31	43502	3	Agency	$20	$21	Occasional performance bonus	Yes	Yes, heard from agency but doesn't know details
30	X	2	Agency	$17	$19.55	Travel costs	Yes	No
49	43611	4	Agency	$15-16	$20	None	Yes	Yes, heard from a DODD town hall
22	43615	1	IP	X	$29.72	Travel costs	Yes	Yes, found it on DODD website
34	43205	5	Agency	$15-20 depending on client	$17-20	Health insurance, travel costs, retirement, training	Yes	Yes, heard from word of mouth
30	43606	3	Agency	$13	$15	Health insurance	Yes	Yes, heard from agency but had to go to director's office to hear about it
27	43615	6	Agency	$19.20	$21	Health insurance, biannual bonus	Yes	Yes, heard from news report
30	42645	5	Agency	$48k-60k annually	$20k as of 07/30/2024	Retirement, travel costs	Yes	Yes, Heard from ODM email
28	43609	4	Agency	$14	$17	Travel costs	Yes	Yes, heard from news report
25	43220	3	Agency	$19.55	$20	Unpaid vacation	No	No
30	43213	6	Agency	$16.45	$18	None	No	No

38	44081	2	Agency	$16	$18	None	Yes	Yes, heard from word of mouth
33	44146	3	Agency	$48k annually	$25K as of 08/01/2024	Travel costs	No	Yes, heard from ODM email
25	43540	3	Agency	$20	$20	Retirement	No	No
32	43558	2	Agency	$17	$18	Health insurance, retirement	Yes	Yes, heard from agency in July 2024
30	45229	4	Agency	$36K annually	Similar, "haven't calculated"	Travel costs	No	No
28	43017	2	Agency	$18.56	$20	Travel costs	Yes	No
26	43214	5	Agency	$15	$17	None	No	No
28	44313	2	Agency	$19	$22	None	Yes	No
28	43015	2	Agency	$21	$22	Retirement	Yes	Yes, heard from LinkedIn post by a different agency
36	43617	2.5	Agency	$17 ($19 for some clients)	$20	None	Yes	Yes, heard from word of mouth in July 2024
30	45807	3	Agency	$15	$17	Health insurance	Yes	No
29	43613	3	Agency	$17 base	$18	None	No	No
60	43608	1	Agency and IP	$12.50	$16.50	None	Yes	Yes, heard from agency

[i] Veto of OH. HB 33 (2023) (letter from Gov. DeWine July 3, 2023), https://www.legislature.ohio.gov/assets/legislation/legislation-documents/135/VetoMessageAmSubHB33.pdf

[ii] Ohio Department of Medicaid, Ohio HCBS Waiver Programs, available at https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/waivers/ HCBS Waiver programs include the Assisted Living, MyCare Ohio, Ohio Home Care, PASSPORT, Individual Options, Level One, and SELF HCBS Waivers.

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[xii] Ohio Direct Care Expansion Working Group Report (2022), available at https://dam.assets.ohio.gov/image/upload/jfs.ohio.gov/owd/WIOA/docs/DirectCareReport2022.pdf.
[xiii] KFF, Payment Rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges, available at https://www.kff.org/report-section/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges-appendix-tables/
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[xxiii] OlmsteadRights, Ohio Disability Resources and Advocacy Organizations, https://www.olmsteadrights.org/self-helptools/advocacy-resources/item.6637-Ohio_Disability_Resources_and_Advocacy_Organizations (accessed 2/11/2025).
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