The Cost of Aging

Medicaid, Long-Term Care, and Ohio's Fiscal Future

By Rea S. Hederman Jr. and Donavan Rees Lingerfelt

THE BUCKEYE INSTITUTE

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EXECUTIVE SUMMARY

Ohio's long-term care problem is outpacing policy responses. With 2.2 million residents older than 65, the state's elderly population is growing faster than the national average[1] and by 2030, more than one in four Ohioans will be 60 or older.[2] The demand for long-term care services and supports will accelerate, and the state's healthcare infrastructure, workforce, and financing mechanisms are not equipped to meet it.

Medicaid is the state's primary payer for long-term care services. It already accounts for 37 percent of the state budget[3] and—when including federal dollars—Medicaid spending represents more than 50 percent of Ohio's general revenue fund budget for FY 2025.[4] Roughly 20 percent of Ohio's Medicaid expenditures are already dedicated to long-term services and supports[5] and that percentage will likely rise as the state's population ages. If Ohio does not explore and adopt durable, cost-effective solutions to providing long-term care (LTC) for its aging population, policymakers will soon be in the untenable position of choosing between raising taxes, cutting benefits, or foregoing other spending priorities altogether.

As nursing home admissions have declined, home and community-based services (HCBS) have become increasingly popular alternatives to hospitals and institutional care centers. HCBS waivers, such as MyCare Ohio and the Ohio Department of Aging's Pre-Admission Screening System Providing Options and Resources Today (PASSPORT), which funds home care and personal care services for older adults, now serve tens of thousands of patients at a fraction of institutional costs. But key HCBS programs remain under capacity and vulnerable to fraud, waste, and workforce shortages. Those challenges must be addressed.

Ohio must make significant changes to its long-term care policies and ground them in five fundamental principles: sustainability, consumer choice, cost efficiency, quality improvement, and fiscal responsibility. The Buckeye Institute recommends strengthening the state's community-based care infrastructure, modernizing

[1] Madeleine Shea, Ph.D., **Preparing for Ohio's Aging Future: With Federal Uncertainty, Local Innovation Must Lead**, Health Management Associates, July 17, 2025.
[2] **Ohio Population Research**, Scripps Gerontology Center, Miami University (last visited, July 17, 2026).
[3] **Expenses by Agency and Line Item**, Ohio Checkbook.com (last visited, July 17, 2026).
[4] **Medicaid Expenditures**, Ohio Legislative Service Commission, November 2025.
[5] **How much does Medicaid cost in Ohio?**, USAFacts.org (last visited, July 17, 2026).

Medicaid reimbursement, reducing regulatory friction without sacrificing accountability, expanding the direct care workforce, incentivizing private LTC planning, and deploying supportive advanced technologies to increase care provider efficiency and reduce administrative burdens.

INTRODUCTION

Americans are living longer and having fewer children, which means there will be more seniors with fewer family members to help support them as they age. One in 10 Americans older than 50 already live alone without a child or spouse.[6] Ohio's older adult population—its fastest growing age group—ranks sixth in the nation[7] and is expected to increase by more than 33 percent by 2030.[8] Without adequate family caregiving, Ohio's elderly population will rely on LTC services paid for out of pocket, through insurance, or, most commonly, by Medicaid.

On average, a 65-year-old American already will spend $120,900 on future long-term services and supports (LTSS).[9] More than a third of adults cite high medical costs as the reason they declined or postponed seeking medical treatment.[10] And as demand for LTC services rises with the aging population, so will their prohibitive prices. Nursing homes already struggle to retain nurses and nursing aides who can earn more elsewhere,[11] and to attract and keep them will cost even more in the near future.

The rising costs of LTC and LTSS present significant challenges for not just Ohio but other state and federal policymakers. Medicaid spent more than $250 billion on LTSS in 2023[12] and has over seven million recipients of LTC aid, with 83 percent using HCBS.[13] Private payers cover only 31 percent of LTSS costs, with private insurance covering less than 10 percent of total costs.[14] And because Medicare does

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[6] Veronica Dagher, **More Americans Are Aging Alone. One Woman Told Us What It's Like**, *The Wall Street Journal*, May 30, 2026.
[7] **Aging Summit**, Office of Geriatrics and Gerontology, The Ohio State University (last visited, July 17, 2026).
[8] Reem Aly, Hailey Akah, and Zach Reat, ***Summary Assessment of Older Ohioans***, Ohio Department of Aging and Health Policy Institute of Ohio, June 1, 2020.
[9] Richard W. Johnson and Judith Dey, ***Long-Term Services and Supports for Older Americans: Risks and Financing, 2022***, U.S. Department of Health and Human Services, August 2022.
[10] Grace Sparks, Lunna Lopes, Alex Montero, Marley Presiado, and Liz Hamel, ***Americans' Challenges with Health Care Costs***, Kaiser Family Foundation, April 30, 2026.
[11] Cheryl Heiks and Nicole Sabine, "**Long Term Care and Skilled Nursing Facilities**," *Delaware Journal of Public Health*, Volume 8, Issue 5 (December 2022) p. 144-149.
[12] Kirsten J. Collelo and Isobel Sorenson, ***Who Pays for Long-Term Services and Supports?***, Congressional Research Service, August 28, 2025.
[13] **LTSS Users by State, County and Setting**, ATIadvisory.com (last visited, July 17, 2026).
[14] Kirsten J. Collelo and Isobel Sorenson, ***Who Pays for Long-Term Services and Supports?***, Congressional Research Service, August 28, 2025.

not typically cover LTSS, many patients have only a few options for care.[15] As the population ages, LTC providers retire or change jobs, and market demands for LTC and LTSS push prices higher, policymakers need to make sober, evidence-based assessments of Ohio's LTC system—understand its past and present—and face its future with viable, comprehensive solutions.

[15] Richard W. Johnson, ***What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports?***, Urban Institute, April 2019.

BACKGROUND

Nursing Homes, Medicaid, and Assisted Living Facilities

The Social Security Act of 1935 allowed low-income older adults to receive federal financial assistance. But that assistance could not be used for public nursing homes. Congress wanted to discourage states from relying on public poorhouses as the primary means of caring for the elderly poor, and it wanted to encourage low-income elderly to receive care at home. America's elderly quickly flocked to private long-term care facilities and the modern nursing home industry was born.[16]

In Ohio, as in most states, Medicaid is the primary payer for long-term care and the healthcare expenses of low-income individuals,[17] accounting for more than half of all national spending in this sector.[18] The program now accounts for 37 percent of Ohio's budget,[19] and approximately 20 percent of all Ohio Medicaid spending paid for long-term services in FY 2023.[20] Under a matching agreement, the federal government pays a portion of each dollar state governments spend on Medicaid—at least 50 percent will be covered in richer states, and up to 83 percent in poorer states.[21] The federal reimbursement arrangement gives states little incentive to cut Medicaid costs or reduce program spending. For a rich state with a 50 percent federal match rate to cut Medicaid spending by $1 million, it would actually have to cut total spending by $2 million. And a poor state, like Mississippi, for example, would need to cut $3.76 million to save $1 million.

Nursing homes play a significant role in Ohio's LTC system. The state ranks fourth nationally in the number of certified nursing home beds[22] even as its total bed count and occupancy rates have declined recently as more elderly choose home

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[16] **The History of Nursing Homes**, Foundation Aiding The Elderly (accessed July 17, 2026).
[17] Medicare, by contrast, covers some conditions that require skilled nursing facility care, but it only pays for stays up to 100 consecutive days. Medicare patients bear the full cost of medical care from day 101 onward and are responsible to cover their own custodial care—burdens that often require patients to "spend down" their assets and income to qualify for Medicaid.
[18] Caitlyn Murray, Michelle Eckstein, Debra Lipson, and Andrea Wysocki, ***Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020***, Centers for Medicare & Medicaid Services, June 9, 2023.
[19] **Expenses by Agency and Line Item**, Ohio Checkbook.com (last visited, July 17, 2026).
[20] **How much does Medicaid cost in Ohio?**, USAFacts.org (last visited, July 17, 2026).
[21] Alison Mitchell, ***Medicaid's Federal Medical Assistance Percentage (FMAP)***, Congressional Research Service, April 2, 2025.
[22] Matt Nelson, John R. Bowblis, Ph.D., Robert Applebaum, Ph.D., and Oksana Dikhtyar, PhD., ***Nursing Homes in Ohio: A Profile***, Ohio Department of Aging, February 12, 2026.

and community-based services to "age in place."[23] It pays nursing homes through a daily rate that accounts for each facility's direct care costs (periodically rebased) and a performance-based quality incentive rate. Ohio's 2024–2025 biennial budget directed 60 percent of any funding increase from rebasing flow to the quality incentive pool, with 40 percent going to base rates,[24] in order to tie more Medicaid funding to quality outcomes rather than volume. The Ohio Supreme Court subsequently ordered the Ohio Department of Medicaid to recalculate quality incentive payments because the department had not followed the statutory formula,[25] and the General Assembly then approved $875 million in payments to nursing homes.[26]

Unlike nursing homes, which require nurses and aides to routinely monitor patients, assisted living facilities offer a more independent environment that help seniors with daily activities, such as bathing, cooking, and dressing. And unlike nursing homes, assisted living facilities are not subject to federal oversight. Instead, they are regulated and licensed by Ohio agencies, including the Ohio Department of Health, Bureau of Long-Term Care, and Division of Quality Assurance. Nursing homes increasingly serve patients who need skilled nursing care,[27] while assisted living environments tend to help lower-acuity patients receive care. In Ohio, the MyCare Ohio waiver program helps pay for assisted living services and home care, reducing medical expenses for program participants.[28] And unsurprisingly, assisted living facilities are considerably less expensive than around-the-clock nursing home care. A recent cost of care survey shows annual expenses for assisted living facilities average $66,000, compared to nursing home costs that exceed $120,000 per year.[29]

Given the relative costs of any LTC facility, "smart" home technologies that allow patients to remain at home longer, preventing or delaying nursing home admissions, offer patients and their families valuable alternative services. For

[23] *Ibid.*
[24] Dan Trevas, **State must recalculate Medicaid payments to nursing homes**, Akron Legal News, September 15, 2025.
[25] *Ibid.*
[26] Mary Frances McGowan, **Ohio passes bill to pay nursing homes $875 million after state Supreme Court ruling**, Cleveland.com, June 10, 2026.
[27] David C. Grabowski, David G. Stevenson, and Portia Y. Cornell, "**Assisted Living Expansion and the Market for Nursing Home Care**," *Health Services Research*, Volume 47, Issue 6 (December 2012) p. 2,296-2,315.
[28] John R. Bowblis, Robert Applebaum, Jennifer Heston-Mullins, Matt Nelson, Katherine M. Abbott, Lorin Ranbom, Virginia A. Folcik Nivar, and Michael Nau, ***Evaluation of Ohio's MyCare Demonstration***, Scripps Gerontology Center, Miami University (accessed July 17, 2026).
[29] **Long-Term Care Costs Increase in Ohio, On Par with National Costs**, Genworth Financial press release, March 4, 2025.

example, wearable technologies that use artificial intelligence can monitor patient activity and behavior patterns to flag health anomalies for caregivers before a fall or hospitalization. When falls do occur, wearable at-home devices immediately notify caregivers that help is needed. Patients with wearable monitoring devices are nearly 40 percent less likely to be hospitalized than patients without such devices.[30] And the average fall rate for those with wearable devices was 69 percent lower than the control group.[31] Given that nearly 80 percent of fall-related hospital visits originate from falls at home, these innovations can prevent expensive hospital stays and nursing home admissions.[32]

Home and Community-Based Services

The Omnibus Budget Reconciliation Act of 1981 allowed states to allocate funds to home-based care. Starting in 1984, Ohio, an early adopter of this initiative, launched the PASSPORT pilot program to provide low-income elderly adults with an alternative to traditional institutional long-term care.

In 2005, the Deficit Reduction Act permitted states to explore options to reform their Medicaid programs.[33] Starting in 2007, the Ohio Long-Term Care Insurance Partnership Program was a collaborative effort between various Ohio state agencies and private insurers. This initiative aims to encourage Ohioans to prepare for long-term care expenses. The defining aspect of the program possesses a dollar-for-dollar protection: for every dollar a qualified policy paid for in benefits, an equal dollar of the policyholder's personal assets is protected from Medicaid's spend-down rule. Prior to this program, individuals needed only $2,000 in assets to qualify for Medicaid. However, if a person purchased a $500,000 policy through this program and exhausted their benefits, they would not have to deplete most of their assets to qualify for Medicaid's long-term coverage.

Ohio adopted its own version of the federal Money Follows the Person program, creating the HOME Choice plan, which helps individuals transition from a long-

[30] Gerald Wilmink, Ph.D., Katherine Dupey, Schon Alkire, Jeffrey Grote, Gregory Zobel, Howard M Fillit, and Satish Movva, "**Artificial Intelligence–Powered Digital Health Platform and Wearable Devices Improve Outcomes for Older Adults in Assisted Living Communities: Pilot Intervention Study**," *JMIR Aging*, Volume 3, Issue 2 (September 2020).
[31] *Ibid.*
[32] Briana L. Moreland, Ramakrishna Kakara, Yara K. Haddad, Iju Shakya, and Gwen Bergen, "**A Descriptive Analysis of Location of Older Adult Falls That Resulted in Emergency Department Visits in the United States, 2015**," *American Journal of Lifestyle Medicine*, Volume 15, Issue 6 (August 2020) p. 590-597.
[33] Anne Rossier Markus and Sara Rosenbaum, ***The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services***, The Commonwealth Fund, October 1, 2006.

term care facility to a home or community-based setting. Individuals who are enrolled in Medicaid, 18 years or older, and have been in a long-term care facility for at least 60 consecutive days are eligible. Transition coordinators help find appropriate housing options for recipients. HOME Choice also offers financial assistance to help these individuals comfortably transition into a life of self-sufficiency. Through this program, more than 16,000 Ohioans have moved from a life of institutionalization to independent living.[34]

Dual-eligible recipients of Medicare and Medicaid generally have more complex and costly care needs, which prompted Ohio to create MyCare Ohio in 2014 as a pilot program across Ohio's major urban areas. This managed care program fuses Medicaid and Medicare benefits—including medical, behavioral health, and long-term services—into a single plan for dual-eligibles. For dual-eligibles living in any of the 29 participating counties, enrollment is required, and unlike the PASSPORT program, there are no enrollment caps. Over the years since its inception, evidence suggests that residents in these counties are less likely to be admitted to a hospital or a nursing facility.[35] Based on its success, efforts are being made to expand the program to all counties by mid-2026, renaming it the Next Generation MyCare program.[36] This rebalancing represents sound policy: HCBS aligns more with patient preferences, supports greater independence and dignity, and generally costs the state less per beneficiary than skilled nursing facility care.

Home and community-based services allow patients to avoid expensive institutional healthcare and instead receive medical treatment more affordably in the comfort of their own homes. Home-based services in Ohio are 22 percent less expensive than institutional long-term care.[37] Their lower costs and other advantages have made them increasingly popular, especially among the elderly population.[38] And that rising popularity saves taxpayers millions of dollars in

[34] **HOME Choice**, Ohio Department of Medicaid (accessed July 17, 2026).
[35] **Financial Alignment Initiative (FAI) MyCare Ohio Demonstration**, Centers for Medicare & Medicaid Services (accessed July 17, 2026).
[36] Next Generation MyCare Program, **Stakeholders and Partners**, Ohio Department of Medicaid (accessed July 17, 2026).
[37] Amy Rohling McGee, Nick Wiselogel, and Brian O'Rourke, Ph.D., ***Medicaid and home- and community-based services in Ohio***, Health Policy Institute of Ohio, June 5, 2026.
[38] Michelle R. Davis, **Despite Pandemic, Percentage of Older Adults Who Want to Age in Place Stays Steady**, AARP.org, November 22, 2022.

publicly funded healthcare.[39] More importantly, seniors who "age in place" are less likely to be depressed and report a higher quality of life.[40]

Unfortunately, inadequate oversight of HCBS has failed to protect vulnerable populations and Medicaid against waste, fraud, and abuse.[41] Improper travel payments, fraudulent billing for unrendered services, and artificially inflated invoices plague these programs. Ohio Senate Bill 315 responds to the problem by strengthening oversight and requiring care providers to use GPS-based verification technology that documents hours spent with patients.[42] The legislation mandates in-person and on-site inspections for prospective care providers and facilities, with subsequent in-person inspections every three years and re-credentialing every two years. And Senate Bill 315 raises the criminal penalties for Medicaid fraud and treats such fraud as severely as any other theft.[43]

At the federal level, a recent opinion issued by the Department of Justice[44] reinterpreting the U.S. Supreme Court's *Olmstead v. L.C.* (1999)[45] decision has sparked speculation that the federal government may slowly return to institutionalizing disabled individuals rather than pay for home-based care. Responding to the Justice Department memorandum, the American Association of People with Disabilities warned against regressive policies that would undermine individual autonomy by disallowing patients to remain and receive care in their homes and communities.[46] Research suggests that HCBS generally yields better health outcomes less expensively than comparable institutional care,[47] making it an integral part of Ohio's medical care system. Policy moves at the state

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[39] Ohio Legislative Service Commission, ***MyCare Ohio Evaluation 2018***, Ohio Department of Medicaid (accessed July 17, 2026).

[40] Ludovico Carrino, Erica Reinhard and Mauricio Avendano, "**There Is No Place Like Home: The Impact of Public Home-Based Care on the Mental Health and Well-Being of Older People,**" *Health Economics*, Volume 34, Issue 6 (February 2025) p. 1085-1102.

[41] Rea S. Hederman Jr., vice president of policy, The Buckeye Institute, **Interested Party Testimony** on Ohio House Bill 795, June 8, 2026.

[42] **S.B. 315**, 136th General Assembly (Ohio 2026).

[43] *Ibid.*

[44] Lanora C. Pettit, **Application of the Rehabilitation Act and Americans with Disabilities Act to State Institutionalization of Patients with Severe Mental Illness or Disabilities**, U.S. Department of Justice, June 18, 2026.

[45] ***Olmstead v. L.C.*, 527 U.S. 581 (1999)**.

[46] Jess Davidson, **DOJ Memo Is Attempting to Turn Back the Clock on Integration and Olmstead's Promise**, American Association of People with Disabilities press release, June 18, 2026.

[47] Joe Caldwell, Laurin Bixby, Ruby Siegel, Syd Pickern, Kaitlin Stober, and David Cahn, ***Home and Community-Based Services Improve Outcomes While Reducing Costs***, Community Living Policy Center, Brandeis University, April 2026.

and federal level that hinder rather than help in-home long-term care—especially for the elderly and disabled demographics—would be misguided.

THE CHALLENGE

Ohio has been proactively expanding home-based care services throughout the state but remains vulnerable to bloated and rising Medicaid costs. From 2012 to 2025, total Medicaid spending grew from $18.4 billion to $43.2 billion, a 135 percent increase. Program spending is projected to rise to $118 billion by 2040. Spending on the program's aged, blind, and disabled (ABD) population—a relatively small but cost-intensive category—jumped from $9.9 billion to $21.2 billion between 2012 and 2025, with analysts projecting ABD spending to surpass $51 billion by 2040, or more than $60,000 for each ABD enrollee. (See Table 1.) Without effective controls, skyrocketing Medicaid expenses can pressure states to choose between raising taxes, neglecting other budget priorities, and cutting Medicaid reimbursement rates to care providers.

Table 1 | Historical and Projected Medicaid Enrollment and Spending[48]

Year	Total Medicaid Enrollees	ABD Enrollees	Total Medicaid Spending	ABD Spending	Total Spending Per Enrollee	ABD Spending Per Enrollee
2012	2.3 M	392.0 K	$18.4 B	$9.9 B	$8,000	$25,300
2013	2.3 M	403.8 K	$18.2 B	$9.6 B	$7,800	$23,700
2014	2.7 M	416.0 K	$20.1 B	$10.3 B	$7,500	$24,600
2015	3.0 M	388.8 K	$24.1 B	$11.8 B	$8,200	$30,400
2016	3.0 M	365.6 K	$26.9 B	$12.9 B	$9,100	$35,300
2017	3.0 M	447.2 K	$27.5 B	$13.0 B	$9,200	$29,100
2018	3.2 M	472.2 K	$27.7 B	$12.9 B	$8,700	$27,300
2019	2.7 M	469.9 K	$28.4 B	$13.1 B	$10,300	$27,800
2020	3.1 M	553.9 K	$29.8 B	$13.6 B	$9,600	$24,500
2021	3.1 M	532.5 K	$33.1 B	$14.9 B	$10,500	$28,000
2022	3.3 M	543.3 K	$35.4 B	$15.9 B	$10,800	$29,300
2023	3.4 M	552.4 K	$37.8 B	$17.2 B	$11,000	$31,100
2024	3.5 M	544.5 K	$38.9 B	$17.9 B	$11,200	$32,800
2025	3.4 M	542.1 K	$43.2 B	$21.2 B	$12,800	$39,000
Projected						
2027	3.6 M	573.2 K	$49.4 B	$23.9 B	$13,800	$41,600
2028	3.7 M	589.4 K	$52.8 B	$25.3 B	$14,300	$43,000
2029	3.8 M	606.1 K	$56.5 B	$26.9 B	$14,800	$44,400
2030	3.9 M	623.3 K	$60.4 B	$28.5 B	$15,300	$45,800
2031	4.1 M	640.9 K	$64.6 B	$30.3 B	$15,800	$47,300
2032	4.2 M	659.0 K	$69.0 B	$32.2 B	$16,400	$48,800
2033	4.3 M	677.7 K	$73.8 B	$34.1 B	$17,000	$50,400
2034	4.5 M	696.9 K	$78.9 B	$36.2 B	$17,600	$52,000
2035	4.6 M	716.6 K	$84.4 B	$38.5 B	$18,200	$53,700
2036	4.8 M	736.9 K	$90.2 B	$40.9 B	$18,900	$55,400
2037	4.9 M	757.8 K	$96.5 B	$43.4 B	$19,600	$57,200
2038	5.1 M	779.2 K	$103.2 B	$46.0 B	$20,300	$59,100
2039	5.3 M	801.3 K	$110.3 B	$48.9 B	$21,000	$61,000
2040	5.4 M	824.0 K	$118.0 B	$51.9 B	$21,700	$63,000

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[48] MACStats Archive, **Medicaid and CHIP Payment and Access Commission** (Last visited July 17, 2026). Projections calculated by The Buckeye Institute.

Projected healthcare expenditures and caregiver shortages require Ohio to adopt sustainable, cost-effective healthcare policies that allow patients and their families to meet their medical needs affordably and without sacrificing quality of care. By 2030, Ohio is projected to suffer a shortage of nearly 5,000 physicians across all specialties.[49] Nursing home staff fell precipitously following the COVID pandemic, and staffing levels are only slowly recovering.[50] Workforce staffing shortages result in adverse patient conditions and outcomes. To increase the state's supply of care providers, Ohio should eliminate unnecessary scope-of-practice regulations for certain care worker categories. And Ohio should simplify and realign its quality incentive systems to improve administration and achieve its goals. By rewarding facilities that reduce avoidable hospitalizations, prevent unnecessary institutional care, and improve care coordination, the quality incentive system can slow the growth of LTC costs and improve patient outcomes. Aligning financial incentives with staffing and patient outcomes would encourage facilities to recruit and retain caregivers to help address the workforce shortage.

[49] **Workforce Projections**, Health Resource and Services Administration (last visited, July 17, 2026).
[50] ***Nursing Home Workforce Report***, American Health Care Association, January 2026.

POTENTIAL SOLUTIONS

Without meaningful reform, Ohio's Medicaid long-term care expenditures are expected to reach $14.9 billion by 2036. (See Table 2.) Even a modest improvement — bending the annual cost growth of 4.9 percent curve by just one-tenth of one percent through technology, more providers, fewer adverse events, and stronger community-based alternatives — would save almost $200 million a year by 2036. So, the savings from even incremental long-term care reforms are not insignificant. Investing in technology and expanding the medical workforce today is not just the right thing to do for Ohio's nursing home residents; it is one of the most cost-effective steps the General Assembly can take to protect the long-term integrity of the state budget.

"Swing" Beds and Home and Community-Based Care Improvements

Because small rural hospitals often sit in communities with few nursing home beds, the Omnibus Reconciliation Act of 1980 authorized eligible hospitals to "swing" up to 25 inpatient beds[51] from acute-care to skilled nursing or long-term care as needed.[52] The law quickly improved access to post-acute care in underserved areas without requiring costly new construction of long-term care facilities.[53] "Swing" beds saved Medicare roughly $5 million soon after they were authorized,[54] and they have helped give rural patients closer-to-home recovery care ever since.[55] In Nebraska, swing beds have decreased some readmission rates.[56] And a 2022 swing-bed program in Texas made hospitals in counties with populations of 100,000 or less eligible for Medicaid nursing-facility payments for swing-bed patients when nearby nursing home beds are unavailable.[57] Ohio faces a similar lack of access to care in its rural communities, particularly in Appalachian counties.[58] Following Texas's example, Ohio should protect its Medicare-certified

[51] **Critical Access Hospitals (CAHs)**, Rural Health Information Hub (accessed July 17, 2026).
[52] **H.R. 7765**, 96th Cong. (1980), Omnibus Reconciliation Act of 1980, Congress.gov (accessed July 17, 2026).
[53] Peter W. Shaughnessy, Robert E. Schlenker, and Herbert A. Silverman, "**Evaluation of the national swing-bed program in rural hospitals**," *Health Care Financing Review*, Volume 10, Issue 1 (Fall 1988) p. 87-94.
[54] *Ibid.*
[55] Jenn Lukens, **Rural Post-Acute Care: Improving Transitions to Enhance Patient Recovery**, Rural Health Information Hub, May 2, 2018.
[56] *Ibid.*
[57] **Texas Administrative Code § 554.2326 (2022)**.
[58] Hannah Vandertie, **Ohio rural healthcare access — an advanced solution?**, Ohio Capital Journal, May 8, 2026.

swing-bed program while expanding Medicaid reimbursement for eligible patients. Under Ohio law, the swing-bed program does not trigger Certificate of Need requirements, since the beds remain licensed hospital beds rather than a permanent conversion into skilled nursing beds.[59] Recategorizing beds this way, however, would impose these constraining rules on hospitals, delaying care until state approval is granted. A path to Medicaid swing-bed reimbursement for counties below an appropriate population threshold would extend meaningful care access to underserved residents by using existing infrastructure and available beds, rather than building expensive new facilities.

In addition to protecting viable "swing" bed programs, Ohio policymakers should also improve its home and community-based service options. Medicaid-eligible patients of all ages prefer HCBS over institutional care because it preserves patient dignity, privacy, and independence in ways that institutions often cannot, while costing the state considerably less than facility-based care. Ohio's HCBS expansion has already saved hundreds of millions of dollars over the past decade, and the program's growth reflects patient preference and sound fiscal policy.[60]

Unfortunately, inadequate oversight has compromised the integrity of Ohio's HCBS programs. Inflated caregiver billing, improper travel reimbursements, and payments for services never rendered[61] contribute to a 15 percent payment error rate,[62] with significant sums diverted from vulnerable patients who depend on the program. The problem is sharpest in the independent and self-directed program segments in which individuals choose and manage their own caregivers rather than receiving services through a certified agency. Self-direction offers meaningful autonomy but with less regulatory oversight and fewer training requirements for caregivers, which exposes participants to undisclosed incidents, unverified service delivery, and erroneous billing.[63] Expanding HCBS without strengthening accountability structures is not sustainable, and Ohio must take steps to improve programmatic integrity.

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[59] **Ohio Revised Code 3702.521** (2024).
[60] **Governor DeWine Announces New Medicaid Fraud Prevention Initiatives**, Office of Governor Mike DeWine news release, May 13, 2026.
[61] **Lake County Woman Sentenced in $775,000 Medicaid Scheme**, Ohio Attorney General's Office news release, February 27, 2026; **9 Medicaid Providers Indicted on Fraud Charges**, Ohio Attorney General's Office news release, July 10, 2025; and **Nine Medicaid Providers Facing Fraud, Theft Charges**, Ohio Attorney General's Office news release, April 17, 2026.
[62] **Annual State of Ohio Single Audit Details $45 Billion in Spending Through 371 Federally Funded Programs**, Ohio Auditor of State's Office press release, March 27, 2026.
[63] **Ohio Administrative Code 5123-2-08 (2024)**.

Expand and Support the Long-Term Care Workforce

Ohio currently ranks 39th in the country in nursing home quality, with staffing shortages reported in 28 percent of facilities.[64] The state's nursing homes already struggled to retain and recruit staff prior to COVID-19, but the pandemic made a chronic problem acute, with serious consequences for residents. Inadequate nursing home staffing exacerbates medication errors, unattended residents, and delayed and unanswered calls for assistance.[65] Staffing shortfalls have cascaded from the lowest-paid direct care positions to nurses and administrators, leaving facilities unable to deliver consistent, compassionate care.

In 2023, Ohio's Nursing Home Quality & Accountability Task Force and the Ohio Department of Aging conducted 11 community listening sessions in seven cities.[66] Their report recommends standardizing training resources for caregivers supporting dementia patients and others with complex physical care needs. It encourages using technologies to improve workforce efficiency and alleviate workplace burdens; and partnering with schools and community centers to grow the clinical workforce. A pilot certification program in Texas high schools designed to increase the state's healthcare workforce found that most participating students completed and responded positively to the program,[67] but a lack of part-time, entry-level healthcare positions that allowed students to work while attending college full-time posed a significant barrier to workforce entry. This pilot program signals that expanding training opportunities alone will not be enough to strengthen the long-term care workforce. Ohio must also give students and new healthcare workers access to flexible entry-level roles that allow them to build experience and earn income while completing their education.

Ohio can take several other steps to address the worker shortages in its long-term care centers.

First, the state can further expand its authorized telehealth services to include out-of-state care providers. Ohio permits Medicaid reimbursement for certain

[64] Stephen Koff, **Advocates Push for Nursing Home Reform**, AARP.org, November 1, 2023.
[65] Paula Christian, **'Sometimes they don't come back at all': Staffing issues plague nursing homes as task force visits Cincinnati**, WCPO.org, March 17, 2023.
[66] Ohio Governor's Nursing Home Quality & Accountability Task Force, ***Nursing Home Quality & Accountability Task Force Recommendations Report***, Ohio Department of Aging, May 26, 2023.
[67] Maja Djukic, D'hania L. Miller, Ana Lorena Hermosilla, Stephanie Hulsey, and Rosemary Pine, "**Nursing Pipeline Program for High School Students in Career Technical Education: A Feasibility Pilot Study**," *Western Journal of Nursing Research*, Volume 48, Issue 2 (February 2026) p. 175-183.

telehealth services, subject to specific restrictions.[68] Telehealth offers flexible care options for patients and providers, reducing the need for in-person office visits and minimizing or eliminating long-distance travel. Unfortunately, Ohio joined an interstate licensure compact that adds fees and administrative requirements for out-of-state telehealth service providers, which discourages physician participation and reduces access to care.[69] In 2024, Colorado permitted clinicians with an active, unrestricted medical license in good standing from another state to provide telehealth services in Colorado. Following Colorado's lead would increase the supply of available care providers, improve Ohio's physician-to-patient ratio, and enhance in-home care efficiency, which would mitigate the state's persistent workforce shortage.

Second, Ohio can ease scope of practice restrictions that unreasonably limit the care that trained healthcare professionals may legally provide. Advanced nurse practitioners, for example, have advanced medical training and can help care for many LTC patients, but state regulations restrict the care they may offer. Authorizing these practitioners to provide more care in institutional and home-based care settings can reduce hospitalization, improve patient outcomes,[70] and enhance the quality of patient care.[71]

Third, House Bill 530 proposes a Long-Term Care Workforce Study Commission to develop a comprehensive strategy to recruit, train, and retain direct care workers in Ohio's nursing homes, assisted living facilities, and home- and community-based settings.[72] The Commission would examine the education pipeline for care workers—identifying gaps in training programs, credentialing pathways, and community college curricula. It would develop recruitment strategies, particularly for rural and Appalachian communities with acute workforce shortages and long commutes to training centers. And it would review the various barriers—*e.g.*, wages, regulations, culture, and logistics—that discourage prospective workers from entering the healthcare profession. The strategic initiatives recommended by the Commission should help Ohio increase its supply of long-term care providers.

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[68] **H.B. 123**, 130th General Assembly (Ohio 2014); **H.B. 122**, 134th General Assembly (Ohio 2022).
[69] **Participating States**, Interstate Medical Licensure Compact (last visited, July 17, 2026).
[70] Kira L. Ryskina, Junning Liang, Ashley Z. Ritter, Joanne Spetz, and Hilary Barnes, "**State scope of practice restrictions and nurse practitioner practice in nursing homes: 2012-2019**," *Health Affairs Scholar*, Volume 2, Issue 2 (February 2024) p. 1-8.
[71] ***Reforming America's Healthcare System Through Choice and Competition***, U.S. Department of Health and Human Services, December 3, 2018.
[72] **H.B 530**, 136th General Assembly (Ohio 2025).

Finally, and most creatively, state officials could ask the U.S. State Department to expand the federal au pair program to include care for the elderly. A senior-care au pair model could provide older adults with transportation assistance, companionship, meal preparation, medication reminders, and help with basic daily activities, while allowing them to remain in their homes. Without raising taxes, such a program could collaborate with sponsor organizations that screen participants, match caregivers with host families, and monitor compliance to reduce the risk of abuse or poor fit.[73] The program would set clear limits on the level of care an au pair could provide, reserving participation for seniors whose needs do not require skilled nursing.

Provider Payment Reform

Ohio's payment structure for nursing homes is over-complicated. Payment errors and delays exacerbate the other challenges nursing homes face and reduce the quality of patient care. Unfortunately, traditional payment models in Medicaid and Medicare created an incentive for providers to maximize revenue rather than prioritize care.[74] To improve nursing home practices and care quality, Ohio implemented a value-based improvement plan that provides bonus payments to nursing homes that meet quality benchmarks. Early results have been promising with better patient outcomes and improved care delivery.[75]

Ohio should continue to streamline and clarify payment rules and monitor nursing homes that have failed to improve their quality and are falling behind. The state should not reduce its standards for attaining bonus payments but should instead incentivize nursing homes to improve or transfer patients to other care environments.

Tightening Medicaid Asset Tests and Strengthening Private Long-Term Care Insurance

Lenient government policies make it too easy for too many to receive Medicaid funding for LTC that they are financially ineligible to receive. Financial advisors, accountants, and lawyers help clients obtain LTC through Medicaid even when those clients have financial assets that exceed the Medicaid asset limits.[76] State

[73] Kristin Shapiro, **Au Pairs for Senior Care**, Independent Women's Forum, April 10, 2024.
[74] Martin B. Hackmann, R. Vincent Pohl and Nicolas R. Zierbarth, "**Patient versus Provider Incentives in Long-Term Care**," *American Economic Journal: Applied Economics*, Volume 16, Issue 3 (July 2024), p. 178-218.
[75] Kimberly Marselas, **Incentivizing nursing home quality: The Ohio success story**, McKnights, November 6, 2025.
[76] Stephen A. Moses, ***Long-Term Care: The Problem***, Paragon Health Institute, October 2022.

agencies can legally recover funds from the estates of ineligible Medicaid recipients, but chasing those dollars after they are spent is difficult and politically unpopular.

Stricter eligibility tests for Medicaid LTSS offer a better solution. Individuals with homes worth more than $1 million dollars should not be eligible for benefits designed for the less fortunate. Ohio can and should review other asset classes and recent fund transfers to ensure Medicaid applicants are eligible before authorizing payment.[77] The state will need to advertise income and asset restrictions, so residents can proactively save for their own care or buy private insurance. And Ohio should resist the temptation to follow the state of Washington's program, which taxes residents to pay for LTC benefits, but exempts those who purchase private LTC insurance. Washington has seen an increase in private LTC insurance, but creating another state entitlement system is ill-advised.[78]

Use Technology to Help Patients and Support Caregivers

Technology can help strengthen Ohio's long-term care system by augmenting healthcare workers and providing care more efficiently and cost-effectively.[79] Telehealth technologies, remote patient monitoring, and digital medication management allow the elderly and individuals with disabilities to receive care safely in the comfort of their homes, and they help assisted living residents remain independent longer, while easing burdens on healthcare workers.

Remote patient monitoring (RPM) allows care providers to monitor patients' conditions between in-person visits, identify warning signs earlier, and intervene before minor problems become health emergencies, expanding the effective reach of home-based care without displacing the health workers who provide it. Through wearable devices, connected home monitors, and smartphone-based applications, RPM lets clinicians track patient health data such as blood pressure, heart rate, glucose levels, weight, and activity outside traditional clinical settings. Research shows that RPM can improve chronic disease management, lower blood pressure, and reduce cardiovascular events to reduce hospital readmissions.[80]

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[77] Stephen A. Moses, ***Long-Term Care: The Solution***, Paragon Health Institute, October 2023.
[78] *Ibid.*
[79] Aziz Rezapour, Seyede Sedighe Hosseinijebeli, Saeed Bagheri Faradonbeh, "**Economic evaluation of E-health interventions compared with alternative treatments in older persons' care: A systematic review**," *Journal of Education and Health Promotion*, Volume 10 (May 2021) p. 134.
[80] Mingfu Hou, Shihe Di, Jian Li, and Jinze Yu, "**A Range Review of Remote Monitoring Influence on Elderly Rehabilitation Effectiveness**," *Current Research in Medical Sciences*, Volume 3, Issue 4 (December 2024) p. 25-33.

Smart home technologies, including artificial intelligence-powered devices, RPM systems, and socially assistive robots, are increasingly used in long-term care settings to support older adults aging in place and avoid costly institutional care. These tools are designed to enhance safety, improve care coordination, and reduce reliance on nursing homes and assisted living facilities. They improve fall prevention, increase emotional well-being, and offer more engagement in daily activities.[81] So, it is not surprising that the technology sector for older adults is a $740 billion industry that could reach $1.1 trillion by 2030.[82]

Artificial intelligence (AI) is already deployed in nursing homes, assisted living facilities, and home care settings across the country. Within home-based care, AI-enabled systems can support aging in place through ambient sensors, fall detection algorithms, medication adherence monitoring, and conversational AI tools that provide reminders, companionship, and basic assistance. Falls among older adults generate more than $50 billion in annual healthcare costs in the United States, driven primarily by emergency department visits, hospitalizations, and long-term disability following injury.[83]

For residents at assisted living facilities, smart technology devices can reduce reliance on staff for routine tasks, such as controlling lights, appliances, and other household accessories. For example, JubileeTV now allows family members to remotely control an older adult's television, making it easier for them to participate in video calls and remain socially connected with loved ones.[84] The device has made aging in place more affordable and less stressful.[85] Likewise, an assisted living facility in Florida has installed smart home technologies to track sleep patterns of patients via remote patient monitoring devices and use smart speakers that allow patients to have two-way communication with staff members.[86]

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[81] Ahmed Elsheikh, Achraf Othman, and Dena Al-Thani, "**Systematic analysis of cutting-edge technology for the wellbeing and safety of older persons**," *Disability and Rehabilitation: Assistive Technology*, Volume 20, Issue 8 (September 2025) p. 2,691-2,724.

[82] Michael Abadir, William Dineen, Daniel Myers, Simone Yu, and Phillip Phan, "**Navigating the future of artificial intelligence technologies for improving the care of older adults**," *Innovation in Aging*, Volume 9, Issue 1 (September 2025) p. 24-32.

[83] Yara K Haddad, Gabrielle F Miller, Ramakrishna Kakara, Curtis Florence, Gwen Bergen, Elizabeth Rose Burns, and Adam Atherly, "**Healthcare spending for non-fatal falls among older adults, USA**," *Journal of the International Society for Child and Adolescent Injury Prevention*, Volume 30, Issue 4 (July 2024) p. 272-276.

[84] Simon Hill, **Review: JubileeTV**, Wired.com, November 16, 2024.

[85] Noah Sheidlower, **Meet the families using tech to help grandma stay independent longer**, Business Insider, July 12, 2026.

[86] Kimberly Bonvissuto, **AI adoption making inroads in senior living organizations**, McKnights Senior Living, December 3, 2025.

AI can also improve caregiver efficiency by automating some routine tasks and answering common questions.[87] Employees can then direct their attention to resident care and improve response times for urgent needs. This saves LTC facilities valuable time[88] and helps them retain more employees.[89]

Assisted living facilities are a viable option for individuals who need help with their daily activities but want to remain independent for as long as possible without sacrificing their financial security. With institutional care often exceeding $120,000 annually,[90] assisted living offers a more satisfying and cost-effective alternative.[91] Encouraging assisted living facilities to use technologies that support caregivers and extend safe independent living can help Ohio's elderly adults remain at home longer, avoid expensive nursing home placements, and improve access to high-quality care without compromising outcomes.

Telehealth is another innovation that reduces travel burdens for patients and providers, expands access to specialists in rural and underserved areas, and makes it easier for overstretched care teams to manage routine follow-up visits, medication checks, and chronic disease monitoring. Advances in telehealth technology, however, will only benefit patients that can use it properly. Unfortunately, telehealth use by older adults is hindered by digital literacy gaps, inaccessible interfaces, physical and cognitive limitations, and connectivity problems in rural areas.[92] Telehealth is more successful when caregivers are incorporated into the care model and when platforms are designed for accessibility and ease of use.[93] Investing in telehealth, RPM, AI, and other advanced technologies for deployment in Ohio's LTC system can help reduce healthcare costs and system burdens by supporting—not replacing—direct care workers. These technologies multiply human effectiveness by providing predictive analytics, automated documentation, and AI-assisted scheduling so that care providers can

[87] *Ibid.*
[88] **Masonic Village at Elizabethtown – K4Connect Resident Check-In Improves Resident Safety and Saves Staff Time**, K4Connect.com, April 2, 2025.
[89] Lois A. Bowers, **Artificial intelligence helps Sunrise improve one-year retention rate by 14%**, McKnights Senior Living, January 30, 2019.
[90] **Long-Term Care Costs Increase in Ohio, On Par with National Costs**, Genworth Financial press release, March 4, 2025.
[91] Katherine Wood, Nader Mehri, Nytasia Hicks, and Jonathon Vivoda, "**Family Satisfaction: Differences Between Nursing Homes and Residential Care Facilities**," *Journal of Applied Gerontology*, Volume 40, Issue 12 (November 2020) p. 1733-1742.
[92] Jaeyu Park, "**Telehealth and the Elderly: A Scoping Review on Technology Use, Adoption Barriers, and Health Outcomes**," *International Journal of Recent Innovations in Academic Research*, Volume 9, Issue 2 (May 2025) p. 309-322.
[93] *Ibid.*

serve more residents more safely with less administrative hassle. Studies of telehealth and RPM among older adults, for example, emphasize that these technologies are most effective when they are tailored to patients' medical conditions, physical abilities, and level of digital literacy.[94]

Ohio should treat telehealth and RPM not as stand-alone substitutes for direct care, but as complementary support tools that can augment the long-term care workforce when paired with accessible design, caregiver assistance, and clear integration into home-based care delivery. That complementary support can reduce strain on Ohio's long-term care workforce.

[94] A. Hasan Sapci, MD, and H. Aylin Sapci, MD, "**Innovative Assisted Living Tools, Remote Monitoring Technologies, Artificial Intelligence-Driven Solutions, and Robotic Systems for Aging Societies: Systematic Review**," *JMIR Aging*, Volume 2, Issue 2 (2019).

PROJECTED COSTS AND SAVINGS

Total Ohio Medicaid spending in 2025 was $43.2 billion and is projected to reach $118 billion by 2040. (See Table 1.) The ABD population—those most reliant on long-term care—accounts for nearly half of all Medicaid expenditures despite representing just 17 percent of enrollees.[95] Not all ABD spending goes toward long-term care services. ABD beneficiaries can also receive other Medicaid-covered services, including prescription drugs, X-rays, and rehabilitative care.[96] But a system that fails to bend that cost curve will force lawmakers into impossible choices: cutting services for vulnerable patients, raising taxes, or crowding out every other state priority. Even a modest reduction in the annual rate of cost growth—one-tenth of one percent—would generate more than $911 million in savings over the next decade. (See Chart 1.)

Chart 1 | Projected Medicaid Savings

Based on a one-tenth-of-a-percent decrease in spending

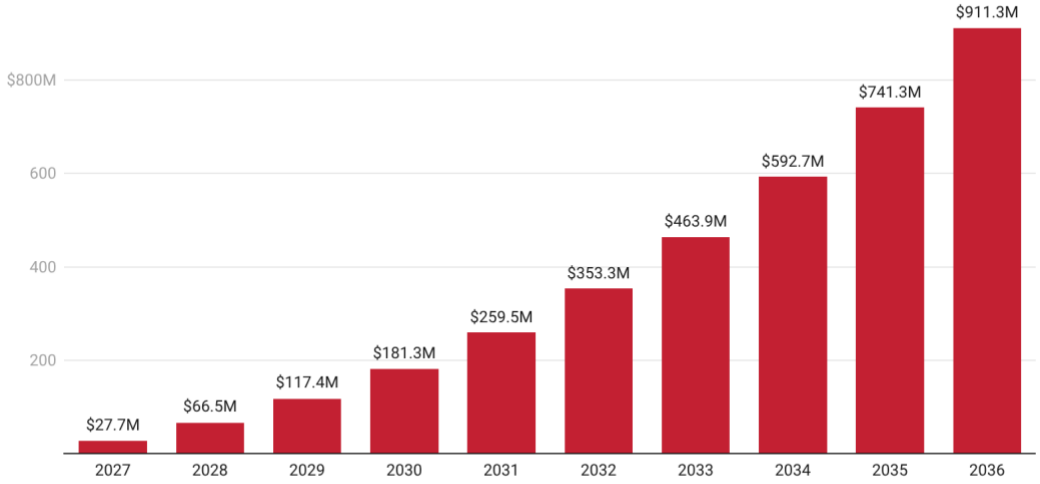

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Chart: Projections calculated by The Buckeye Institute • Source: MACPAC Stats • Created with Datawrapper

The accumulated savings from this small decrease in spending would total more than $911 million over the next 10 years. (See Table 2.)

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[95] Edith Nkenganyi and Hailey Akah, ***Ohio Medicaid Basics 2025***, Health Policy Institute of Ohio, February 2025.

[96] **Medicaid For The Aged, Blind, Or Disabled (ABD)**, Stark County Job & Family Services (accessed July 17, 2026).

Table 2 | Projected Medicaid Spending and Saving[97]

Year	Total LTSS Current Growth	Total LTSS Lower Growth	Annual Total LTSS Savings	Cumulative Total LTSS Savings
2027	$9.7 B	$9.7 B	$27.7 M	$27.7 M
2028	$10.2 B	$10.1 B	$38.8 M	$66.5 M
2029	$10.7 B	$10.6 B	$50.8 M	$117.4 M
2030	$11.2 B	$11.1 B	$64.0 M	$181.3 M
2031	$11.8 B	$11.7 B	$78.2 M	$259.5 M
2032	$12.3 B	$12.2 B	$93.8 M	$353.3 M
2033	$12.9 B	$12.8 B	$110.6 M	$463.9 M
2034	$13.6 B	$13.4 B	$128.8 M	$592.7 M
2035	$14.2 B	$14.1 B	$148.6 M	$741.3 M
2036	$14.9 B	$14.8 B	$170.0 M	$911.3 M

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[97] MACStats Archive, **Medicaid and CHIP Payment and Access Commission** (last visited, July 17, 2026). Projections calculated by The Buckeye Institute.

Conclusion

Ohio faces a long-term care crisis. Demographic and fiscal pressures will only intensify if nothing changes. The state's older adult population is growing faster than the national average, Medicaid already consumes 37 percent of the state budget, and the direct care workforce that holds the system together is understaffed, underpaid, and undertrained.[98] These are not separate problems. They are connected failures of a long-term care system that has not modernized to meet market demands. Various programs and policy initiatives, including investments in home and community-based care, MyCare Ohio, expanded telehealth reimbursement, and the Nursing Home Quality and Accountability Task Force are meeting these challenges. But the General Assembly must pursue durable, structural reforms before demographic and fiscal pressures foreclose more affordable solutions. Strengthening the direct care workforce pipeline, expanding HCBS infrastructure while enhancing its integrity, modernizing and simplifying provider payment, reducing unnecessary regulatory barriers to care, encouraging private long-term care planning, and deploying advanced technology to support caregivers are essential for sustaining Ohio's fiscal and medical health.

[98] **Expenses by Agency and Line Item**, Ohio Checkbook.com (last visited, July 17, 2026).

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