Policy Does Matter: Changing an Unchangeable Long-Term Services System

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Abstract

Because long-term services policy is largely driven by state decisions, this study examines the impact of state-level changes on Ohio's long-term services system. Using longitudinal data collected over twenty-six years, this paper tracks system changes, showing that despite a continued and dramatic increase in Ohio's older population, nursing home (NH) use has declined. The paper also documents the growth of in-home services, assisted living, and the increase in short-term institutional care. Advances in state policy, along with industry changes, such as the expansion of private pay home care and assisted living, have resulted in a changed long-term services and supports (LTSS) landscape. Driven by continued demographic changes and associated resource constraints, tomorrow's challenges will be even more difficult to address. The paper concludes with a discussion about how the system will need to be reformed to meet the challenges ahead.

Keywords: long-term services system reform, re-balancing long-term services, future long-term services policy

La política importa: cambiar un sistema de servicios a largo plazo inmutable

Resumen

Debido a que la política de servicios a largo plazo depende en gran medida de las decisiones estatales, este estudio examina el impacto de los cambios a nivel estatal en el sistema de servicios a largo plazo de Ohio. Utilizando datos longitudinales recopilados durante veintiséis años, este documento rastrea los cambios del sistema, mostrando que a pesar de un aumento continuo y dramático en la población de ancianos de Ohio, el uso de hogares de ancianos (NH) ha disminuido. El documento también documenta el crecimiento de los servicios en el hogar, la vida asistida y el aumento de la atención institucional a corto plazo. Los avances en la política estatal, junto con los cambios de la industria, como la expansión de la atención domiciliaria privada y la vida asistida, han dado como resultado un cambio en el panorama de los servicios y apoyos a largo plazo (LTSS). Impulsados por los continuos cambios demográficos y las limitaciones de recursos asociadas, los desafíos del mañana serán aún más difíciles de abordar. El documento concluye con una discusión sobre cómo será necesario reformar el sistema para enfrentar los desafíos futuros.

Palabras clave: reforma del sistema de servicios a largo plazo, reequilibrio de los servicios a largo plazo, política futura de servicios a largo plazo

政策确实重要：改变一个无法改变的长期（护理）服务体系

摘要

鉴于长期服务政策在很大程度上由各州决策所驱动，本研究检验了州级变化对俄亥俄州长期服务体系产生的影响。通过使用长达26年的纵向数据，本文追踪了体系变化，并表明尽管俄亥俄州中老年人口出现持续且显著的增长，护理院（NH）的使用却有所下降。本文还记录了居家护理服务和辅助生活服务的增长情况，以及短期机构护理服务的增加。州政策的进步，加上产业变革，例如私人支付家庭护理和辅助生活服务的扩大，已造成长期服务及支持（LTSS）局面发

生变化。受持续的人口变化和相关资源限制的驱动，今后的挑战将更难解决。本文结论探讨了该体系将如何需要改革以应对未来挑战。

关键词：长期服务体系改革，重新平衡长期服务，未来长期服务政策

Background

The debate in western society about whether to provide care in an institutional setting (indoor relief) or community-based location (outdoor relief) dates back to the Elizabethan Poor Law of 1601 (Axinn & Stern, 2005). Evaluation research has accompanied the indoor versus outdoor relief controversy, with the first US study completed by Josiah Quincy in 1821. The Quincy Report concluded that indoor relief was the most efficient means of support since conditions were so unpleasant in the almshouse that only those truly in need would use the assistance (Poverty USA, 1971). Swinging back and forth in pendulum fashion for more than 400 years, the arguments about efficiency and effectiveness of how best to provide services are ongoing. As nursing home (NH) care expanded alongside a growing older population, the home care versus institutional care controversy broadened in scope from basic societal welfare to the aging and disability policy arenas.

Federal and state policy in the 1960s and 1970s leaned heavily toward institutional long-term care as the primary approach to serving older people with disabilities. While incentivized through federal legislation, for many decision-makers the development of a formal NH option was viewed as an improvement over the small care homes that had grown across the state and nation. Driven by a desire to protect older people and to create more healthcare-like facilities, the industry expanded dramatically. Accompanying the growth of the NH industry was the development of professional associations that dedicated substantial resources to educating and influencing policymakers, particularly state legislators. This resulted in policy changes at the state level that contributed to a further preference for "indoor" institutional care rather than services provided in the community. By the middle of the 1990s, concerns about the lack of balance between settings in the LTSS system were common, and Ohio, the focus of our study, was ranked as one of the least balanced LTSS states in the nation (forty-seventh) (Burwell, 1999).

In response to the criticism that federal and state policy gave preference to institutional care, beginning in the 1980s, the federal government respond-

ed with a series of policy changes, including the 1981 Medicaid Home- and Community-Based Waiver Program, with Oregon becoming the first state to be granted waivers, and the 1990 Americans with Disability Act and the Olmstead court decision, both setting the stage legally for improved access to long-term services. Despite these efforts, many states were slow to expand home- and community-based services (HCBS), with concerns that such options would merely increase the numbers served, an idea referred to with the pejorative term "the woodwork effect." However, considerable efforts by aging and disability advocates, combined with federal policy changes, made it more difficult for states to resist balancing pressures in the LTSS arena.

Even with the strong political position experienced by the NH industry in Ohio, community-based care advocates, spurred on by the state's participation in the National Long-Term Care Channeling Demonstration, began to make political inroads with efforts to create a more balanced system. In response to the concerns about costs and balancing in the long-term services system, Ohio initiated a study in 1993 to track state long-term system changes. Over the past twenty-six years the study has collected data on in-home services, residential care - including assisted living - and NH care, with a focus on how cost and use patterns have evolved over time. Today Ohio's LTSS system has changed substantially. Ohio has a large HCBS waiver program for individuals age sixty and older called PASSPORT, an assisted living waiver covering all adults, a separate waiver for adults with disabilities under age sixty, and several waivers for individuals with developmental disabilities. Since 2014, Ohio also has participated in a Center for Medicare and Medicaid Services (CMS)-approved integrated care demonstration called MyCare, which has been implemented in the urban counties of the state. This paper describes these LTSS shifts and addresses the new policy issues that have arisen as a result of today's system structure. Reshaping the long-term services delivery system did not happen quickly or easily, but a transformation has occurred, indicating that policy can matter.

Study Methods

This study is unique in that it uses data from an array of sources to form a detailed picture of long-term services use over an extended period of time. To collect data from long-term care facilities in Ohio, we surveyed all operating NH and residential care facility every other year since 1993. The Biennial Survey of Long-Term Care Facilities has recorded consistently high response rates over the thirteen waves of data collection, ranging between 90 and 96% for NHs and from 85% to 93% for residential care facilities (Applebaum et al., 2019; Mehdizadeh et al., 2007; Mehdizadeh et al., 2011; Mehdizadeh et al., 2013; Mehdizadeh et al., 2017; Nelson et al., 2015). The most recent NH survey achieved a 91% response rate (Applebaum et al., 2019). This survey records facility characteristics, payer mix, admissions, and occupancy rates.

The longitudinal biennial survey data have been combined with a series of other LTSS data sources. The Nursing Home Minimum Data Set (MDS, 3.0), records the characteristics of nursing facility residents and is used to calculate the length of stay for all NH admissions, both long- and short-stay residents. The Ohio Medicaid Cost Report supplements the occupancy rate calculations and Medicaid and Medicare utilization rates. The Ohio PASSPORT Information Management System tracks service use and costs for HCBS participants and includes the full array of waiver services paid for under the program. Finally, the federal Certification and Survey Provider Enhanced Reports data provided additional characteristics about long-term care facilities in the state and is used to examine the Medicare-only facilities that do not complete the survey. Data cover the time period from 1993 through 2017.

Results

A review of the long-term services system for the past two decades shows an industry in significant transition. Our data indicate dramatic changes in where and how older people with impairments receive LTSS. Major trends identified include considerably higher numbers of admissions reflecting shorter resident stays driven by increasing proportions of Medicare residents, declining overall occupancy rates in NHs, despite a growing older population with severe disabilities, a dramatic expansion of HCBS, and changes in the profile of individuals using NHs.

Increasing Numbers of Medicare Residents

As shown in Table 1, over the twenty-five-year time period of the study, the number of NH beds in service has remained relatively constant, decreasing slightly from 91,500 in 1993 to 90,500 in 2017. Despite stability in the supply of beds in service, the number of short-term admissions has grown substantially. Short-term care surged across the nation motivated by an array of industry and policy changes, including the 1983 Medicare prospective payment system; ongoing cuts to Medicaid reimbursement rates, which made Medicare a more attractive financing source; and continued growth in HCBS options (Morrisey, Sloan, & Valvona, 1988; Tyler et al., 2018).

In Ohio between 1993 and 2017, the number of NH admissions nearly tripled, from 71,000 annual admissions to 206,000. Most of that increase came from individuals entering facilities with Medicare support, with those annual admissions increasing from 30,000 to 147,000. This increase in the proportion of residents admitted for post-acute care occurred across the US, with the average share of residents whose care was reimbursed by Medicare increasing from 9% to 15% between 2000 and 2015 (Fashaw et al., 2019). A shift in the proportion of beds certified for both Medicaid and Medicare also occurred during this time period, reflected in the growth of dually-certified NHs to 97% in 2015 from 33% in 1985 (Fashaw et al., 2019). In Ohio, 41% of NH beds in 1993 were Medicare certified, and by

Table 1. Ohio Nursing Facility Admissions, Discharges, and Occupancy Rates, 1993-2017

	1993	1999	2001	2005	2009	2011	2013	2015	2017
Total beds in Service	91,531	95,701	94,231	91,274	93,209	94,710	92,787	91,503	90,464
Medicaid certified	80,211	93,077	87,634	87,090	90,876	90,724	89,063	88,479	88,016
Medicare certified	37,389	47,534	62,088	86,701	91,928	91,650	90,730	89,555	89,307
Number of Admissions									
Total	70,879	149,838	149,905	190,150	197,233	207,148	218,992	211,338	206,636
Medicaid resident	17,968	28,150	24,442	34,432	27,040	31,212	36,859	35,182	35,647
Medicare resident	30,359	78,856	90,693	116,810	109,315	148,426	144,959	146,756	147,194
Occupancy Rate (percent)									
Total	91.9	83.5	83.2	86.4	84.7	83.2	83.9	84.7	81.0
Medicaid resident	67.4	55.4	58.5	58.8	55.4	54.9	54.3	54.3	53.6

2017, almost all (99%) had dual certification. Some of the push for this expansion came from states that wanted to ensure that residents who could be supported by Medicare were receiving this benefit. Facilities themselves also were incentivized to add Medicare as a funder, since states had begun to restrict Medicaid funding growth, and Medicare as an acute care funder and social insurance had been a more generous payer. Finally, since Ohio has been involved in the integrated care MyCare demonstration, those eligible for Medicaid and Medicare must enroll in a managed care health plan. The MyCare health plans are funded through a capitated rate with a financial incentive to reduce the use of institutional care. Limited evaluation data exist on the impacts of this demonstration, but it has resulted in increasing the proportion of Medicare Advantage enrollees in the state to about 40%. The sum of these changes meant that for many residents, NH care was no longer long-term care, but rather a short rehabilitation stay as they transitioned back to the community (Saliba et al., 2018; Xu & Intrator, 2019).

Declining Occupancy Rates

Despite a growing older population, there has been a national decline in NH occupancy, driven by the expansion of in-home services, the development and phenomenal growth of the assisted living industry, and a shift into serving more short-term residents (Applebaum et al., 2019; Castle, 2008; Castle, Liu, & Engberg, 2008; Tyler et al., 2018). The National Investment Center (NIC, 2019) reported that national NH occupancy rates decreased from about 88% in 2012 to 83% in 2019. While this data source is not a census of all US NHs, the pattern of declining occupancy is reflected in the monthly sample of 1,389 NHs in forty-seven states and from historical data. A study using a nationally representative sample of NHs similarly found a decline in the average occupancy rates from about 87% in 1995 to 81% in 2015 (Fashaw et al., 2019). This decline in occupancy rates appears to be the result of a combination of factors. For example, the expansion of the Medicaid HCBS waiver programs has been dramatic, with many states now serving more old people with severe disabilities in the community than in NHs (Eiken et al., 2018). Private payment for home care services and the development of the assisted living industry created a much wider range of options to enable older adults to age in place, even with increasing functional or cognitive declines (Hahn et al., 2011; Kwiatkowski & Gyurmey, 2019; Walters, 2012).

In Ohio, the annual nursing facility occupancy rate declined by 11 percentage points from 91.9% to 81.0% between 1993 and 2017 (see Table 1), despite an increase of more than 150,000 older people age eighty-five and older. As shown in Figure 1, the decline in average daily census was fueled by changes in two areas. Ohio experienced a substantial drop in the number of long-term residents supported by Medicaid, going from an average daily census of more than 54,000 in 1997 to an average daily census of 47,000 in 2017. Access to private options is reflected in a big drop

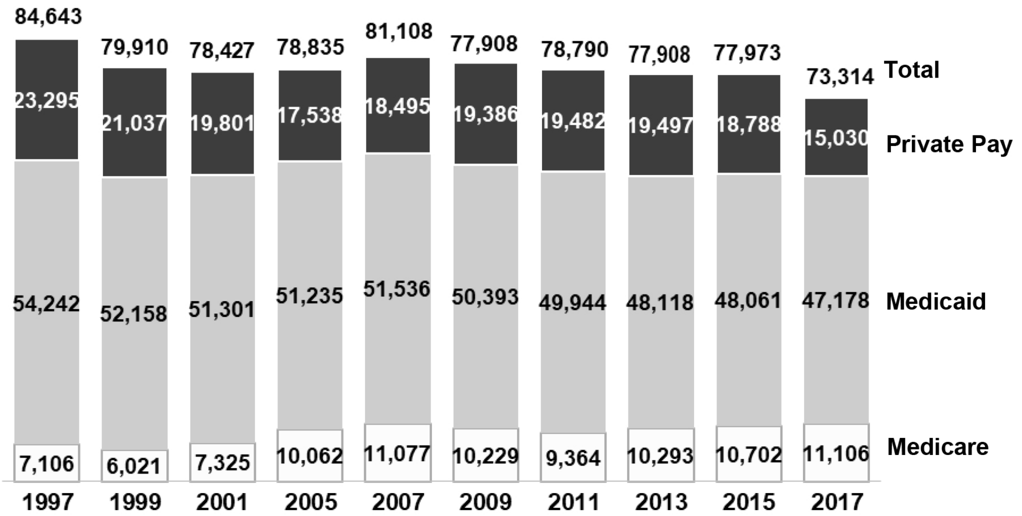

Figure 1. Average Daily Nursing Facilities Census, 1997-2017

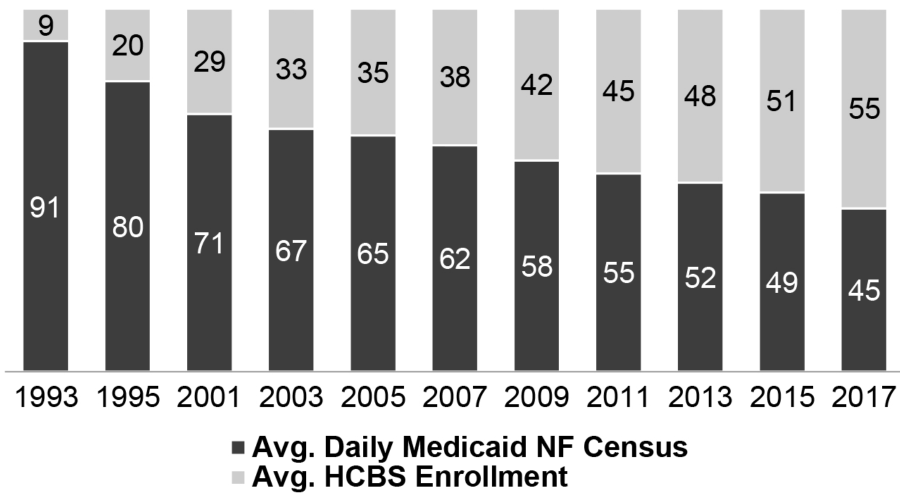

Figure 2. Proportion of Ohio's Medicaid HCBS and Nursing Facility Use by People Age 60 and Older, 1993-2017

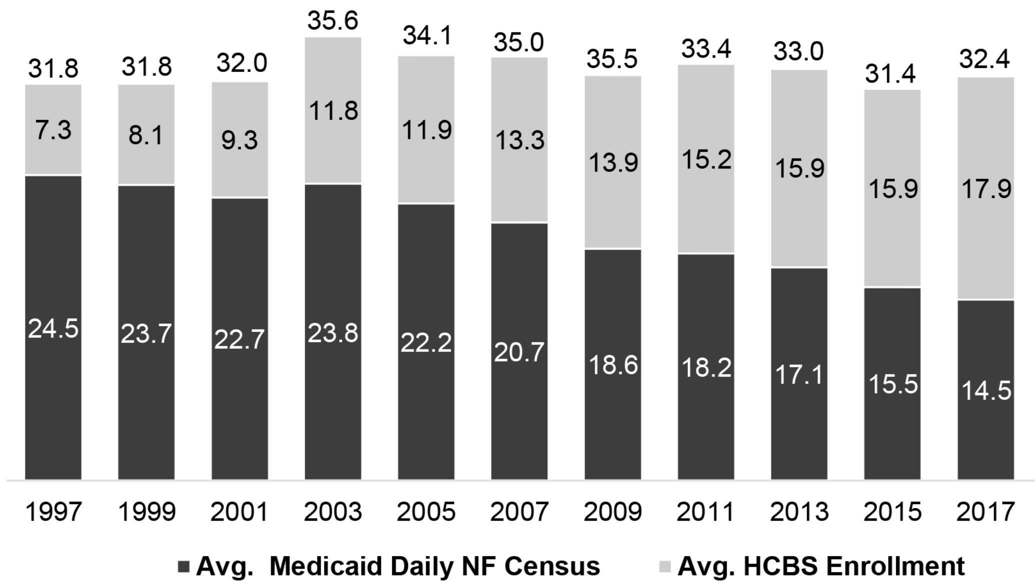

Figure 3. Number of People Age 60 and Older on Medicaid Residing in Nursing Facility or Enrolled in HCBS (including MyCare) per 1,000 Older Persons in Population, 1997-2017

in private-pay residents, declining from 23,000 average daily census in 1997 to about 15,000 in 2017.

System Balancing

The expansion of HCBS combined with reductions in NH use means that Ohio has substantially changed its approach to providing long-term services over the past two decades. Figure 2 illustrates the dramatic shift in LTSS utilization, going from fewer than 10% of older Ohioans on Medicaid using HCBS in 1993 to over half of Medicaid LTSS recipients age sixty and older receiving services in the community in 2017.

A second way to examine system balancing is by tracking Medicaid expenditures. Expenditure data is more readily available for national comparisons, and while NHs are generally more expensive than HCBS, the trends are similar. In 1994, 7.5% of Ohio's Medicaid expenditures for individuals age sixty and over were spent on HCBS. By 2017, the proportion had increased to 37%. Ohio recorded the third highest increase in state HCBS spending (12.7%) between 2012 and 2016 (Eiken et al., 2018).

In the past, a common concern from policy-makers was that an expansion of HCBS would add costs to the LTSS system. Essentially, some argued that expanding HCBS by adding to an already high-cost system was bad policy. Figure 3 shows that, despite an increase in the population eighty-five and over—the group most likely to need LTSS—the proportion of adults age sixty and over relying on Medicaid LTSS has remained stable during an

era of tremendous home care expansion (31.8/1,000 age sixty and older in 1997 to 32.4/1,000 age sixty and older in 2017). This provides clear evidence that the hypothesized "woodwork effect" did not occur (Berish et al., 2019). While findings demonstrate that the Medicaid utilization rate for individuals age sixty and older remained constant over the twenty-year time period, the way Medicaid spent funds changed. The NH utilization rate of 24.5/1,000 older individuals in 1997 dropped to 14.5/1,000 in 2017, while the HCBS rate went from 7.3/1,000 to 17.9/1,000.

Profile Changes of the Nursing Home Population

A review of the profile of NH residents reinforces industry changes. The shift to more short-term care has been coupled with a change in the profile of residents. As shown in Table 2, today's nursing facility residents are less likely to be female (63% vs. 74% in 1995), and more likely to be married (24% vs. 16%). One of the surprising trends has been an increase in facility use by individuals under age sixty-five, increasing in Ohio from 9% in 1996 to 19% in 2018. Nationally, the percentage of NH residents under the age of sixty-five has grown as well, increasing from 10% in 2000 to 16.5% in 2016 (Harris-Kojetin et al., 2019). Several factors contribute to this increase, including psychiatric hospital closures, a short supply of community behavioral health services, increased rates of obesity and associated chronic diseases, and limited housing alternatives for individuals with disabilities (Fashaw et al., 2019; Jervis, 2002; Kaldy, 2012; Mullins, Mushel, & Hermanns, 1994; Persson & Ostwald, 2009; Shapiro, 2010; Smith, 2004). Our review in Ohio also suggests that a sizable portion of the residents under sixty-five may not be in the best place to receive long-term services, with critics suggesting that the community mental health system has not kept pace with this growing population. About half of these younger Medicaid residents have a diagnosis of severe mental illness, a trend that has increased in recent years (Nelson & Bowblis, 2017). Over one-quarter of these individuals (28.0%) had zero or one impairment in activities of daily living, which appears to be below the eligibility threshold for Ohio's level of care qualifications for Medicaid NH care.

Policy Challenges in a Changing World of Long-Term Services

These data paint a picture of an industry that has changed dramatically over the past two decades. Some of these shifts represent policy ideas that were part of bipartisan legislative and administrative initiatives designed and implemented by Ohio policymakers. Other changes were driven by federal policies, industry strategies, or facility reactions to the market. In sum, the LTSS system is dramatically different from the system of twenty-five years ago. While it is difficult to link specific policy decisions to specific outcomes, what we know is that these factors working in concert resulted in a dramatically changed LTSS system. Despite these impacts, our contention is that state and federal policies

Table 2 Demographic Characteristics of Ohio's Certified Nursing Facility Residents over Time, 1996, 2006–2018

	1996 (Percentages)	2006 (Percentages)	2012 (Percentages)	2014 (Percentages)	2016 (Percentages)	2018 (Percentages)
Age						
45 and under	2.6	2.7	2.3	2.1	2.1	2.1
46-59	3.8	9.1	10.4	10.4	9.9	9.5
60-64	2.6	4.5	6.4	6.5	7.1	7.6
65-69	4.4	5.9	7.9	8.3	9.6	9.7
70-74	8.1	8.1	9.5	9.7	9.9	11.0
75-79	13.1	13.2	12.0	12.1	12.3	12.9
80-84	18.7	19.2	16.4	15.3	14.5	14.4
85-89	21.2	19.4	18.2	17.6	16.7	15.3
90+	25.5	17.9	16.9	18.0	17.9	17.5
Average Age	80.7	78.4	77.3	77.5	77.2	77.0
Gender						
Female	73.5	68.5	65.5	65.1	63.8	62.8
Race						
White	88.3	86.3	86.0	85.5	85.3	84.5
Marital Status						
Never married	13.8	15.1	16.1	16.7	17.9	19.0
Widowed/Divorced/ Separated	70.7	63.7	58.7	59.9	57.9	57.3
Married	15.5	21.2	25.2	23.4	24.2	23.7
Population	80,417♦	92,297♦	107,737*	101,279*	100,881*	97,305*

have not adapted to today's changed system or the challenges ahead. In fact, recent efforts to roll back federal regulations in the NH sector appear to be in direct conflict with the increasing levels of disability experienced by today's NH residents. On the financing side, while there has been a dramatic shift in how Medicaid funds are used, the reliance on Medicaid as the major long-term financing approach fails to reflect the fact that the majority of elders are not eligible for the Medicaid program. This structural lag in financing and regulatory behaviors create a problem as we look to develop a LTSS system that will work for the large wave of boomers coming down the road. Based on the changes experienced over the past two decades, we have identified a series of policy challenges that need to be addressed to ensure a high-quality long-term services system in the future.

Implications for a New Long-Term Services System

Pre-Admission Screening

As noted, one of the biggest policy challenges is that some traditional long-term services, such as the NH, are not long-stays for many residents. The dramatic increase in short-term NH stays has major implications for program policies and procedures. For example, in 1993, Ohio implemented an extensive pre-admission screening and resident review requirement for individuals being admitted to Ohio's skilled nursing facilities. At that time there was a concern that individuals were entering NHs inappropriately, because of limited HCBS options and limited information to consumers about possible HCBS alternatives. In 1993, when pre-admission screening was initially implemented, about 60% of those admitted continued to reside in the facility after three months, compared to 16% two decades later. Ohio continues to spend considerable resources conducting pre-admission reviews for individuals who will stay only a short period of time.

The challenge is that while the current approach needs modification, there are still individuals admitted to skilled nursing facilities who would benefit from a pre-admission screen. Sometimes these individuals enter as short-term rehabilitation admissions but become long-stayers; efforts to identify these individuals are critical. An improved method for identifying mental health needs of those being admitted is also important in today's system. Individuals with behavioral health conditions might enter facilities under appropriate circumstances, but there is no required post-admission review. A delayed assessment might be considerably more practical than a pre-admission review for admissions.

Quality and Regulation

A second challenge involves the quality and regulatory models in place. For example, our state and national regulatory efforts for NHs remain anchored in the annual survey, which has become predictable for providers. Despite a number of federal initiatives, such as the creation of a Special Focus Facilities

program for low-quality NHs, the provision of public consumer information and quality measures through Nursing Home Compare, and the modification of the survey process to involve quality processes, poor quality facilities remain. In fact, recent trends indicate a shift in federal policies designed to reduce regulatory requirements and to limit resident litigation rights. With a resident population experiencing higher acuity rates and a higher proportion of long-stay residents experiencing dementia, improving regulatory approaches continues to challenge the system.

The expanded HCBS system means that improvements in quality approaches are needed also in this sector of the LTSS industry. HCBS and even assisted living are often limited in regulatory scope. For example, Ohio does not license HCBS providers, although most have an affiliation with a payer such as Medicaid or Medicare that does require specific structures and processes. Assisted living is largely private-pay, with individual states setting their own requirements for licensing. Despite a dramatic expansion of HCBS, quality approaches and measures are not systematically implemented across the nation. A recent, but unsuccessful effort by the National Quality Forum to develop uniform HCBS quality measures highlighted a continued lack of consensus in this area. While we celebrate the expansion of options for individuals to live in their setting of choice, improvements in HCBS quality strategies remain a priority for states and the federal government.

Reimbursement

Another question involves the reimbursement approach. Medicaid has long been viewed as the long-term public funding mechanism for NHs, while Medicare was the short-term rehabilitation funder of services. One surprising finding from our work is that many Medicaid admissions are also for short stays, with 72% of these individuals discharged within three months. Should there be a differing reimbursement rate for short- and long-term individuals using Medicaid? Many states attempt to control Medicaid expenditures by either cutting reimbursement rates, or moving to managed Medicaid LTSS, leaving facilities unclear about state priorities for services. A review of financing and regulatory policies is necessary.

Workforce Challenges

Long-term services, regardless of setting, will remain a labor-intensive and personal set of services. Our most recent survey of NHs found an annual average retention rate of 60% of state-trained nursing assistants. In some facilities, those rates were below 20%. Ohio's in-home care providers also report workforce challenges. The LTSS worker shortage is one of the most critical challenges now facing long-term service providers. Wages and benefits, staffing patterns, organizational structure, market conditions, and a host of other factors have been shown to impact workforce quality and rates of turnover. For example, a recent study reported higher nursing assistant retention was a significant predictor of fewer

NH deficiency citations (Castle et al., 2020). Our data show that even in similar labor markets, variation in retention rates is significant, suggesting that technical assistance and administrative and policy changes can have a considerable impact in this area. As a result, researchers continue to investigate the effects of managerial practices, including empowerment and consistent assignment, organizational culture, financial benefits, and the working environment on NH workforce stability.

Impacts of the Under Sixty-Five Age Group of Nursing Home Residents

Nearly one in four Ohio NH residents are under the age of sixty. About 45% of this group stay three months or less, suggesting that Medicaid has become a short-term rehabilitation funding source for many younger participants. However, three in ten of the under-sixty age group are NH residents for one year or more. This age group generally has lower overall rates of disability, which raises questions about the appropriateness of the NH setting for these individuals. As Ohio has expanded HCBS options, considerable efforts have been made to ensure individuals of all ages reside in the most appropriate setting. A recent evaluation of the Money Follows the Person program found that Ohio had the largest number of transitions from NHs to the community in the nation in 2015 and 43% of those leaving the facilities were individuals with mental illness (Irvin et al., 2017). A comprehensive study of the factors contributing to younger residents' longer stays in NHs is warranted.

Shifting from the Medicaid Paradigm

More than half of all older people in Ohio with severe disabilities use long-term services funded through the Medicaid program. If the disability rate remains constant between now and 2040, the economic pressures to the state could overshadow other areas of need. Today, 90% of older people living in the community do not use Medicaid, but two-thirds of NH residents rely on the program. Moderate- and middle-income elders typically do not turn to Medicaid until they require NH care or their disability becomes so severe that they need substantial assistance at home or in assisted living. A proactive question to consider is how to reduce the proportion of older people that will need Medicaid assistance.

Several recent studies have identified the importance of supportive services, such as home-delivered meals, homemaker assistance, and transportation for groceries and medical appointments on the use of NHs by individuals with low-care needs (Thomas & Mor, 2013). As an example, the AARP Long-Term Services and Supports Score Card reported that 11.2% of Ohio's NH residents are considered low care, giving Ohio a ranking of 25th. With services and support, those low-care residents can often reside in the community. The best state in the nation had a rate of 4.1% (Reinhard et al., 2017). Today supportive services available through

the federal Older Americans Act are inadequate. Therefore, it will be critical to provide resources to target supportive and preventive services to those with moderate levels of disability and moderate-income levels to prevent premature reliance on Medicaid.

Conclusion

This paper has documented the tremendous changes that have occurred in the long-term services and support system, using Ohio as an example of a state that has made dramatic changes based on dedicated policy efforts. The shifts that have occurred in Ohio were unexpected and in fact were deemed politically unimaginable two decades ago. The changes have been dramatic and are the result of an array of public and private decisions. Despite this progress, the challenges of tomorrow are more daunting than the hurdles we have already faced. As the population of older people with disabilities continues to increase, it will be critical to adapt our approach to delivering, financing, regulating, and staffing our system of long-term services and supports. Future policy decisions will indeed matter.

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