The Importance of Long-Term Services and Supports to a High-Performance Rural Health System: Demographic, Policy and Economic Challenges

Prepared by the RUPRI Health Panel
Alva O. Ferdinand, DrPh, JD
Mark Holmes, PhD
Alana D. Knudson, PhD
Jennifer P. Lundblad, PhD, MBA
A. Clinton MacKinney, MD, MS
Timothy D. McBride, PhD
Keith J. Mueller, PhD (Chair)

Guest Author:
Hari Sharma, PhD

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PURPOSE AND INTRODUCTION

The RUPRI Health Panel has established a vision of a high-performing rural system, with the pillars of affordability, accessibility, high-quality care, and community health and built upon a foundation of meeting the health needs of all rural residents.[1] The Panel reaffirms its early attestation that long-term services and supports (LTSS) provide vital medical and social support. Services and supports include residential care in long term care facilities, support in assisted living, home health care, and home and community-based services such as assistance with meals and home modifications such as wheelchair ramps) for those who are 65 and older and those with disabilities, groups that represent a large and growing segment of the rural population.[2] As such, LTSS are a critical component of the high-performing rural health system.

Transforming the rural health system for LTSS faces considerable challenges driven by demographic, economic and policy forces. Payments for older adults and disabled populations represented over half (50.6%) of all spending for the Medicaid program in 2023 (Figure 1). In 2023, public sources account for about 70% of the $563.7 billion spent on LTSS, with Medicaid covering over 45% of the spending (Figure 2).[3] Those payments may be at risk due to planned expenditure reductions to Medicaid over the 2026-2034 period, representing 14% and 36% of federal and state spending for Medicaid, respectively.[4] As states adjust to reduced federal revenues, all Medicaid payments will be at risk even if not explicitly targeted by changes in federal policy. *The purpose of this Policy Brief is to assess potential impact of The One Big Beautiful Bill Act of 2025 (HR 1) on sustaining LTSS in rural areas as an important element of a high performing rural health system*.

BACKGROUND

Recent trends in population characteristics, availability of health care resources (facilities and workforce), and ability to pay for services (affordability and health insurance) accentuate the challenges of caring for older adults in rural America. Further stressing the health care system serving the older population is the need for the same LTSS for a younger population with long term disabilities. As public policies affect capacity to meet the increasing demand, such as the upcoming reductions in Medicaid revenues through changes to eligibility, innovative approaches will be required to sustain a high performing rural health system. We summarize the trends in this background section. Reacting to those trends, many states included specific actions to meet health needs of older populations in their rural health transformation program proposals.

Changes in Rural Populations

Population is getting older: The United States is undergoing a major demographic shift. Nationally, approximately 17.7% of the population was over age 65 in 2023, but the rate was higher in rural communities at 24%.[5] The U.S. population continues to get older, and about 20% will be over 65 by 2030[6], when older adults will outnumber children for the first time in US history.[7] For all age groups over 55, the proportion of the population in each age group is higher in rural areas than it is in urban areas in each age group from age 55-84 (Figure 3). Additionally, the number of people 85 years and older is

projected to nearly double by 2035 (from 6.5 million in 2019 to 11.8 million in 2035).[8] This cohort of older urban and rural adults are more likely to need LTSS.

Diversity of Older Rural Americans: The U.S. population is becoming more diverse racially and ethnically, including in rural areas, with Asian, Hispanic, and multiracial populations projected to more than double in the next two decades. This growth in diversity has consequences for development of programs serving these populations, based on different cultural needs.

Chronic diseases: Rural areas face higher rates of chronic diseases, which increase the need for LTSS: 27.8% of people living in nonmetropolitan areas had two more chronic conditions, compared to 23.1% of those living in metro areas in 2017.[9] An analysis of the ten most prevalent and costly diseases showed that the highest prevalence areas were in smaller population size areas and that residents need to travel longer distances for health care services, characteristics that are typical of rural places.[10]

Changes in Resource Availability

Closures of rural nursing homes. Despite the increasing needs for LTSS, nursing homes have been closing in rural and urban areas. The number of active nursing homes has declined from 15,661 in 2018 to 14,731 in 2026. [11]The closures of nursing homes are not uniform across geography, and this has implications for access to LTSS for rural populations. When compared to urban ZIP codes, rural ZIP codes experiencing nursing home closure had higher distances to the closest nursing home providing post-acute care (6.4 vs. 0.94 miles) and long term care (LTC) services (7.2 vs. 1.1 miles); distances to the closest providers with LTC services were even higher for rural ZIP codes experiencing nursing home closures or with no nursing homes (about 6.1%of rural ZIP codes with nursing home closures and 15.7% of rural ZIP codes with no nursing homes had no PAC or LTC providers within 25 miles).[12] There has been a long term trend towards the closure of nursing homes in the U.S. and a shift towards other parts of the LTSS continuum (e.g., home health, adult day care, assisted living), but challenges remain in meeting the LTSS needs, especially in rural areas. But those alternatives are less likely to be available in rural areas as compared to urban areas.

Workforce. Workforce challenges to serve the LTSS population remain a challenge and became particularly intensified during the pandemic, when workers left LTSS for other sectors. For example, a recent analysis found that less than one in five (19%) of nursing facilities currently meet three posited staffing minimums, which include 3.48 hours per resident day (HPRD) overall, 0.55 registered nurse HPRD, and 2.45 nursing assistant HPRD.[13] In recent years, employment in LTSS has recovered to some extent. However, staffing challenges in LTSS have not been adequately addressed. Many nursing homes have empty beds, but they are unable to accept new residents if they cannot adequately staff. CMS has recently initiated a “Improving Care Through Increased Staffing” campaign that will include financial incentives for nurses, and training opportunities for CNAs, among many others. However, concrete efforts to recruit and retain staff in rural nursing homes are needed to sustain rural nursing homes and other LTSS providers.[14] As the population grows older, and in particular as the population over age of 85

and with chronic health care grows, needs for appropriate levels of staffing for LTSS will become more challenging in rural areas.

Ability to Pay for LTSS

Ability to finance public health and income support programs: An increasing population of older Americans with multiple health care needs requiring clinical and personal intervention creates challenges for social programs. Supply of health care and other workers may not keep pace: the worker-to-beneficiary ratio will decline from 3.4 in 2000 to 2.5 in 2030 (see Figure 4)[15], making it difficult to grow programs that support older people in the U.S., such as Medicare, Medicaid, and Social Security. The worker-to-beneficiary ratio is 2.5 in remote rural areas in 2023, while the ratio is 3.4 in urban areas.[16] Beyond the paid workforce, the increasing numbers of older Americans stress the capacity of informal caregivers, who in turn require support services.

Affordability issues: Older adults face many issues related to health care affordability; nearly 30% of Medicare beneficiaries in 2022 spent more than 20% of their income on health.[10] Long-term care costs are high with an annual nursing home stay costing more than $119,000 for a shared room. [17]On a broader level, several factors affect affordability including higher health spending with age, low income and asset levels in retirement, and poor protection against out-of-pocket costs in Medicare. Affordability is an even greater problem for people from historically marginalized backgrounds, and for those with chronic and disabling conditions.

Long-term care insurance is not working: Only 3-4% of Americans 50 or older purchase long-term care insurance even though a large majority of individuals 65 and older will eventually need some form of long-term care. Several factors likely explain a low proportion of people buying long-term care insurance including high premiums, low expectation about the need, and Medicaid coverage of LTSS.[18]

Rural Health Transformation Programs

As of March 2, 2026, all 50 states received notification of funding from the Centers for Medicare and Medicaid Services (CMS) and submitted final work plans consistent with the level of funding awarded (Ranging from $147 million to $281 million for the first year). A review of those plans by the National Academy for State Health Policy found actions in these areas (selected from a list of 12):

- Workforce initiatives targeting services such as direct care in 33 states
- Long term care system support in 32 states
- Initiatives to serve dually eligible individuals in 25 states
- Supporting family caregivers in 11 states
- Create or support Program of All-Inclusive Care for the Elderly in 10 states.[19]

UNINTENDED CONSEQUENCES OF CHANGES TO FEDERAL MEDICAID POLICIES

Medicaid policy changes enacted in H.R. 1 will have the intended effects of reducing national Medicaid expenditure by an estimated $911 billion over a ten-year period, based on KFF calculations using Congressional Budget Office projections.[20] Estimates are that spending reductions in rural areas will amount to $137 billion over that period.[21]

Reductions in federal spending for Medicaid are achieved through changes in eligibility or payment limits. Eligibility changes, including work requirements, changes to rules that streamline eligibility determination and enrollment, and more frequent verification of enrollment, will reduce the likelihood of people being insured and therefore increase uncompensated care. Changes in payment policies, including reducing the ceiling for provider taxes and state directed payments, will reduce revenues to health care providers. Healthcare providers affected by any increase in uncompensated care include hospitals and clinics. However, other providers engaged in LTSS, including nursing homes and home health agencies, could be affected in two ways: by an increase in clients without Medicaid coverage (dually eligible Medicare beneficiaries, young adults with disabilities that lose eligibility because of redetermination) or by losing supplemental payments or state directed payments. In addition to direct effects, there could be indirect effects because of adjustments made by state Medicaid programs to compensate for reduced federal revenue. According to the Congressional Budget Office (CBO), Medicaid spending reductions are likely to be achieved through the following: 36% through work requirements, roughly 19% through repealing eligibility and renewal processes, 21% through cuts in the growth of provider taxes, 17% through payment limits for state directed payments, and 7% through more frequent verification of enrollment (see Figure 5). Most of these provisions are aimed at Medicaid recipients age 19-64; however, some policy changes are not limited to certain age groups (e.g. the provider tax and state directed payment provisions), and LTSS services are not exclusively used by older adults. In all cases, how states respond to these cuts in federal payment will determine the direct impact on Medicaid recipients, providers, and communities including rural people and businesses.

The *intended* consequence of these changes will be to lower federal spending and reduce the number of individuals (particularly adults aged 18-65, (although one of the effected rules is for enrollment of dually eligible Medicare beneficiaries) eligible for Medicaid enrollment. However, achieving those spending reductions may have *unintended* consequences, through changes in revenues supporting patient care without offsets in the costs of maintaining services. For example, Idaho's response to a budget shortfall in Medicaid was to reduce reimbursement rates for 4 percent for nursing homes and other providers, which may foretell similar actions there and in other states (North Carolina nursing homes face a 10 percent rate cut).[22] Given the reality that a high percentage of Medicaid spending is for long-term supports and services, the unintended consequences of reducing federal revenues supporting Medicaid programs may affect older and disabled populations not intended to be directly affected.

Some states could choose to meet the federal payment cuts by raising state payments to offset the payment cuts (perhaps by raising taxes or cutting payment in other areas), potentially leading to some "unintended implications" from the policy enacted. In other states, if they choose not to raise taxes or cut spending elsewhere, the state will need to cut Medicaid spending to balance the state budget. This could be done through a range of policy changes including reducing reimbursement to providers, eliminating or reducing optional services (including waivers or Medicaid expansions) provided under Medicaid (e.g., dental, mental health, HCBS, adult expansion). Since (Figure 1) over half of Medicaid

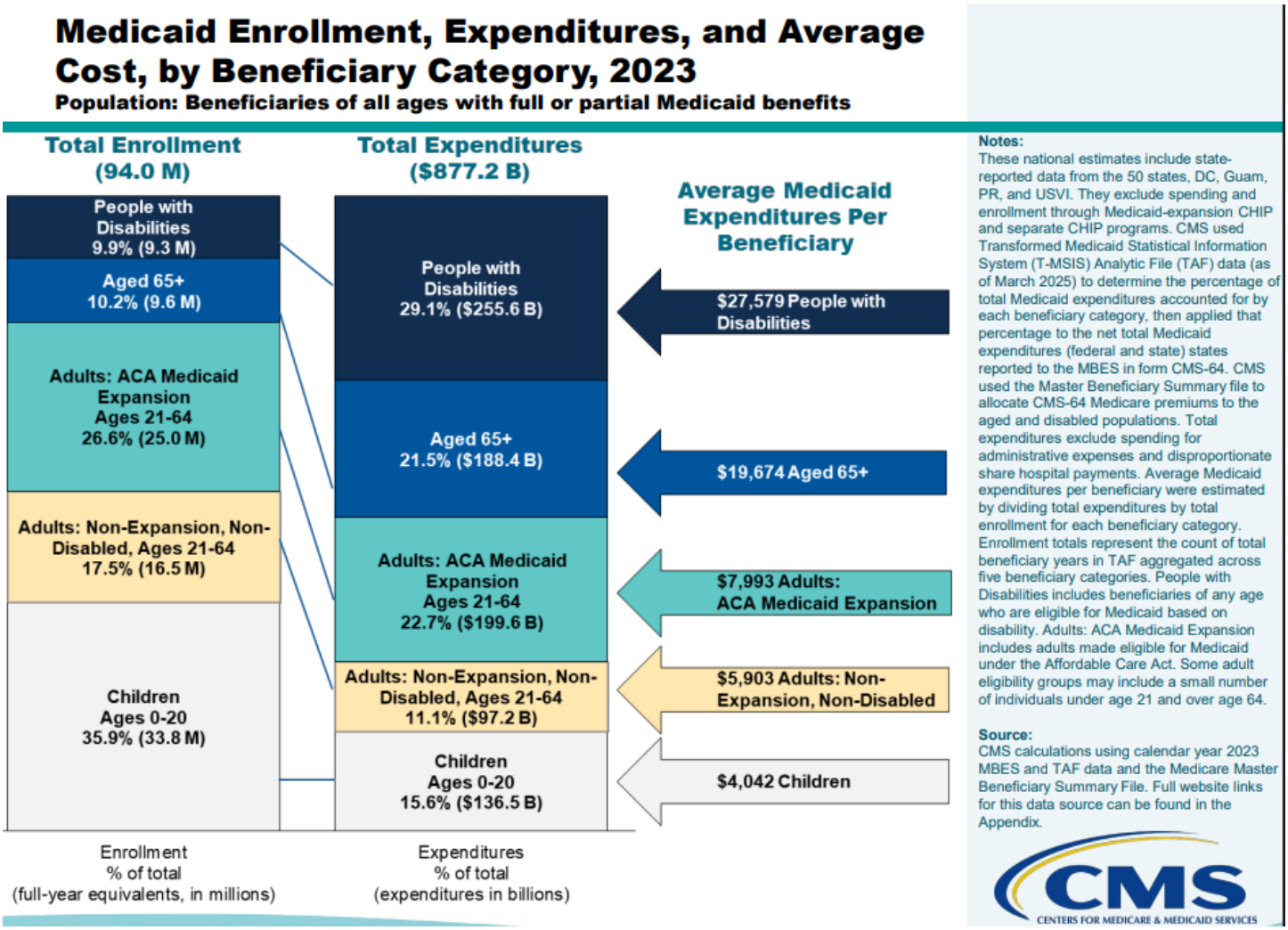
spending nationwide is allocated to the older adults, blind and disabled populations (including LTSS), the services and payments to these recipients will be at risk in many states. States that use state directed payments to support LTSS providers such as nursing homes may choose to reduce payments (in contrast to providing the same level of support from state sources without a federal match).

CONCLUSION

This *policy brief* explored two major themes. First, the policy landscape affecting LTSS in rural America is undergoing substantial changes in population characteristics (older population with multiple chronic conditions), health care resources (facilities and workforce) and finance (pressure on health expenditures generally and on payment for LTSS specifically). Second, forthcoming major changes in federal Medicare policies are projected to reduce payments currently available to rural healthcare providers, including LTSS. The combination of those themes is reason to consider unintended consequences of H.R. 1, preparing to address any adverse consequences with mitigating actions within the health care system and policy adjustments. As of this writing in early 2026, we cannot be certain of all effects, but we can nonetheless acknowledge possibilities as we continue to build a high performing rural health system.

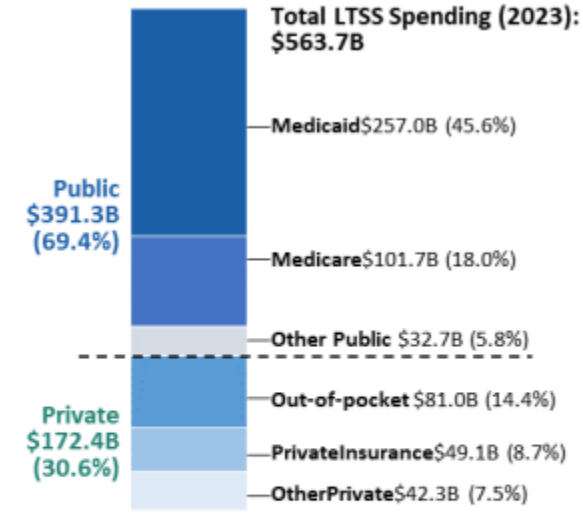
APPENDIX

Figure 1. Medicaid Coverage and Expenditures



Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2026.pdf

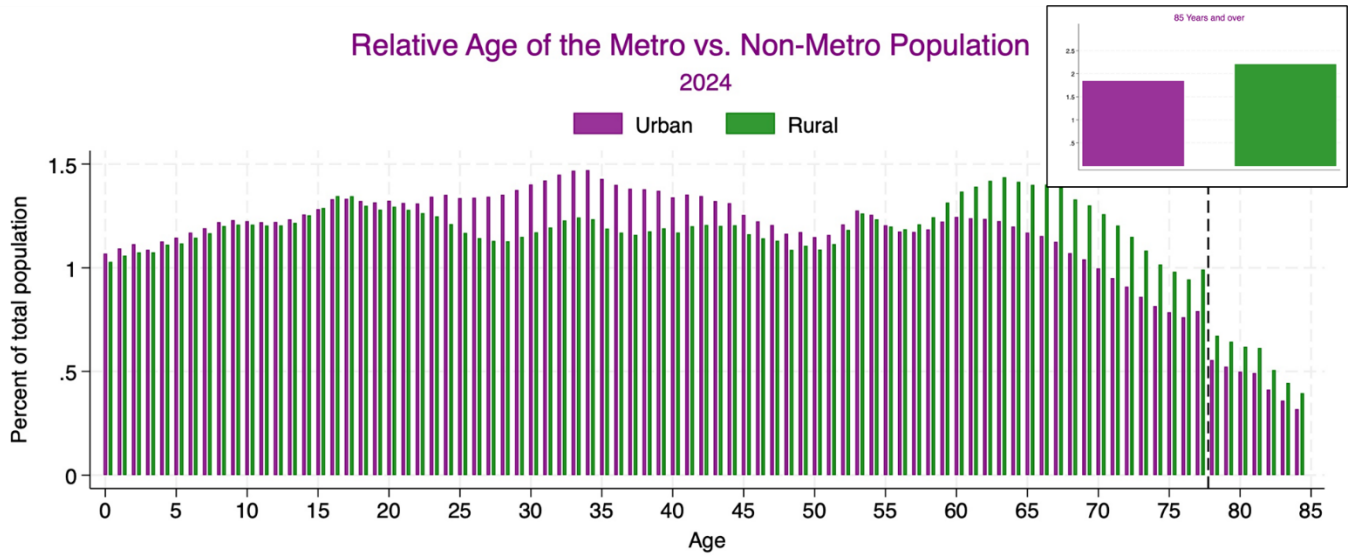
Figure 2. Long-term Services and Supports (LTSS) Spending, by Payer, 2023 (in billions)



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2024.
Notes: Analysis includes Medicare post-acute care spending in an expanded definition of LTSS spending. Percentages may not sum to 100% due to rounding.

Source : https://www.congress.gov/crs-product/IF10343

Figure 3. Age Distribution by Rurality



Data source: Annual County and Puerto Rico Municipio Resident Population Estimates by Single Year of Age and Sex: July 1, 2024 (U.S. Census Bureau).
Metro status as of 2023. Dashed line denotes age of those born in 1946.

Figure 4. Covered Workers-to-beneficiaries Ratio, 1980-2060.

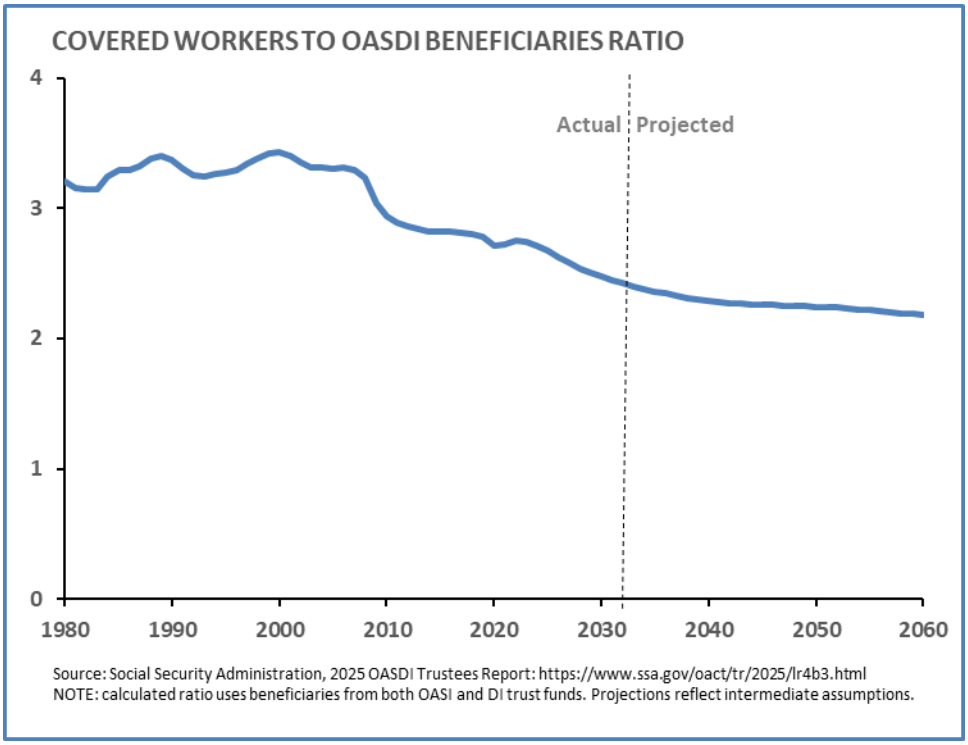
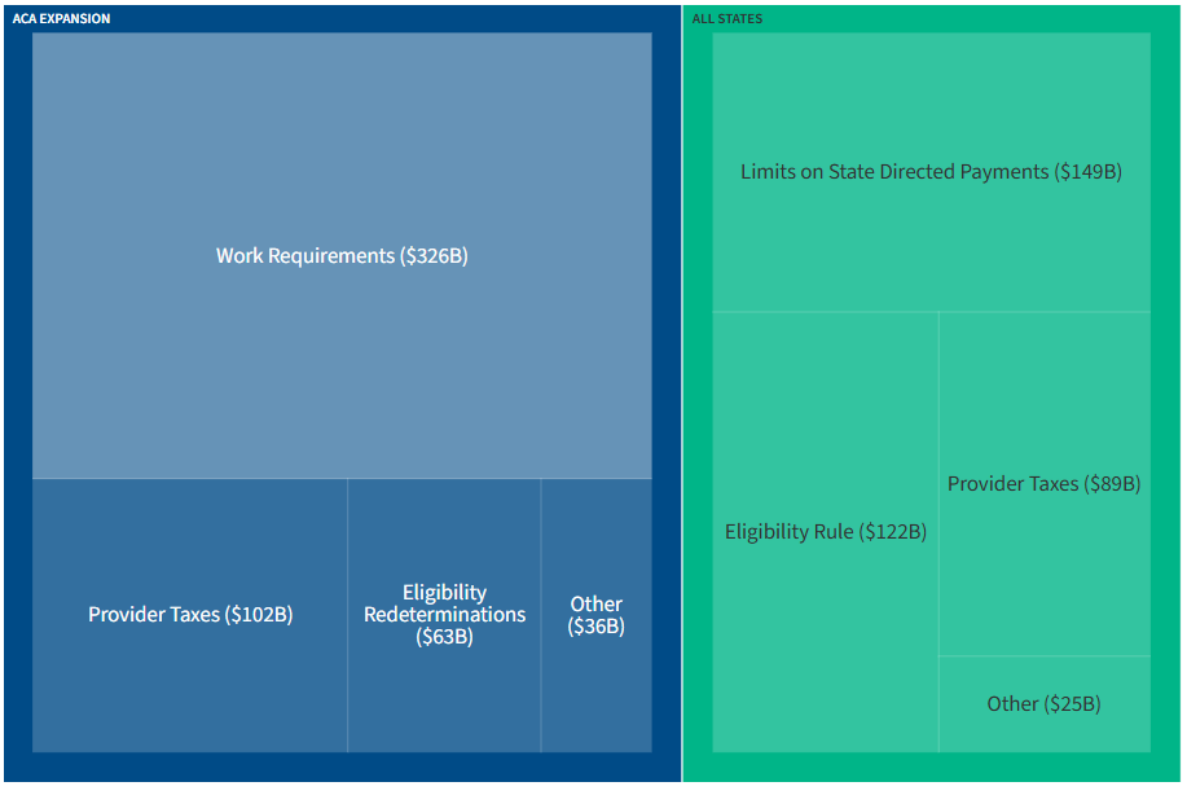


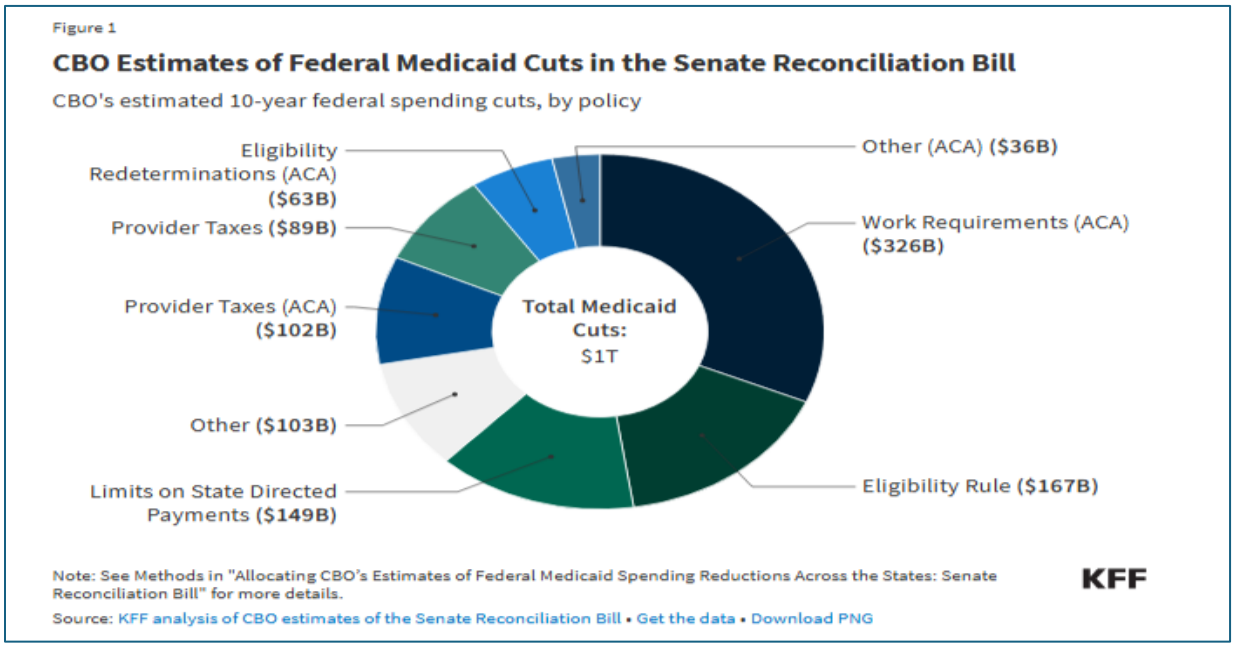
Figure 5. Estimates of Federal Medicaid Cuts in Senate Reconciliation Bill, 2026-2034



Note: Over the 10-year period, the Medicaid spending reductions total $911B, including $79B in estimated Medicaid spending interactions. Without accounting for interactions, the total is $990B. See Methods in "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package" for more details.
Source: KFF analysis of CBO estimates of the enacted reconciliation package

KFF

Source: https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/



ENDNOTES

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