Long-Term Services & Supports: What's New & What's Next

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Introduction & Objectives

Long-Term Services and Supports (LTSS) are services assisting individuals with daily living over an extended period, supporting aging, chronic illness, or disability.

Presentation Objectives:

- Current Landscape and the Impact of the Reconciliation Bill
- Trends and Policy Outlook

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The Clients We Serve

Aging and Disability Demographics

Examining the changing landscape of our client populations and how these demographics shape LTSS

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Aging Demographics

By 2030, one in five Americans will be 65+ as our population continues to age dramatically:

14.2%
Growth Rate
Fastest growing demographic segment from 2025-2030

71.6M
Seniors by 2030
Up from 62.7M in 2025

20.7%
Population Share
Seniors will exceed youth population (20.2%)

For the first time in US history, seniors will outnumber children by 2030, creating unprecedented challenges.

Data from Claritas Pop-Facts 2024

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Disability Demographics

Disability rates increase dramatically with age. Americans with disabilities face unique legal and financial challenges, including higher poverty rates (22% vs. 11% for those without disabilities) and increased healthcare needs, highlighting the importance of disability-focused elder law advocacy.

46%
Ages 75+
Nearly half of elderly Americans report having a disability, presenting significant elder care challenges

24%
Ages 65-74
One in four Americans in early retirement years face disability-related needs

12%
Ages 35-64
Working-age adults show lower but still significant disability rates

8%
Under 35
Youngest adult demographic has the lowest disability prevalence

Data source: Census Bureau's 2021 American Community Survey (ACS)

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Long-Term Care Cost Trends - Nationwide

The 2024 Genworth Cost of Care Survey reveals significant increases in long-term care expenses, creating additional financial pressure on aging Americans and their families:

$111,325
Semi-Private Nursing Home
7% increase from 2023

$127,750
Private Nursing Home
9% increase from 2023

$70,800
Assisted Living
10% increase from 2023

$297,840
24/7 Home Care
3% increase from 2023

Assisted living occupancy rates jumped from 77% to 84%, potentially driving costs higher as demand outpaces available facilities. These rising costs highlight the critical importance of proactive long-term care planning for aging clients.

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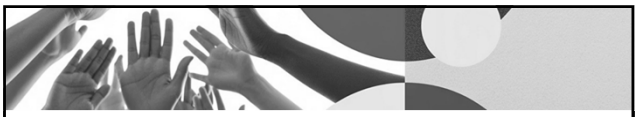

What are Long-Term Services and Support?

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Understanding Long-Term Service & Supports (LTSS)

LTSS encompasses a wide range of medical and non-medical services for people with disabilities or chronic conditions who need assistance with daily activities over an extended period. These services help maintain dignity, independence, and quality of life.

Home & Community-Based Services
Support services delivered in private homes or community settings, allowing individuals to maintain independence while receiving necessary care.

Institutional Care
Comprehensive services provided in nursing homes, assisted living facilities, and other residential settings for those needing 24-hour supervision.

Caregiver Support
Resources and assistance for family members providing unpaid care, including respite services, training, and counseling.

Financing Options
Funding mechanisms including Medicaid, Medicare, private insurance, and personal savings that help cover the rising costs of long-term care.

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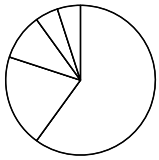
LTSS Funding Sources Nationwide



Long-term services and supports are extremely expensive and not generally covered by Medicare or health insurance. The primary funding for Long-Term Services and Supports (LTSS) in the United States is through public programs like Medicaid, which covers the largest portion. However, a significant burden falls on individuals and families through out-of-pocket payments, highlighting the need for comprehensive financial planning for long-term care. Medicare provides limited coverage, primarily for skilled nursing and rehabilitation, while private long-term care insurance accounts for a smaller percentage of overall funding.

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Medicaid LTSS Eligibility Criteria

Medical Criteria

- **Need for assistance with Activities of Daily Living (ADLs) such as bathing, dressing, eating, toileting, transferring, continence**
- **Cognitive impairment requiring supervision**
- **Nursing home level of care determination**
- **Physician certification of medical necessity**

Financial Criteria

- **Income limits (typically around 300% of SSI federal benefit rate)**
- **Asset limits (usually $2,000 for individuals, varies by state)**
- **Spousal impoverishment protections for married couples**
- **Look-back period for asset transfers (5 years)**
- **Home equity limits**

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Medicaid Key Numbers

- ☐ **SSI and Spousal Impoverishment Standards**
  Updated standards released for 2025 affecting long-term care eligibility and community spouse resource allowances. **Official guidance document available.**
- ☐ **Medicare Premium Updates**
  2025 Medicare Part B premiums and deductibles have been revised. Access the complete **CMS fact sheet** for details on adjustments affecting elder clients.

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State-by-State LTSS Comparison Resources

Medicaid Eligibility Income Chart by State (2025)
Interactive resource with monthly income limits for institutional, HCBS waiver, and regular Aged, Blind, Disabled Medicaid by state, including single and married limits.

KFF Medicaid State Fact Sheets
Kaiser Family Foundation's state fact sheets comparing Medicaid eligibility, enrollment, and coverage details including LTSS for all 50 states.

AARP LTSS State Scorecard
Provides data and narrative comparisons of state LTSS system performance including affordability, access, choice, quality, and family caregiver support with state rankings.

Medicaid.gov State Overviews
Official CMS resource with interactive profiles for each state's Medicaid and CHIP programs including eligibility pathways and program options.

NY NAELA's 50 State Medicaid Chart
Provides essential practice resources for elder law attorneys with comprehensive state-by-state Medicaid comparisons. **Available through NAELA**.

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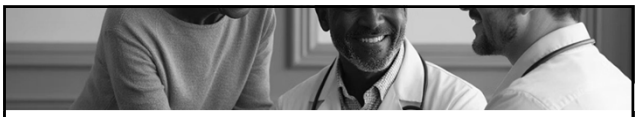

LTSS Models and Delivery Systems

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Core LTSS Models

Long-Term Services and Supports (LTSS) are delivered through different models, evolving to meet diverse needs while focusing on consumer preference and cost-effectiveness. The sector is undergoing a significant rebalancing trend. **Among the 6 million people who use Medicaid LTSS in the U.S., most are using HCBS (75%) and over half are under 65 (57%). Nationally more than 700,000 people are on waiting lists for HCBS, most of whom have intellectual or developmental disabilities.**

Institutional Settings

Traditional models providing comprehensive care in residential facilities.

- Nursing Homes
- Rehabilitation Centers

Rebalancing Trend

A strategic shift from institution-based care towards Home and Community-Based Services (HCBS), driven by:

- **Cost-efficiency:** Often more affordable than institutional care.
- **Consumer Preference:** Individuals prefer to receive care in their own homes and communities.
- **Policy Evolution:** Government initiatives and funding increasingly favor HCBS.

Home & Community-Based Services (HCBS)

Support services that allow individuals to live independently in their homes or communities.

- In-Home Aides
- Adult Day Care
- Remote Monitoring
- Family Support Programs

This transition emphasizes providing care in the least restrictive environment, aligning with individual autonomy and quality of life.

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Comparison of Institutional v. HCBS

	Institutional LTSS	Home & Community-Based Services (HCBS)
Setting	Licensed residential facilities (e.g., nursing homes, hospitals)	Individual's home, community centers, adult day care facilities
Service Delivery	24/7 medical and personal care in a structured environment	Flexible, personalized care; intermittent or ongoing support
Caregiver Types	Professional staff (nurses, therapists, certified nursing assistants)	Formal (paid aides, therapists) and informal (family, friends) caregivers
Medicaid Spending Share	Historically dominant, but declining	Rapidly increasing, exceeding institutional spending in many states
Cost	Generally higher due to facility overhead and intensive staffing	Generally lower, often more cost-effective for comparable services
Quality/Outcomes	Regulated environment, can sometimes lead to loss of independence; better for acute medical needs	Focus on autonomy, community integration, and higher patient satisfaction; varies by program
Patient Preference	Often considered a last resort; less preferred by most individuals	Strongly preferred by the majority of older adults and individuals with disabilities

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Managed Care Models for LTSS: Introduction

Definition: Managed Long-Term Services and Supports (MLTSS)

MLTSS deliver LTSS through capitated Medicaid managed care contracts instead of traditional fee-for-service models, aiming to improve coordination and cost-efficiency.

Growth & Adoption

24 states now operate MLTSS programs, with the majority integrating these services into broader Medicaid managed care plans, signifying a shift in long-term care delivery.

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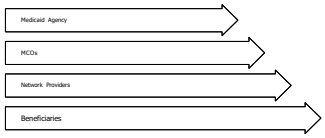
Features of Managed LTSS Models

Key Characteristics

- Capitated payments to managed care organizations (MCOs)
- Service coordination (acute, behavioral, and long-term care)
- Provider network management, quality oversight, outcome reporting
- Operate under federal authorities: Section 1115, 1915(b), 1915(c)



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Why States Use Managed LTSS

Predictable Budgeting

Allows for more stable and forecasted spending within Medicaid programs.

Service Rebalancing

Enables a shift of services from institutional settings to more preferred home and community-based care.

Improved Care & Efficiency

Fosters better care management, coordination, accountability, and overall operational efficiency.

Innovation & Integration

Provides a foundation for new models and integration with Medicare for dually eligible individuals.

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Challenges with Managed LTSS

Access Barriers
Many individuals face difficulties accessing necessary services due to complex eligibility criteria, lack of information, or geographic limitations, particularly in underserved areas.

Provider Network Limitations
Managed LTSS often struggles with an insufficient number of specialized providers and a lack of culturally competent care, leading to gaps in service delivery.

Care Coordination Problems
Fragmentation of services and poor communication among different providers can result in disjointed care, making it challenging to integrate medical and non-medical supports effectively.

Administrative Burden
Both members and providers encounter extensive paperwork, complex authorization processes, and significant delays in service approval, increasing frustration and inefficiency.

Quality Concerns
Ensuring consistent quality and measuring outcomes remain significant challenges, with variability in service standards and difficulties in guaranteeing truly person-centered care.

Member Advocacy Challenges
Members often struggle to navigate the complex system and advocate for their own needs, with limited support available for resolving disputes or ensuring their voice is heard.

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Trends & Future Directions for Managed LTSS

The landscape of Managed Long-Term Services and Supports (LTSS) is continuously evolving, driven by the need for more efficient, integrated, and person-centered care. Several key trends are shaping its future:

Growth of Comprehensive Plans
Managed care plans are increasingly covering the full spectrum of LTSS, moving towards a more holistic approach to member care.

Enhanced Management & Monitoring
There's an expanded focus on robust care management and rigorous outcome monitoring to ensure quality and effectiveness of services.

Evolving Integration & Quality
Statutory and quality measures are continuously evolving, with a trajectory towards further integration of services and improved accountability.

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LTSS Trends and Policy Implications

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LTSS Rebalancing

Rebalancing Effort

There's a significant national effort to shift LTSS away from institutional care towards HCBS, driven by:

- **Cost-effectiveness:** HCBS often provides care at a lower cost.
- **Consumer Preference:** Most individuals prefer to age in place or receive care in community settings.
- **Policy Evolution:** Federal and state policies increasingly incentivize and fund HCBS.

Impact on the System

This rebalancing aims to create a more person-centered, efficient, and sustainable LTSS system, but it requires:

- Robust workforce development for HCBS.
- Adequate funding and infrastructure for community-based programs.
- Integrated care coordination across settings.

Both institutional and HCBS models deliver similar clinical services but fundamentally differ in their cost structures, promotion of individual autonomy, and inherent risk profiles.

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Workforce and Provider Challenges

Increasing Demand

LTSS workforce demand is projected to grow significantly, an estimated 39% from 2022 to 2037, necessitating a substantial increase in skilled professionals.

Critical Shortages

Persistent shortages in direct care workers, coupled with high turnover rates and low wages, severely challenge the quality of care delivery and patient access to essential services.

Legal and Fiduciary Risks

Workforce supply issues carry significant legal ramifications, potentially impacting institutions' fiduciary and planning obligations, and increasing liability for LTSS providers.

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Disparities in LTSS Access

Equitable access to Long-Term Services and Supports (LTSS) is crucial, yet significant disparities persist across various demographics. These disparities, driven by factors such as income, race, and geographic location, exacerbate challenges for vulnerable populations and hinder their ability to receive necessary care.

Income Disparities

Low-income individuals often face substantial barriers to accessing LTSS, including affordability issues, limited insurance coverage, and fewer choices in care providers. This often leads to reliance on less formal, potentially inadequate, support systems.

For instance, 45% of low-income older adults report unmet LTSS needs, compared to 15% of high-income older adults.

Racial & Ethnic Disparities

Racial and ethnic minority groups frequently encounter systemic barriers, such as cultural insensitivity, language barriers, and historical mistrust of healthcare systems. These factors contribute to lower utilization rates of formal LTSS and poorer health outcomes.

Data indicates Black and Hispanic older adults are 50% more likely to rely on informal care compared to white older adults due to access issues.

Geographic Disparities

Access to LTSS can vary significantly based on geographic location, particularly between urban and rural areas. Rural communities often suffer from a shortage of qualified providers, limited transportation options, and fewer diverse care settings, leaving residents with fewer choices.

Rural areas have 60% fewer LTSS providers per capita compared to urban centers, limiting options for residents.

Illustrative statistics based on common trends in LTSS access research.

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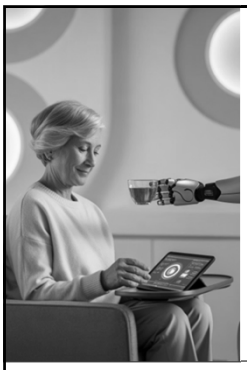

Technology & Innovation in LTSS

Growing Role of Technology
Wearables, telehealth, remote monitoring, digital twins, and home sensors are increasingly integrated into LTSS, transforming care delivery.

Workforce & Care Enhancement with Oversight
Technology can ease workforce shortages and enhance care, but requires robust legal oversight for contracts, privacy, and patient safety protocols.

Elevated Legal Risk & Complexity
Electronic health records (EHRs), interoperability, and cross-system data sharing elevate legal risk and planning complexity for providers and institutions.

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New and Emerging Trends

Aging in Place Advancements
Integration of health, social services, and community-based support to enable individuals to remain in their homes as they age.

Person-Centered & Integrated Care
Models focused on complex needs, including intellectual and developmental disabilities (IDD) and behavioral health, ensuring holistic support.

Public-Private Partnerships & Housing
New collaborative models and innovative housing solutions are emerging to address long-term care needs effectively.

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Financing and Sustainability Concerns

Funding Model Debates
Ongoing political debate surrounds funding models, entitlement scope, and solutions for the "middle market" in long-term care.

Advocacy for Sustainable Solutions
There is strong advocacy for expanded public coverage and incentives to encourage private savings for long-term care (LTC).

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Budget Reconciliation - The OBBA

Key Medicaid & Medicare Provisions affecting long-term care planning, eligibility, and coverage

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State Funding & Provider Tax Cap: Impacts

Reduced Federal Medicaid Payments

Federal policy changes have lowered the overall Medicaid funding sent to states, tightening LTSS budgets and increasing cost pressures.

Stricter Provider Tax Cap

States now face new limits on how much provider-based taxes can be used for Medicaid matching funds, requiring major updates to state funding models.

Consequences for LTSS

- Fewer provider contracts and service cutbacks
- Longer waitlists and reduced access for clients
- Greater financial strain on individuals and families

☐ **Action Point:** Legal advisors and planners should prepare for possible reductions in LTSS availability and anticipate higher out-of-pocket costs as state budgets adapt to new constraints.

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Medicaid Expansion Changes

1

Effective January 1, 2026

Elimination of the temporary 5% Federal Medical Assistance Percentage (FMAP) increase for states that adopted Medicaid expansion under the American Rescue Plan

States will need to adjust budgets as this and other federal funding support ends or is reduced

2

Effective October 1, 2028

Introduction of **cost sharing up to $35 per service** for expansion adults with incomes 100-138% of Federal Poverty Level (FPL). The FPL for 2025 is $15,650 for a single person.

- Exemptions for primary care services
- Exemptions for mental health services
- Exemptions for substance use disorder treatments
- Prescription drugs limited to nominal cost sharing amounts

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Medicaid Work Requirements - Timeline & Implications

Effective December 31, 2026

Federal deadline for states to implement mandatory Medicaid work requirements for ACA expansion adults (ages 19-64)

Implementation Timeline

States can implement requirements earlier at their discretion, potentially creating a patchwork of implementation dates across the country

Coverage Impact

Beneficiaries denied or disenrolled due to work requirements will also be ineligible for subsidized Marketplace coverage, creating significant coverage gaps

Individuals must work or participate in qualifying activities for **at least 80 hours monthly** to maintain Medicaid eligibility

Work Requirement Exemptions:

- Pregnant individuals
- People with disabilities
- Medically frail individuals
- Caretakers of dependents f13 years

Vulnerable populations at highest risk include low-wage workers with variable schedules, rural residents with limited employment opportunities, and those with undiagnosed or undocumented health conditions.

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Home Equity Limits Reduced

New $1M Cap

Maximum home equity limit capped at **$1,000,000** regardless of inflation, eliminating automatic adjustments that previously protected seniors' primary residences.

Agricultural Exemption

Special provisions allow states to implement different requirements for homes located on farms.

Implementation: January 1, 2028

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Prohibits Enforcement of Important Access Rules

Eligibility and Enrollment Final Rule

Two-part rule aimed at streamlining Medicaid processes and reducing barriers to enrollment for Medicaid and Medicare Savings Programs.

Implementation Stopped

Variable deadlines across provisions with many already in effect. This Bill prohibits the Secretary from implementing, administering or enforcing certain provisions until October 1, 2034.

Delayed enforcement creates uncertainty for beneficiaries and advocates

These rules were designed to improve transitions between Medicaid, CHIP, and Marketplace coverage while eliminating enrollment barriers, but enforcement restrictions significantly limit their effectiveness for vulnerable populations.

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Enhanced Verification Requirements for Medicaid

1. **Bi-Annual Redeterminations**
   States must conduct eligibility redeterminations for Medicaid expansion adults **at least every 6 months** rather than annually, significantly increasing administrative burden and potential coverage disruptions.
   Effective: For renewals scheduled on or after December 31, 2026

2. **Enhanced Address Verification**
   States must implement robust systems to regularly update enrollee address information using "reliable data sources" to reduce returned mail and improper disenrollments.
   Managed care entities must promptly forward updated address information to the state.
   Effective: January 1, 2027

3. **National SSN Verification System**
   States must submit each enrollee's Social Security Number to a new federal verification system, creating additional administrative requirements.
   Effective: October 1, 2029

4. **Deceased Beneficiary Checks**
   States must review the death master file **at least quarterly** to identify and remove deceased beneficiaries from Medicaid rolls.
   Implementation timeline not specified

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Not So Beautiful - Impact on Retroactive Coverage

This reduction in retroactive eligibility significantly narrows the financial safety net for those who delay applying for Medicaid while receiving medical care, potentially increasing uncompensated care and medical debt.

Traditional Enrollees
Retroactive coverage limited to **two months** prior to application date

Impacts vulnerable populations including children, pregnant women, elderly, and disabled individuals

Expansion Enrollees
Retroactive coverage limited to **only one month** prior to application date

Affects adults ages 19-64 with incomes up to 138% of federal poverty level

Implementation
Effective Date: January 1, 2027
Gives states approximately 3 years to update systems and procedures

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Impact of the Bill on Nursing Home Care

Staffing Requirements Delayed
Prohibits HHS from implementing minimum staffing levels required by final rule until **October 1, 2034** 4 a decade-long pause affecting quality of care for nursing home residents. The rule required 3.5 nursing hours per patient per day.

State Requirements Still Apply

These changes could significantly impact quality of care and access to nursing home services for vulnerable seniors.

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LTCCC's Nursing Home Staffing Reports

The **Long-Term Care Community Coalition's reports** provide information on nursing home staffing, five-star ratings, special focus facilities, ombudsman programs, and more

- **Comprehensive Staffing Data**
  Detailed nurse staffing levels including administrative positions and contract staff ratios - statewide and for individual nursing homes
- **Beyond Nursing Coverage**
  Important non-nursing positions tracked, including administrators and activities staff
- **Multi-Level Analysis**
  Summary data at state, CMS region, and national levels with turnover rates and weekend staffing metrics

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IDD Providers Increasingly Acquired by Private Equity

Major Shift in Ownership

Intellectual Developmental Disability (IDD) service providers across the nation are increasingly being acquired by investment firms raising serious questions about implications for care quality.

Traditionally, providers of residential care, home health, personal assistance, and other services for people with intellectual and developmental disabilities were nonprofit or religious organizations.

Concerning Trends

Between 2013 and 2023 alone, there were more than 1,000 private equity acquisitions of disability and elder care providers.

Multiple private equity firms now employ tens of thousands of people serving those with disabilities, often operating under subsidiaries with various names that obscure their ownership.

Source: ***Private Equity Stakeholder Project***

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Private Equity Firms Buying Nursing Homes

5-13% **5%** **100%**

Ownership Range
The percentage of American nursing homes now owned by private equity firms ranges from 5% to 13%, with the upper range more likely due to complex ownership structures.

Confirmed Minimum
The Government Accountability Office reported that federal data shows at least 5% of nursing homes nationwide are owned by private equity firms.

Data Reliability
The GAO noted that federal ownership data is flawed, and the true number of private equity-owned facilities is likely higher than reported.

A new national study by the Private Equity Stakeholder Project found that private equity firms continue to purchase and then bankrupt nursing homes around the nation, raising serious concerns about quality of care and financial stability.

Related: **Deadline for Nursing Home Ownership Disclosure** delayed until August 1, 2025

Source: Private Equity Stakeholder Project

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Legal Considerations for Fiduciaries

Exploring the legal issues and responsibilities for individuals managing long-term care decisions.

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Key Fiduciary Duties in LTSS Decision-Making

01

Loyalty

Act solely in the best interests of the beneficiary, placing their needs above those of the fiduciary or other parties, especially when selecting or changing LTSS providers and programs.

02

Care and Prudence

Exercise the diligence, skill, and reasonable care of a prudent professional when researching, recommending, and securing appropriate LTSS options (e.g., facility-based, home care, managed models).

03

Stay Informed

Remain up-to-date on federal and state LTSS eligibility rules, funding changes, local service availability, and emerging best practices to inform recommendations and avoid coverage/ineligibility issues.

04

Impartiality

Balance the divergent interests and needs of all trust beneficiaries4such as those desiring home-based versus institutional care4and make fair, unbiased decisions.

05

Documentation

Maintain detailed, transparent records of LTSS-related research, communications, decision rationales, and applications to show compliance and defend actions if challenged.

06

Avoid Conflicts of Interest

Exclude any arrangements or recommendations that could benefit the fiduciary personally or otherwise compromise the beneficiary's interests (e.g., steering to affiliated providers).

07

Facilitate Access

Ensure timely and effective support for applications, transitions between care levels, benefit enrollment, and appeals, so beneficiaries receive needed services without avoidable delay.

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Financial Planning Tools for LTSS Qualification

Asset Protection Trusts

Establish irrevocable trusts to protect assets from being counted towards Medicaid eligibility, ensuring they are preserved for beneficiaries while still qualifying for long-term care services.

Spend-Down Strategies

Strategically reduce countable assets by paying for legitimate expenses, such as home modifications, medical bills, or purchasing exempt assets, to meet Medicaid's financial thresholds.

Medicaid-Compliant Annuities

Convert countable assets into an income stream through a specialized annuity that complies with Medicaid rules, allowing an applicant to qualify for benefits while providing for a spouse.

Caregiver Agreements

Formalize agreements to pay family members for caregiving services. This allows for fair compensation and can help spend down assets in a Medicaid-compliant manner.

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Medical Assistance Estate Recovery and LTSS

MERP requires states to seek repayment from the estates of deceased Medicaid beneficiaries for certain medical expenses paid by Medicaid on their behalf. This includes costs associated with nursing facility services, home and community-based services (HCBS), and related hospital and prescription drug services for individuals aged 55 or older, or for those of any age who received services in a nursing facility.

Assets Subject to Recovery

The assets subject to recovery primarily include those that pass through probate. However, states have the option to expand their definition of "estate" to include non-probate assets. Common assets subject to recovery include:

- **Probate Assets:** Real property (e.g., a home) and personal property (e.g., bank accounts, vehicles) held solely in the deceased beneficiary's name.
- **Non-Probate Assets (depending on state law):** In some states, MERP can extend to assets that avoid probate, such as joint tenancy property, assets in a living trust, life estates, or certain annuities. It is essential to understand your state's specific rules regarding estate definition.

Hardship Waivers

States must establish procedures for waiving estate recovery if it would cause an "undue hardship" for the heirs. The criteria for an undue hardship waiver vary by state.

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Thank You!

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