Statement of Eric Carlson

"Ensuring Access to Quality Post-Acute Care"

Health Subcommittee of House Committee on Ways and Means

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I appreciate the opportunity to testify on this important topic, and to submit this written statement. I work as Director of Long-Term Services and Supports Advocacy for Justice in Aging, a national nonprofit focusing on the well-being of low-income older Americans. I have specialized in long-term services and supports (LTSS), Medicaid, and related issues for over 30 years, including ten years representing individual low-income older Americans to help them access needed LTSS.

In today's policy environment, two issues are the absolute top priority in ensuring access to quality post-acute care: 1) maintaining adequate funding for the Medicaid program, and 2) implementing the nursing facility staffing standards that were announced by the Centers for Medicare & Medicaid Services (CMS) last year.

I. To Protect Access to Long-Term Care in a Nursing Facility or at Home, Congress Must Maintain Adequate Funding for the Medicaid Program and Reject Current Proposals that Would Devastate the Program.

The current House budget resolution calls for the Energy and Commerce Committee to reduce funding within its jurisdiction by $880 billion over ten years.[1] An analysis from the Congressional Budget Office (CBO) shows that cuts of that magnitude would necessarily be taken largely from the Medicaid program.[2]

As the CBO explains, the programs under the jurisdiction of the Energy and Commerce Committee (excluding Medicare) have mandatory outlays of approximately $8,791 billion dollars over the next ten years: this is comprised of $8,410 billion for Medicaid and the related Children's Health Insurance Program (CHIP), and $381 billion for all other programs.[3] Thus, even if funding for those "other" programs were completely eliminated — which could not realistically occur — Medicaid/CHIP still would be subject to a staggering funding reduction of at least $499 billion, resulting in catastrophic consequences for the program and the older Americans, persons with disabilities and children that it serves.

Cuts of this magnitude would eviscerate access to post-acute care and LTSS generally, given Medicaid's central role in funding those services. Contrary to many people's expectation, it is Medicaid — and not Medicare — that covers most LTSS for older Americans. Consider, for example, Medicare's nursing facility coverage. The Medicare program only pays for nursing

facility care on a short-term basis — the average length of a Medicare-funded nursing facility stay is 28 days.[4] For most older Americans, however, long-term care is not limited to a few weeks. Instead, they have ongoing, chronic conditions — Alzheimer's disease, for example – that require daily hands-on assistance as well as health care and other services. Only Medicaid covers needed nursing facility services on an ongoing basis.

Also, Medicaid is flexible enough to allow needed services to be provided at home rather than in a nursing facility. Over the last 40-plus years, Medicaid has developed a variety of mechanisms that allow for needed LTSS to be provided in a home or another community-based setting (a day care center, for example). These programs include Medicaid home and community-based services (HCBS) waivers, the HCBS State Plan Option, Community First Choice, and Medicaid demonstration waivers.[5] Because of these programs' growth and popularity, the Medicaid LTSS system has been steadily "rebalanced" towards HCBS and away from nursing facility care, to the point where a strong majority of Medicaid LTSS funding — 62 percent — is devoted to HCBS rather than facility-based care.[6]

Medicaid's vital role in covering LTSS expenses is illustrated by the nursing facility payer mix. Nationwide, Medicaid is the primary payer for 63 percent of nursing facility residents, and this percentage exceeds 70 percent in five states: Alaska, Georgia, Louisiana, Mississippi, and West Virginia.[7]

These high percentages translate of course to high overall enrollment levels. A recent AARP Fact Sheet cites nationwide Medicaid coverage for 923,957 nursing facility residents of age 65 and above, with Medicaid covering HCBS for another 1,531,843 persons in that age range.[8]

It bears repeating that Medicare coverage for such services is extremely limited. Consequently, Medicare beneficiaries rely on Medicaid to cover LTSS expenses. Of the persons covered by Medicaid for LTSS, over 60 percent are Medicare beneficiaries. Also, nearly 30 percent of overall Medicaid funding is spent on Medicare beneficiaries, and over half is expended for persons of age 65 and over, and persons with disabilities.[9]

Without Medicaid, many older Americans would be in a hopeless situation, given that LTSS for them frequently is both absolutely necessary and stupendously expensive. First, a need for LTSS is a common and frequently unavoidable part of growing older. A person who reaches age 65 has almost a 70 percent chance of needing some type of long-term services and supports during their lifetime.[10]

Of course, the expense of LTSS can be crushing. Nursing home care costs over $110,000 per year,[11] and can consume a person's life savings in relatively short order. Also, although home care is less expensive than facility-based care, it is still substantial: the federal government cites an average annual cost of over $40,000 for home care.[12] Unfortunately, long-term care

insurance is largely unaffordable: as a result, only 14 percent of persons age 65 or older have any level of private long-term care insurance.[13]

The threatened funding cuts would be especially damaging to older American's ability to access home and community-based services. HCBS programs are extremely popular: more than 70 percent of older Americans wish to stay in their homes as they age, rather than moving to a long-term care facility.[14] But, under the Medicaid Act, HCBS programs are provided at a state's option, as opposed to mandatory benefits such as physician services and nursing facility care.[15] As a result, threatened cuts to Medicaid, if carried out, would lead state Medicaid programs to reduce or eliminate HCBS and other optional programs.[16]

Regarding Medicare beneficiaries, it should also be noted that more than 10 million low-income Medicare beneficiaries rely on Medicaid (specifically, its Medicare Savings Programs (MSPs)) to pay Medicare premiums, co-pays, and deductibles.[17] If not for the MSPs, these low-income Medicare beneficiaries could not afford their Medicare benefits,[18] and the threatened Medicaid cuts will imperial the continued availability of such MSPs.

For all these reasons, Congress should retain at least current funding levels for the Medicaid program. Also, Congress should reject any effort to add work requirements to the Medicaid program. Such requirements would serve largely as an administrative stratagem to terminate coverage, as illustrated by the counterproductive work requirements adopted in Georgia and Arkansas.

Georgia recently created a Medicaid program with work requirements as an alternative to expansion Medicaid. Relatively few Georgians have enrolled, and more than 90 percent of the program funds have been spent for administrative and consulting expenses, rather than health care coverage.[19] In Arkansas, similarly, imposition of work requirements resulted in over 18,000 persons losing coverage for failure to meet work/reporting requirements, with only 11 percent of those persons regaining coverage the following year.[20]

II. CMS's Nursing Facility Staffing Standards Are Vital to Residents' Health and Well-Being; Congress Should Reject Pending Legislation that Would Both Eliminate Those Standards and Prevent CMS in Perpetuity from Enacting Similar Standards.

a. Higher Staffing Levels, Including Registered Nurse Staffing, Has Been Shown to Improve Nursing Facility Residents' Health and Well-Being.

In May 2024, CMS issued a rule to establish reasonable minimum nursing facility staffing standards,[21] but there is legislation in both houses of Congress to eliminate those standards before they even go into effect, and prohibit CMS in perpetuity from issuing similar standards.[22] To protect residents' health and well-being, Congress should reject the proposed legislation.

The federal nursing facility law was enacted in 1987, and became effective in October 1990.[23] It applies to any nursing facility certified for Medicare and/or Medicaid.[24] This means in practice

that virtually every nursing facility in the country is subject to the federal law. Because (as discussed above) many nursing facility residents rely on Medicare or Medicaid coverage, facilities are obligated as a business necessity to seek certification under both programs.

The law required around-the-clock nursing coverage (either registered or licensed nurse) and registered nurse staffing for at least eight hours per day. The law, however, but did not set any specific standards for overall nursing services (i.e., registered nurses, licensed nurses and nurse aides).[25] Federal regulations issued in 1991 required only that the overall nursing staffing be "sufficient" to meet resident needs.[26]

The laxity of the "sufficient" standard became evident over the years. Some facilities staffed at egregiously low levels, and residents suffered harm as a result. In response to a Request for Information on nursing facility staffing issued by CMS in 2023, commenters submitted examples of "residents going entire shifts without receiving toileting or multiple days without bathing assistance, increases in falls, residents not receiving basic feeding or changing services, and even abuse in cases where no one was watching."[27]

Consistent with these comments, a plethora of studies have established clear links between staffing levels and resident health and well-being. Improved staffing levels have been found to correlate to improved quality of care in numerous aspects, including the following:

- Retention of functional abilities.
- Fewer pressure ulcers.
- Avoiding weight loss.
- Less use of physical restraints.
- Fewer violations of nursing facility regulations (deficiencies).
- Better pain management.
- Fewer emergency department visits.
- Increased vaccination rates for influenza and pneumonia.
- Lower mortality rates.[28]

These issues came to the fore during and after the COVID pandemic. Through January 2022, 200,000 residents and staff of long-term care facilities died due to COVID, which accounted for almost a quarter of the COVID-related deaths nationally.[29] Low staffing was implicated as a contributing factor: numerous studies found that better staffing was associated with lower COVID infection rates.[30]

A related issue has been the presence of registered nurses: as mentioned, the federal law historically has required registered nurse staffing for only eight hours per day. Many studies, however, have highlighted the importance of higher registered nurse staffing levels. A recent review of relevant studies found that that higher registered nurse staffing, as well as higher ratios of registered nurses in the nursing skill mix, were correlated with improvement in nursing

facility quality of care.[31] Likewise, in a study based on residents' medical records, increases in registered-nurse-provided direct care were associated with fewer pressure ulcers and urinary tract infections, less weight loss, better retained ability to perform activities of daily living, lessened use of catheters, and fewer hospitalizations.[32]

In one 2020 study, with data drawn from all of Connecticut's 215 nursing facilities, a 20-minute increase in daily direct care provided by registered nurses was correlated to 22 and 26 percent reductions in COVID cases and COVID-related deaths, respectively.[33] A California study found a relationship between improved registered nurse staffing and fewer cited deficiencies,[34] and a longitudinal study found that improved levels of registered nurse staffing led to fewer pressure ulcers and urinary tract infections.[35] Other studies similarly have found positive correlations between higher registered nurse staffing levels; and lessened use of antipsychotic medication and fewer deficiencies.[36]

b. **CMS's Minimum Staffing Standards Are an Important Advancement for Nursing Facility Residents' Health and Well-Being.**

In the aftermath of the many COVID nursing facility deaths, CMS commissioned a study from Abt Associates, issued a proposed rule and then, after reviewing and considering the relevant research plus over 46,000 comments to the proposed rule, finalized new minimum nursing facility staffing standards.[37]

These standards require a registered nurse around the clock. Also, a facility must provide at least 3.48 hours of direct-care assistance per resident per day. This must include at least 2.45 hours of care from a nurse aide, and .55 hours of care from a registered nurse. The remaining direct service time to meet the 3.48 hour total can come from any combination of registered nurses, licensed nurses, or nurse aides.[38]

The nurse aide staffing requirement translates approximately to one nurse aide for every 10 residents.[39] Because staffing levels generally are lower during the overnight shift, this might be divided between the shifts as one aide for every 9 residents during the day and evening shifts, and for every 14 residents during the overnight shift.[40] This is not an extravagance, but merely a necessary protection that makes it less likely that aides are overwhelmed by assigned work.

These standards will make a real difference. Researchers at the University of Pennsylvania estimate that implementation of these standards will save the lives of 13,000 residents each year, not to mention residents' improved health and quality of life.

The impact of the new standards, appropriately, will be felt most in those facilities that have been routinely understaffed. The 3.48 hour standard is less than the current national average, so the majority of nursing facilities are either in compliance already, or out of compliance but by a relatively small margin. In those facilities in the bottom quartile of staffing levels, however, application of the new standards will lead to a 30 percent improvement in nurse aide staffing,

with each aide being responsible for 9 rather than 13 residents during the morning and evening shifts, and for 14 rather than 21 residents during the overnight shift.[41]

c. The Minimum Staffing Standards Provide for a Lengthy Phase-In Period, as Well as Hardship Exemptions for Facilities that Make Good Faith Efforts to Meet the Standards.

Unfortunately, the provider lobby has attacked these requirements relentlessly, but those attacks fail to acknowledge the many accommodations already provided. First is the lengthy implementation process. Operators have been given two years, until May 2026, to meet the standards for around-the-clock registered nurse staffing, and the overall staffing requirement. The is extended another year, to May 2027, for the standards specific to registered nurses and nurse aides. In addition, in rural areas these two timelines are extended still further. Facilities must meet the registered nurse and overall staffing requirements by April 2027, with compliance with staff-specific deadlines not required until May 2029.[42]

Also, the requirements include hardship exemptions for providers who face labor shortages. These exemptions apply if the availability of the particular type of worker – a nurse aide or registered nurse – is at least 20 percent below the national average based on data from the Bureau of Labor Statistics and Census Bureau. The provider then must show a good faith attempt to hire adequate staff, including offering at least prevailing wages, as well as a demonstrated financial commitment towards funding direct care services.[43]

In one final accommodation, CMS has developed a nursing facility staffing campaign. This includes financial incentives for registered nurses to work in nursing facilities, and the promotion of training for persons to certify themselves as nurse aides.[44]

III. Conclusion.

For "ensuring access to post-acute care," the highest policy priorities today are protecting the current system from looming threats. When older Americans struggle with health challenges, they depend on the Medicaid program to provide necessary health care and hands-on assistance, whether provided at home or in a long-term care facility. And, if receiving care in a nursing facility, they deserve prompt assistance from an adequately-staffed facility. In fairness to older Americans and persons with disabilities across the country, Congress should retain the Medicaid program in its current form, including the vital nursing facility staffing standards.

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[1] H. Con. Res. 14, Tit. II, § 2001(b)(4), 119th Cong. (2025).
[2] CBO, Letter from Philip L. Swagel, Director, to Rep. Brendan Boyle and Rep. Frank Pallone, Jr., Mandatory Spending under the Jurisdiction of the House Committee on Energy and Commerce (March 5, 2025).
[3] CBO, Letter from Philip L. Swagel, Director, to Rep. Brendan Boyle and Rep. Frank Pallone, Jr., Mandatory Spending under the Jurisdiction of the House Committee on Energy and Commerce (March 5, 2025).
[4] Medicare Payment Advisory Commission (MedPAC), A Data Book: Health Care Spending and the Medicare Program, p. 109, Chart 8-5 (July 2024).

[5] *See* 42 U.S.C. §§ 1315 (demonstration waivers), 1396n(c), (i), (k) (HCBS Waivers, HCBS State Plan Option, and Community First Choice, respectively).
[6] Regina Rutledge et al., RTI Int'l, Rebalancing of Medicaid-Funded Long-Term Services and Supports, 2016-2019: Descriptive Analyses of National and State Rebalancing by Enrollee Age, Health Condition, and Demographic Factors, p. 2-2 (Jan. 2025).
[7] KFF, Distribution of Certified Nursing Facility Residents by Primary Payer Source (2024).
[8] Brendan Flinn & Tobey Oliver, AARP, Medicaid and Its Role for Older Adults, p. 5 (March 2025) (data from 2022).
[9] MedPAC & MACPAC, Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid, p. 30 (Jan. 2024) (27% of Medicaid spending); KFF, 5 Key Facts About Medicaid Eligibility for Seniors and People with Disabilities (Feb. 7, 2025).
[10] LongTermCare.gov, How Much Care Will You Need? (accessed March 7, 2025).
[11] Genworth and CareScout Release Cost of Care Survey Results for 2024, Businesswire, March 4, 2025 ($111,325 and $127,750 annually for median nursing facility cost for shared-occupancy room and private room, respectively).
[12] Federal Long Term Care Insurance Program, *available at* ltcfeds.gov/long-term-care/costs.
[13] KFF, The Affordability of Long-Term Care and Support Services: Findings from a KFF Survey (Nov. 14, 2023).
[14] Joanne Binette & Fanni Farago, AARP, Building for the Future: Creating Homes and Communities for Aging Well; 2024 Home and Community Preferences Survey: A National Survey of Adults Age 18-Plus (Dec. 10, 2024).
[15] *See* 42 U.S.C. § 1396a(a)(10)(A) (mandatory and optional services).
[16] Maiss Mohamed & Alice Burns, KFF, What is Medicaid Home Care (HCBS)? (Feb. 18, 2025).
[17] MACPAC, Report to Congress on Medicaid and CHIP, ch. 3, p. 76 (June 2024).
[18] Maria Peña et al., KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (Jan. 31, 2023).
[19] Andy Miller & Renuka Rayasam, KFF Health News, Georgia's Medicaid Work Requirements Costing Taxpayers Millions Despite Low Enrollment (March 20, 2024).
[20] Robin Rudowitz et al., KFF, February State Data for Medicaid Work Requirements in Arkansas (March 25, 2019); Renuka Rayasam & Sam Whitehead, KFF Health News, The First Year of Georgia's Medicaid Work Requirement Is Mired in Red Tape (Sept. 13, 2024).
[21] Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Fed. Reg. 40,876 (May 10, 2024).
[22] Protecting Rural Seniors' Access to Care Act, S. 750 (Fischer (R. Neb.)); Introductory Statement on S. 750, 171 Cong. Rec. S1399- S1400 (Feb. 26, 2025); H.R. 1303 (Fischbach (R. Minn.)) (introduced without text on Feb. 13, 2025, with the following provisional title: "To prohibit the Sec'y of Health and Human Services from implementing, administering, or enforcing provisions relating to minimum staffing standards for long-term care facilities and Medicaid institutional payment transparency reporting").
[23] Pub. L. No. 100-203, §§ 4201, 4214(a), 101 Stat. 1330, 160, 219 (1987).
[24] *See* 42 U.S.C. §§ 1395i-3; 1396r. Section 1395i-3 applies to Medicare-certified facilities, while section 1396r applies to Medicaid-certified facilities. The two sections are virtually identical.
[25] 42 U.S.C. §§ 1395i-3(b)(4)(C)(i); 1396r(b)(4)(C)(i)(II).
[26] 56 Fed. Reg. 48,826, 48,873-74 (Sept. 26, 1991). The relevant regulatory language, in 42 C.F.R. § 483.30, required that each nursing facility "have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." The nursing services regulation originally was located at section 483.30, but now is located at section 483.35.
[27] 89 Fed. Reg. 40,876, 40,880 (May 10, 2024).
[28] Jane Bostick et al., *Systematic Review of Studies of Staffing and Quality in Nursing Homes*, J. Am. Med. Dir. Ass'n, Vol. 7, pp. 366-376 (July 2006) (functional ability, pressure ulcers & weight loss); Nicholas Castle, *Nursing Home Caregiver Staffing Levels and Quality of Care*, J. Applied Gerontology, Vol. 27, No. 4, pp. 375, 392 (Aug. 2008) (pressure ulcers, physical restraints & deficiencies); Nicholas Castle et al., C*aregiver Staffing in Nursing Homes and Their Influence on Quality of Care*, Med. Care, Vol. 49, No. 6, pp. 545-52 (June 2011) (pressure ulcers, physical restraints & pain management); Charlene Harrington et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, J. Gerontology Series B: Psychological Science & Soc. Science, Vol. 55, No. 5, pp. S278–S287 (Sept. 2000); Patricia Tong, *The Effects of California Minimum Nurse Staffing Laws on Nurse Labor and Patient Mortality*

In Skilled Nursing Facilities, Health Econ., Vol. 20, No. 7, pp. 802-16 (July 2011) (mortality); Laura Wagner et al., *Medical Staffing Organization and Quality of Care Outcomes in Post-Acute Care Settings*, The Gerontologist, Vol. 61, No. 4, pp. 605, 611-12 (2021) (fewer pressure ulcers and ER visits; increased vaccination rates for influenza and pneumonia).

[29] Priya Chidambaram, KFF, Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died From COVID-19 (Feb. 3, 2022).

[30] *See, e.g.*, Jose Figueroa et al., *Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing with COVID-19 Cases*, JAMA, Vol. 324, No. 11, pp. 1103-05 (Aug. 10, 2020); Rebecca Gorges & Tamara Konetzka, *Staffing Levels and COVID-19 Cases and Outbreaks In U.S. Nursing Homes*, J. Am. Geriatrics Soc'y, Vol. 68, pp. 2462, 2465 (Nov. 2020) (better staffing correlated with fewer outbreaks); Christianna Williams et al., *The Association of Nursing Home Quality Ratings and Spread of COVID-19*, J. Am. Geriatrics Soc'y, Vol. 69, No. 8, pp. 2070, 2074-75 (2021).

[31] Mary Ellen Dellefield et al., *The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review* (2008–2014), *Nursing Economic$,* Vol. 33, No. 2, pp. 95–108 (2015).

[32] Susan Horn et al., *RN Staffing and Outcomes of Long-Stay Nursing Home Residents*, Am. J. Nurs., Vol. 105, pp. 58-70 (2005).

[33] Yue Li, et al., *COVID-19 Infections and Deaths Among Connecticut Nursing Home Residents: Facility Correlates*, J. Am. Geriatrics Soc'y, Vol. 69, pp. 1899-1906 (Sept. 2020).

[34] Hongsoo Kim et al., *Registered Nurse Staffing Mix and Quality of Care In Nursing Homes: A Longitudinal Analysis*, Gerontologist, Vol. 49, No. 1, pp. 81-90 (2009).

[35] Tamara Konetzka et al., *The Staffing-Outcomes Relationship in Nursing Homes*, Health Serv. Res., Vol. 43, No. 3, pp. 1025, 1036-37 (June 2008).

[36] Nicholas Castle et al., *Nursing Home Deficiency Citations for Safety*, J. Aging Soc. Policy, Vol. 23, No. 1, pp. 34-57 (Jan. 2011) (deficiencies); Lorraine Phillips et al., *An Observational Study of Antipsychotic Medication Use Among Long-Stay Nursing Home Residents Without Qualifying Diagnoses*, J. Psych. Mental Health Nurs., Vol. 25, pp. 463-74 (Oct. 2018) (antipsychotic medication).

[37] 89 Fed. Reg. 40,876, 40,876-80 (May 10, 2024).

[38] 42 C.F.R. § 483.35(b)(1).

[39] To convert an hours-per-resident-day (HPRD) standard to a number-of-residents-per-staff-member ratio, the number of hours in a day (24, of course) is divided by the HPRD. In this case, 24 ÷ 2.45 = 9.80 residents per aide.

[40] National Consumer Voice for Quality Long-Term Care, Protect the Minimum Staffing Rule in Nursing Homes (2025). These ratios are based on HRPD of .93 during the day and evening shifts, and .59 during the overnight shift. (.93 + .93 + .59 = 2.45)

[41] National Consumer Voice for Quality Long-Term Care, Protect the Minimum Staffing Rule in Nursing Homes (2025). The ratios for the bottom-quartile facilities are based on HRPD of .63 during the day and evening shifts, and .39 during the overnight shift. (.63 + .63 + .39 = 1.65)

[42] 89 Fed. Reg. 40,876, 40,913 (May 10, 2024).

[43] 42 C.F.R. § 483.35(h).

[44] CMS, Nursing Home Staffing Campaign (accessed March 7, 2025; www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/nursing-home-staffing-campaign).