ARGENTUM
EXPANDING SENIOR LIVING

The Case for State Regulation of Assisted Living

Why the State-Based Framework Works — and What a Federal Overlay Would Cost Seniors

Executive Summary

Assisted living is the most consumer-validated model in American long-term care: a residential, state-regulated alternative that more than one million seniors have chosen for its independence, dignity, and community. That success is the product of a regulatory design in which all 50 states license, inspect, and hold communities accountable, while federal health programs separately regulate the certified medical providers who serve residents wherever they live.

Recent proposals would upend that design by extending federal facility regulation — built for highly clinical skilled nursing facilities — to assisted living. The July 2026 GAO report on federal spending in assisted living settings (GAO-26-107884) may be cited as the justification. That reading fails on two fundamental grounds: assisted living communities do not directly receive Medicare payments — separately certified third-party providers do — and assisted living is primarily a residential and social model, not a clinical health care setting. What the report actually documents is a functioning, multi-tiered system with no identified quality or safety issues, federal spending that overwhelmingly flows to already-regulated health care providers or through state-administered Medicaid programs, and challenges — affordability, workforce, and reimbursement — that federal facility regulation cannot solve and would in fact worsen.

This paper makes the following points: **(1)** assisted living is a residence, not a medical facility, and Congress itself has defined it that way; **(2)** the GAO report documents a modest, already-regulated federal footprint — not an oversight gap; **(3)** assisted living's model preserves Medicaid and Medicare budgets; **(4)** the state regulatory framework is rigorous, responsive, and accountable; **(5)** imposing a federal nursing home-style regime would raise costs, shrink Medicaid participation, and reduce options for seniors during the largest age wave in American history.

1. Assisted Living Is a Residence — Not a Medical Facility

> ***Assisted living is a home. Residents live in their own apartments, direct their own lives, and receive support with daily living — not institutional medical care.***

At its core, assisted living is a residential setting. Residents live in their own apartments or rooms, furnish and personalize their space, come and go freely, and make their own decisions about how they spend each day. Communities provide housing, meals, social engagement, and personalized support with activities of daily living — bathing, dressing, medication reminders, mobility. What they do not provide is institutional medical care. When a resident needs skilled clinical services — home health, therapy, hospice, physician visits — those services are delivered by outside professionals and agencies, exactly as they would be in any private home.

Congress has already recognized this distinction. Under Section 232(b) of the National Housing Act, federal law defines assisted living in residential terms: a **state-licensed and state-regulated** setting providing separate dwelling units, common spaces, and supportive services

for activities of daily living. When Congress has spoken, it has placed assisted living in a housing framework — not a medical-facility framework.

The contrast with skilled nursing facilities (SNFs) is structural, not cosmetic. SNFs deliver round-the-clock clinical care to individuals who require physician-ordered, institutional-level services, and they are reimbursed directly and substantially by Medicare and Medicaid — the payment relationship that anchors CMS's regulatory jurisdiction. Assisted living has neither the clinical mission nor the payment relationship. It is a consumer-driven, predominantly private-pay residential model. Treating the two as interchangeable is the central analytical error behind every federalization proposal.

Residents themselves supply the strongest evidence. Consumer studies consistently rank assisted living at the top of the long-term care continuum: 96 percent of residents report feeling safe in their communities, and 91 percent report feeling safer than they did living alone. A March 2024 study published by the National Institutes of Health documented what that means in human terms — seniors who moved from isolated private homes into assisted living communities reported relief from loneliness and depression and described feeling alive again through friendship and daily engagement. Industry research further shows measurable reductions in resident frailty after move-in. These are the outcomes of a social, person-centered model — and they are precisely what a clinical, compliance-driven regime would put at risk.

2. What the GAO Report Actually Found

> ***GAO found a modest federal footprint, already regulated at every point where federal dollars flow — and no evidence that state oversight is failing.***

The GAO report identifies at least $12 billion in federal Medicaid and Medicare spending associated with services delivered in assisted living settings in 2024. That headline is being used to argue that federal dollars demand federal facility regulation. The report's own data dismantles the argument.

Perspective: A Fraction of One Percent

Combined federal Medicare and Medicaid spending exceeds $1.8 trillion annually. The federal Medicaid spending GAO tied to assisted living services — approximately $3.5 billion — represents roughly 0.2 percent of that total. Even accepting GAO's broadest $12 billion figure, the share remains well below one percent.

The Medicare Numbers Describe Federally Regulated Providers — Not Assisted Living

Roughly $8.5 billion — about 70 percent of GAO's total — is traditional Medicare spending for services delivered *in* assisted living settings:

- **$6.1 billion (over 71 percent) was hospice care** delivered by separately Medicare-certified hospice agencies serving terminally ill seniors.
- **$1.4 billion (16 percent) was home health** — skilled nursing and therapy visits by Medicare-certified home health agencies.

- **The remainder paid physicians, clinicians, and medical equipment suppliers** for services delivered to individual beneficiaries.

Every dollar in that $8.5 billion went to a provider that is already certified, surveyed, audited, and regulated by CMS. Medicare pays those providers because a beneficiary is entitled to the benefit wherever she lives — in a single-family house, an apartment, or an assisted living community. Medicare does not pay assisted living communities for housing, room, board, or the residential services they provide.

The home care test. A senior receiving Medicare home health in her own home or apartment does not thereby subject her home or landlord to CMS regulation. An adult daughter who arranges hospice care for her mother does not become a federally regulated health care entity. The same logic applies to assisted living: the community is the resident's home. Claiming federal authority to regulate assisted living because a certified third-party provider delivers medical services to a resident in her assisted living apartment is a clear overreach.

The Medicaid Dollars Flow Through State-Run Programs — By Design

GAO identified approximately $3.5 billion in federal Medicaid spending (about $6.2 billion combined federal-state) supporting services for roughly 300,000 assisted living residents. By law, Medicaid pays for services — personal care, medication management — never for room and board. And every one of those dollars moves through state-administered waiver and state plan authorities in which states set eligibility, define services, qualify providers, control rates, and monitor quality. Forty-four states covered assisted living services under Medicaid as of March 2025, with coverage stable over the past decade. That is the intended architecture of Medicaid home- and community-based services, functioning as Congress designed it.

The report also counts consumer-directed benefits — Supplemental Security Income and veterans' benefits — toward the federal footprint. These are benefits paid to individuals, who direct them to their housing and care as they see fit, exactly as they would anywhere else they lived. A resident spending her own benefit income on her own home is not federal investment in facility operations.

3. Assisted Living Saves Federal Health Care Dollars

> ***Assisted living reduces Medicare and Medicaid spending precisely because it is not a federally medicalized setting — federalizing it would destroy the savings.***

The GAO spending frame misses the sector's most important fiscal fact: assisted living is a net saver for federal health programs.

Medicare savings without Medicare payments. Daily support with nutrition, medication routines, mobility, and social connection — combined with early recognition of changes in condition — reduces the avoidable hospitalizations, emergency visits, and post-acute stays that drive Medicare costs. The model stabilizes frail seniors before crises occur. Those savings accrue to Medicare even though the community never bills it.

Medicaid savings that states can see on their own ledgers. Assisted living gives states a lower-cost, community-based alternative for individuals who need daily support but not

institutional care. GAO's own report captures the delta: New Hampshire estimated annual Medicaid costs of roughly $11,340 per beneficiary for assisted living services versus $55,697 for nursing home care — nearly five to one — and states generally expected assisted living costs to run far below institutional care. GAO further notes that when Medicaid rates are too low for communities to participate, eligible seniors can be diverted into costlier nursing homes.

The fiscal logic is straightforward: the model saves money because it maintains independence and prevents institutional escalation. Wrapping assisted living in SNF-style federal requirements would import SNF-style cost structures and erase the very savings that make the model valuable to both federal and state budgets.

4. State Regulation Is Robust, Layered, and Responsive

> ***Every assisted living community answers to overlapping state and local authorities with real enforcement — and states update their rules faster than federal rulemaking ever could.***

The claim that assisted living is "unregulated" does not reflect how a community actually operates. To open its doors and keep them open, a community must satisfy overlapping mandates from municipal, county, and state authorities:

- **State licensure and survey agencies** — regular, unannounced inspections; mandatory reporting of violations and critical incidents; public enforcement records.
- **Public health authorities** — food safety, sanitation, and infection control oversight.
- **Fire and life safety** — physical plant compliance enforced concurrently by state fire marshals and local fire departments.
- **Zoning, building, and occupancy codes** — local land-use and structural requirements.

While states appropriately tailor their frameworks to local populations, housing markets, and care traditions, foundational protections are universal. Every state mandates defined resident rights and elder abuse protections; staff training, continuing education, and explicit limits on the clinical services communities may provide; staffing ratios or flexible staff-hour requirements scaled to community size and resident acuity; and full enforcement authority — civil penalties, admission bans, and license revocation.

State Oversight of Waivers Drives Flexibility and Innovation

Congress created the Medicaid waiver framework precisely to relieve rigid federal constraints and let states innovate. State-level oversight of these programs is robust, rigorous and essential to localized care goals.

Localization Matters. States face distinct regional housing markets, demographic trends, and caregiver labor pools. State-managed waiver regulations allow local authorities to adapt quickly, shifting program rules to match specific consumer demands in ways a slow, uniform federal mandate never could.

States are dynamic regulators. Roughly 18 states updated their assisted living regulations within the past year alone, and Maryland's expanded manager licensure and enforcement

regime took effect this month. That responsiveness — measured in months, not years — is structurally impossible in federal rulemaking, where a single nursing home staffing rule consumed years of proceedings before being rescinded. State variation is not evidence of failure; it is the system working exactly as Medicaid's community-based services framework intends, matched to demographics, labor markets, and housing costs that differ profoundly across states. Notably, GAO itself describes state frameworks as emphasizing resident independence, dignity, and privacy.

5. The Cost of Getting This Wrong: A Federal Overlay in an Age Wave

> ***Federal facility mandates would raise costs, push providers out of Medicaid, and shrink supply at the exact moment demand is exploding.***

The all-or-nothing trap. Proposals to pull assisted living into a federal benefit framework — for example, by redefining it under Section 1905(a) of the Social Security Act — would hand CMS authority to impose Conditions of Participation on the model. The nursing home experience shows what follows: accepting a single certified bed subjects the entire building to federal survey protocols and more than 150 federal violation codes. Communities would face a binary choice — accept comprehensive federal medicalization, or exit Medicaid entirely. Either outcome harms low-income seniors most.

Cost advantages, erased. Assisted living operates at roughly half the cost of nursing home care in large part because it carries a residential, not institutional, compliance structure. Federal administrative overhead would flatten that advantage, inflate private-pay rates, and invalidate the savings assumptions built into every proposal to expand community-based care.

At the worst possible moment. The population aged 80 and older — 14.7 million Americans in 2025 — will grow nearly 28 percent by 2030 and roughly double by 2035, while smaller families and greater geographic dispersion shrink the pool of family caregivers. Meeting projected demand requires more than 800,000 new senior housing units by 2030 — against just 14,000 new units delivered in 2024 and a development pipeline on pace to meet only a third of the roughly $300 billion in investment needed this decade. Layering new federal compliance costs onto that supply crisis would deepen scarcity, deter capital, and price out the middle-income seniors who already face the fewest options.

Conclusion

The GAO report describes a system working as designed: certified medical providers regulated by CMS wherever they deliver care; state-administered Medicaid programs governing every service dollar; and residential communities licensed, inspected, and held accountable by the states. There is no oversight gap to fill — only a successful, consumer-chosen model to protect. Federal facility regulation would not make assisted living safer; it would make it scarcer, costlier, and less like home. The right policy course is the one the evidence supports: preserve state regulatory primacy and partner on the affordability and workforce challenges that actually stand between American seniors and the care they deserve.