United States Senate

WASHINGTON, DC 20510

March 31, 2025

The Honorable Eugene L. Dodaro
Comptroller General
Government Accountability Office
441 G St., NW
Washington, DC 20548

Dear Comptroller General Dodaro:

We write to request that the Government Accountability Office (GAO) update its 2018 report on state and federal oversight of assisted living facilities that participate in Medicaid. Given the threats to residents' health and safety revealed by GAO's 2018 report,[1] a new review is necessary to evaluate the extent to which the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies have improved their capacity to protect the hundreds of thousands of seniors and individuals with disabilities who reside in these facilities.

Assisted living facilities play an important role in providing long-term care and support for seniors and individuals with disabilities who need assistance with daily activities. These facilities offer a residential alternative to nursing home care for individuals who may prefer to live independently but need more assistance than can be provided through home-based support services. The majority of assisted living residents pay for their care using personal resources, despite the $54,000 median annual cost of residing in a facility.[2] However, in most states, Medicaid pays for some services provided in assisted living facilities. Roughly 1 in 5 residents pay for daily services with Medicaid, although Medicaid does not cover the room and board costs charged by the facilities.[3]

Federal oversight differs for nursing homes and assisted living facilities, although residents of both types of facilities often have physical or cognitive conditions that make them particularly vulnerable to abuse and neglect.[4] In 2022, over half of the residents in assisted living or other residential care communities were 85 years of age or older, and about forty percent had diagnoses of Alzheimer's disease or other dementias.[5] Unlike nursing homes, which are subject to a comprehensive set of federal requirements in order to receive Medicare and Medicaid payment, assisted living facilities are largely regulated by states, who each may impose different

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[1] U.S. Government Accountability Office, "Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed," January 5, 2018, https://www.gao.gov/products/gao-18-179.
[2] American Health Care Association / National Center for Assisted Living, "Facts and Figures," https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx.
[3] *Id.*
[4] U.S. Government Accountability Office, "Elder Abuse: Federal Requirements for Oversight in Nursing Homes and Assisted Living Facilities Differ," August 19, 2019, https://www.gao.gov/products/gao-19-599.
[5] U.S. Centers for Disease Control and Prevention, "Residential Care Community Resident Characteristics: United States, 2022," August 2024, https://www.cdc.gov/nchs/products/databriefs/db506.htm.

reporting requirements and safety standards.[6] This lack of federal requirements and variation in state requirements may impede efforts to identify patterns of incidents in assisted living facilities that affect resident health and welfare, such as abuse and neglect, or other problems affecting residents, such as evictions.

In 2018, GAO reported on state and federal oversight of assisted living facilities that participate in Medicaid, particularly with regard to the reporting of "critical incidents" that seriously threaten residents' health or well-being.[7] The report found that the majority of state Medicaid agencies did not track "the number or nature of critical incidents [affecting Medicaid beneficiaries] in assisted living facilities" and that state agencies defined critical incidents in different ways. For example, 24 states did not consider evictions from assisted living facilities to be critical incidents, seven states did not consider medication errors to be critical incidents, and three states did not consider unexplained deaths to be critical incidents. The report also determined that 14 states did not make information on critical incidents at assisted living facilities available to the public.

In its report, GAO concluded that CMS may be unaware of widespread problems affecting Medicaid beneficiaries at assisted living facilities due to a lack of clear federal guidance on reportable deficiencies and no uniform requirement for state Medicaid agencies to report critical incidents.[8] Troublingly, this may hinder efforts to hold assisted living facilities accountable for endangering residents. It also poses challenges for federal agencies, elected officials, or other groups who seek to evaluate state agencies' oversight of assisted living facilities.

Since GAO's 2018 report was published, new reporting has highlighted the extent of worrying malfeasance that threatens the safety of individuals residing in assisted living facilities. In 2023, the Washington Post published a major investigation revealing that since 2018, thousands of assisted living residents have "wandered away…or been left unattended for hours outside," leading to nearly 100 documented deaths and even more residents unaccounted for.[9] The investigation determined that state agencies "repeatedly found failures by administrators and front-line caregivers" to prevent these incidents.[10]

Likewise, a 2023 ProPublica investigation found that Maine's state health agency uncovered over 700 violations at assisted living facilities between 2020 and 2022 – some of which entailed "serious abuse and neglect" – but almost never fined or penalized those facilities.[11] A new GAO report could provide legislators and the American public with a stronger understanding of why

[6] U.S. Government Accountability Office, "Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed," January 5, 2018, https://www.gao.gov/products/gao-18-179.
[7] U.S. Government Accountability Office, "Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed," January 5, 2018, https://www.gao.gov/products/gao-18-179.
[8] *Id.*
[9] The Washington Post, "Dozens of Assisted-Living Residents Died After Wandering Away Unnoticed," Christopher Rowland, Todd C. Frankel, Yeganeh Torbati, Julie Zauzmer Weil, Peter Whoriskey, and Steven Rich, December 17, 2023, https://www.washingtonpost.com/business/interactive/2023/assisted-living-wander-patient-deaths/.
[10] *Id.*
[11] ProPublica, "Maine Rarely Sanctions Residential Care Facilities Even After Severe Abuse or Neglect Incidents," Rose Lundy, November 12, 2023, https://www.propublica.org/article/maine-rarely-sanctions-residential-care-facilities-abuse-neglect.

assisted living facilities were so rarely held accountable for neglecting the safety of their residents, and could pave the way for future rules, regulations, or laws that more effectively keep assisted living residents safe.

In a January 2024 hearing before the Senate Aging Committee, witnesses described the necessity of strengthening national standards for assisted living facilities. One expert explained that the answers to key questions about the quality of care in these facilities are "often purposefully obfuscated by both operators and the state agencies that are supposed to be protecting residents."[12] Another pointed out that fewer than ten states "shared information about their monitoring and enforcement procedures in a way that would be publicly accessible."[13]

According to witnesses at the hearing, this lack of transparency contributes to an environment where "care, monitoring, and dignity…may be wonderful or slipshod, depending on the facility or, even, the operator's profit goals for the quarter."[14] Multiple witnesses explained that caregivers at assisted living facilities are often inadequately trained, particularly with regard to memory care, and that training requirements are inconsistent across states and "enforced with minimal oversight by state regulatory bodies."[15]

In 2024, CMS finalized regulations that specified new requirements for state Medicaid programs to meet nationwide incident management system standards for monitoring home- and community-based settings, including assisted living facilities that participate in Medicaid.[16] In addition, the regulations require states to submit annual critical incident reports to CMS. This is an important step in the right direction. However, the critical incident management system requirements do not take effect until at least 2027, and the form, manner, and timing of the annual state reports have yet to be specified by CMS.

Given GAO's previous findings on the need for improved oversight of assisted living facilities, and new findings about residents' health and safety, we request that GAO provide an update on this issue by examining the following questions:

1. How do state Medicaid programs currently oversee and monitor the health and welfare of beneficiaries that receive services in assisted living facilities, and how has this oversight changed since GAO's 2018 report was written?

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[12] Written testimony of Richard J. Mollot to the U.S. Senate Special Committee on Aging, January 25, 2024, https://www.aging.senate.gov/imo/media/doc/c6da95f3-df58-6543-be97-ac97c5d276be/Testimony_Mollot%2001.25.24.pdf.

[13] Written testimony of Jennifer Craft Morgan to the U.S. Senate Special Committee on Aging, January 25, 2024, https://www.aging.senate.gov/imo/media/doc/c6da95f3-df58-6543-be97-ac97c5d276be/Testimony_Morgan%2001.25.24.pdf.

[14] Written testimony of Richard J. Mollot to the U.S. Senate Special Committee on Aging, January 25, 2024, https://www.aging.senate.gov/imo/media/doc/c6da95f3-df58-6543-be97-ac97c5d276be/Testimony_Mollot%2001.25.24.pdf.

[15] *Id;* Written testimony of Jennifer Craft Morgan to the U.S. Senate Special Committee on Aging, January 25, 2024, https://www.aging.senate.gov/imo/media/doc/c6da95f3-df58-6543-be97-ac97c5d276be/Testimony_Morgan%2001.25.24.pdf.

[16] Centers for Medicare & Medicaid Services, Federal Register Notice, "Medicaid Program; Ensuring Access to Medicaid Services," May 10, 2024, https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

2. What types of deficiencies and critical incidents have state Medicaid programs or other state or local regulatory agencies identified at assisted living facilities in recent years?

3. How is CMS implementing the requirements for state Medicaid programs to meet new standards for monitoring and reporting on critical incidents in home- and community-based settings such as assisted living facilities, and what other steps has the agency taken to improve federal oversight of beneficiary health and welfare in assisted living facilities?

4. Is there a need for additional federal oversight of assisted living facilities, either through existing programs like Medicaid or via new regulatory efforts?

Thank you for your attention to this important matter.

Sincerely,

Elizabeth Warren
United States Senator

Ron Wyden
United States Senator
Ranking Member, Committee on Finance

Kirsten Gillibrand
United States Senator
Ranking Member, Special Committee on Aging