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IN FOCUS

Overview of Federally Certified Long-Term Care Facilities

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Long-term care facilities (LTCFs), commonly referred to as nursing homes, provide both skilled nursing care over a short period of time for recuperation or rehabilitation after an acute illness or injury (i.e., *post-acute care*), and continuous care for an extended period, including around-the-clock supervision of, and assistance with, basic personal care activities (i.e., *long-term services and supports*, or LTSS).

Individuals may qualify for public LTCF coverage through the federal Medicare program—which covers health care for elderly and certain disabled individuals—or through the state-federal Medicaid program, a means-tested entitlement program that finances primary and acute medical services and LTSS. In general, both programs cover post-acute care, but only Medicaid covers LTSS for eligible beneficiaries.

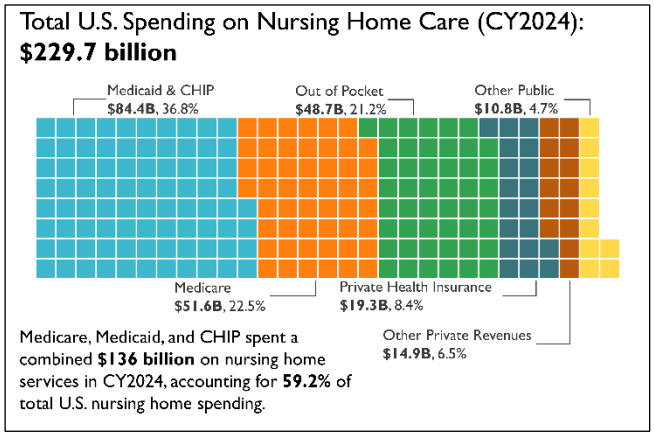
As of July 2026 (from data released August 6, 2026), 14,693 LTCFs, with more than 1.5 million certified beds, participated in Medicare and/or Medicaid. Medicare facilities are designated as *skilled nursing facilities* (SNFs); Medicaid facilities are known as *nursing facilities* (NFs). The vast majority of LTCFs (94.6%) were dually certified *by state survey agencies* (SAs) under federal guidelines to participate in both Medicare and Medicaid, while 3.7% were certified as Medicare only, and 1.7% were certified as Medicaid only. This In Focus uses the term *nursing home* to collectively refer to both types of settings.

Financing

Nursing homes receive payment for services from private and public sources. Medicaid is the primary payment source for most certified nursing home residents. In 2025, Medicaid was the primary payer for 63% of nursing home residents, 23% of residents paid privately or with another payment source (e.g., private insurance), and Medicare was the primary payer for 14% of residents. A nursing home resident's primary payment source may change over time. For example, once a resident has reached Medicare coverage limits and has spent down personal assets on their care, they may use Medicaid as their primary payer, assuming the resident is dually eligible for Medicare and Medicaid.

In the United States, $229.7 billion was spent on nursing home services across all payers in 2024. **Figure 1** shows shares of expenditures on nursing home care by payer or revenue source. Combined, Medicare and Medicaid (state and federal) spent $136 billion on nursing home services in 2024, which accounted for 59.2% of total U.S. nursing home spending.

Figure 1. 2024 U.S. Spending on Nursing Home Care



Source: CRS analysis of National Health Expenditure data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2025.

Notes: Values may not sum to totals due to rounding. Data include freestanding and hospital-based Nursing Care Facility & Continuing Care Retirement Community expenditures; these include estimated shares of Medicare Advantage capitated payments attributable to nursing home care, estimated shares of Medicare payments for hospice care provided by SNFs, and estimated shares of Medicaid payments for hospice care provided by nursing homes. "Other Public" includes other federal, state, and local programs; "Other Private Revenues" include nursing home care expenditures from private sources other than private health insurance or out-of-pocket spending.

Within "traditional" Medicare under Part A, Medicare pays for nursing home services under a prospective payment system (PPS). The PPS pays SNFs a daily amount after adjusting for urban or rural facility locale, resident case mix, and area wage differences.

Under Medicaid, states establish their own payment rates for nursing home services. Federal statute requires that these rates be consistent with efficiency, economy, and quality-of-care standards, as well as sufficient to enlist enough providers so covered benefits are available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area. In some cases, states make supplemental payments to Medicaid providers that are separate from, and in addition to, the standard payment rates for services to Medicaid enrollees.

Medicare-Covered Skilled Nursing Facility Services

SNFs provide post-acute care to qualifying Medicare beneficiaries, on a limited basis, for treatment of different diagnoses and conditions. Medicare pays SNFs for daily skilled nursing, daily skilled rehabilitation, drugs/ biologicals, durable medical equipment, and bed and board provided with such services, among other benefits. To be eligible for Medicare SNF coverage, in general a beneficiary must have had an inpatient

hospital stay of at least three consecutive calendar days (not including the day of discharge) and must be transferred to a participating SNF, usually within 30 days after discharge from a hospital. The participating SNF must provide services for a condition that was treated during the beneficiary's qualifying hospital stay (or an additional condition arising in the SNF).

A beneficiary who qualifies for SNF coverage under Medicare Part A is entitled to up to 100 days of covered care per spell of illness. For traditional Medicare beneficiaries, the first 20 days of a Medicare-covered SNF stay do not require beneficiary cost sharing; for the 21st through the 100th day, daily cost sharing is required ($217 per day coinsurance in 2026). Beneficiaries enrolled in a Medicare Advantage (MA) plan are also covered for comparable eligible SNF services, unless the plan has expanded eligibility or coverage of the benefit. Cost sharing for SNF services provided by MA plans may vary but overall must not exceed that under traditional Medicare.

Medicaid-Covered Nursing Facility Services

NFs provide post-acute care to Medicaid beneficiaries who require skilled nursing care and rehabilitation due to an injury, disability, or illness. NFs also provide LTSS to eligible Medicaid beneficiaries who meet state-defined nursing home eligibility criteria, referred to as *level-of-care criteria*. State Medicaid programs are required to cover NF services for beneficiaries aged 21 and older. States have the option to cover NF services for beneficiaries under the age of 21; all states provide this optional service.

To define level-of-care criteria, states may use *functional* criteria, such as an individual's ability to perform certain activities of daily living (e.g., eating, bathing, dressing, and walking) or to perform certain instrumental activities of daily living (e.g., shopping, housework, and meal preparation) that allow an individual to live independently in the community. States also may use *clinical* criteria, which include diagnosis of an illness, injury, disability, or other medical condition; treatment and medications; and cognitive status, among other information. Most states use a combination of functional and clinical criteria to determine the need for institutional long-term care.

NF services include nursing care and related services, dietary services, specialized rehabilitation services (e.g., physical and occupational therapy, speech pathology and audiology services, and mental health rehabilitative services), dental care, pharmacy services, medically related social services, and a program of activities. Medicaid coverage of NF services also includes room and board.

Minimum Federal Requirements

Nursing homes must meet certain Requirements of Participation (RoPs) to receive federal payment for services provided to qualifying beneficiaries under Medicare and Medicaid. Among other requirements, the RoPs establish standards governing resident rights, quality of care, staffing, and services that facilities must provide. Nursing homes also are subject to state licensing requirements and state regulations.

Home- and Community-Based Settings vs. Institutional Settings

Other types of residential settings that provide housing and services (e.g., assisted living facilities) generally do not provide the type of skilled nursing or continuous care offered in nursing homes. These settings are considered community-based, not institutional. As such, they are not subject to federal Medicare and Medicaid Requirements of Participation (RoPs) for long-term care facilities.

Community-based residential settings are licensed and regulated by states. However, some residential settings may qualify to provide Medicare skilled nursing facility (SNF) care or Medicaid nursing facility (NF) care as part of a continuum of services in, for example, Continuing Care Retirement Communities. To take part in the federal programs and receive payment, the institutional care associated with these settings would have to meet Medicare SNF or Medicaid NF RoPs. In addition, Medicare- and Medicaid-covered services such as home health or personal care may be provided in community-based residential settings, similar to services provided in a participant's private residence. Home health agencies must meet federal requirements to participate in the Medicare and/or Medicaid programs. For more information, see CRS In Focus IF11544, *Overview of Assisted Living Facilities*.

Survey, Certification, and Oversight

Federal law requires a survey and certification process for determining whether nursing homes meet the RoPs and qualify for federal payments. Federal certification differs from state licensure, which permits a provider to operate as a nursing home in a particular state, whereas federal certification determines whether the facility may participate in Medicare and Medicaid. Generally, a nursing home must be licensed by a state before it is operational, and federal certification is typically obtained after state licensure.

Under agreements with the Secretary of Health and Human Services (HHS), SAs conduct initial certification surveys and periodic unannounced inspections to determine continued compliance with federal requirements. Certain survey metrics and quality ratings are publicly available through CMS's "Care Compare" website. When deficiencies are identified, the HHS Secretary is statutorily authorized to impose enforcement actions, including fines, referred to as *civil monetary penalties*. Facilities with persistent compliance problems are subject to enhanced federal oversight through the Special Focus Facility (SFF) program. SFF included 87 nursing homes as of August 2026.

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