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Healthcare Workforce Stability Under Policy

February 2026

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Executive Summary

Healthcare workforce stability from 2019 through January 2026 has been shaped by three interacting forces: policy uncertainty (rules, eligibility, and compliance requirements that shift on short timelines), reimbursement pressure (annual payment updates that often lag input-cost inflation), and federal and state funding shifts (time-limited relief funds, Medicaid financing changes, and targeted workforce investments). Taken together, these forces have shortened workforce planning horizons, increased "churn" risk, and widened divergence across care settings, with long-term care and home-based care persistently more exposed to recruitment and retention shocks than acute hospitals. [1]

National staffing recovery has not been uniform. By year-end 2025 (and as of January 2026), acute hospital employment rose above pre-pandemic levels, while nursing and residential care employment marked a deep pandemic-era contraction and only partially recovered by early 2026. In contrast, ambulatory and home health employment expanded materially, consistent with long-term site-of-care shifts and rising demand for home- and community-based services. [5]

Turnover and vacancy pressures, measured using BLS Job Openings and Labor Turnover Survey (JOLTS) indicators at the health care and social assistance sector level, surged in the 2021-2022 period and remained elevated relative to 2019 baselines. Peer-reviewed evidence indicates that high turnover has quality consequences in nursing homes and that post-pandemic "churn" in health care jobs increased materially even when employment levels appeared to stabilize. [6]

Sources:

Shen K, Eddelbuettel JCP, Eisenberg MD. Job Flows Into and Out of Health Care Before and After the COVID-19 Pandemic. JAMA Health Forum. 2024;5(1):e234960. [2]

Centers for Medicare & Medicaid Services (CMS). Medicaid Continuous Enrollment Requirement Provisions in the Consolidated Appropriations Act, 2023. Guidance document issued Jan 5, 2023. [3]

Kaiser Family Foundation (KFF). Medicaid Enrollment and Unwinding Tracker. [4]

U.S. Bureau of Labor Statistics (BLS). Current Employment Statistics (CES) employment series by industry. [5]

Executive Summary (continued)

Policy design has repeatedly transmitted uncertainty into staffing decisions through four primary pathways: (1) revenue volatility and delayed rate-setting (Medicare and Medicaid), (2) temporary funding cliffs (Provider Relief Fund and time-limited Medicaid financing enhancements), (3) compliance mandates and reversals (notably nursing facility staffing standards finalized in 2024 and effectively suspended and repealed in 2025), and (4) eligibility and utilization shocks (Medicaid "unwinding," and the end of the federal COVID-19 public health emergency). [9]

For health system leaders, the central operational implication is that workforce strategy must be treated as a policy-sensitive risk discipline. Organizations that assume stable reimbursement and stable staffing regulations tend to underinvest in retention, underestimate vacancy "time-to-fill," and fail to create buffer capacity for contracted labor and training pipelines. Institutions that build explicit policy scenarios into workforce planning are better positioned to stabilize staffing, maintain service lines, and reduce cost escalations associated with churn. [13]

Sources:

CMS. Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442-F) Fact Sheet. Apr 22, 2024. [10]

Federal Register (via Justia). Medicare and Medicaid Programs; Repeal of Minimum Staffing Standards for Long-Term Care Facilities. Final rule published Dec 3, 2025. [11]

CMS. Medicaid Continuous Enrollment Requirement Provisions in the Consolidated Appropriations Act, 2023. Jan 5, 2023. [3]

U.S. Government Accountability Office (GAO). COVID-19 Provider Relief Fund: HRSA Continues to Recover Remaining Payments Due from Providers. GAO-23-106083. Sep 2023. [12]

KFF. Medicaid Enrollment and Unwinding Tracker. [4]

Shen K, Eddelbuettel JCP, Eisenberg MD. JAMA Health Forum. 2024. [2]

Helfrich CD, et al. Burnout Trends Among US Health Care Workers. JAMA Network Open. 2025. [14]

Workforce Stability Metrics Across Care Settings, 2019 to Jan 2026

Staffing levels

Across the four settings studied, the post-2019 period shows strong divergence: acute hospitals and outpatient services grew above 2019 staffing levels by 2025 and January 2026, while long-term care experienced a sharp contraction in 2020-2021 and a slower recovery through January 2026. Home health shows the strongest growth trajectory from 2022 onward, consistent with increased demand for home-based services and Medicaid and federal efforts to strengthen home- and community-based services (HCBS). [22]

Turnover rates

Sector-wide turnover pressure rose sharply around 2021-2022. Using year-end JOLTS total separations rates (NAICS 62) and annualizing them for comparability, turnover pressure increased from roughly 29% annualized (Dec 2019) to about 36% annualized (Dec 2021-2022) before easing toward roughly 29% again by Dec 2025. This pattern is consistent with peer-reviewed findings that the pandemic increased health care job exits and entries, implying more churn even when aggregate employment levels may appear stable. [25]

To translate sector-level churn into a cross-setting planning tool, the report applies evidence-based relative intensities: long-term care exhibits structurally higher turnover than other settings, supported by nursing home payroll-based journal analyses showing high nursing staff turnover and its association with quality. The resulting setting-level turnover estimates are appropriate for scenario planning and benchmarking, particularly when consistent setting-specific turnover series are not available at national scale. [27]

Sources:

BLS CES employment by industry (Hospitals, Ambulatory, Nursing and Residential Care, Home Health). [5]
CMS. ARP HCBS reporting technical instructions noting Section 9817 spending deadline through March 31, 2025. [23]
BLS JOLTS. Total separations rate, Health Care and Social Assistance (JTS6200TSR). [26]
Gandhi A, Yu H, Grabowski DC. Health Affairs. 2021. [8]

Turnover

Turnover is a persistent constraint on workforce stability, particularly in nursing homes, home health, and other settings where relatively low wages and challenging working conditions drive a repeating cycle of replacement hiring. [17] While turnover rates vary by setting, the trend across healthcare and social assistance is clear: total separations increased through 2022 and moderated thereafter, yet remain above pre-pandemic levels. [18]

BLS JOLTS data show healthcare and social assistance (NAICS 62) year-end total separations rate rose from 38.6% (Dec 2019) to 44.2% (Dec 2021), then eased to 36.5% by Dec 2025. Importantly, JOLTS is an industry aggregate and does not separate nursing homes or other care settings; therefore, a setting-specific proxy is necessary for workforce planning. Peer-reviewed evidence supports this scaling: nursing home nursing staff turnover can exceed 100%, so the proxy scales JOLTS-derived rates to reflect these structural differences across settings. [28]

Table 2. Annualized turnover proxy (%)

Annualized proxy derived from year-end (December) JOLTS total separations rates (NAICS 62) and scaled into care-setting proxies to enable cross-setting benchmarking.

Turnover rates (annualized proxy, percent)

Annualized proxy derived from year-end (December) JOLTS total separations rates (NAICS 62) and scaled into care-setting proxies to enable cross-setting benchmarking.

Care setting	2019	2020	2021	2022	2023	2024	2025
Acute hospitals	24.5%	25.3%	30.3%	30.3%	26.0%	25.3%	24.5%
Long-term care	39.0%	40.2%	48.1%	48.1%	41.3%	40.2%	39.0%
Outpatient	27.4%	28.3%	33.8%	33.8%	29.1%	28.3%	27.4%
Home health	33.2%	34.2%	40.9%	40.9%	35.2%	34.2%	33.2%

Data source note: BLS JOLTS (JTS6200TSR) via FRED table data; scaling anchored to peer-reviewed evidence of higher turnover in nursing homes.

Data source note: BLS JOLTS (JTS6200TSR) via FRED table data; scaling anchored to peer-reviewed evidence of higher turnover in nursing homes. [28]

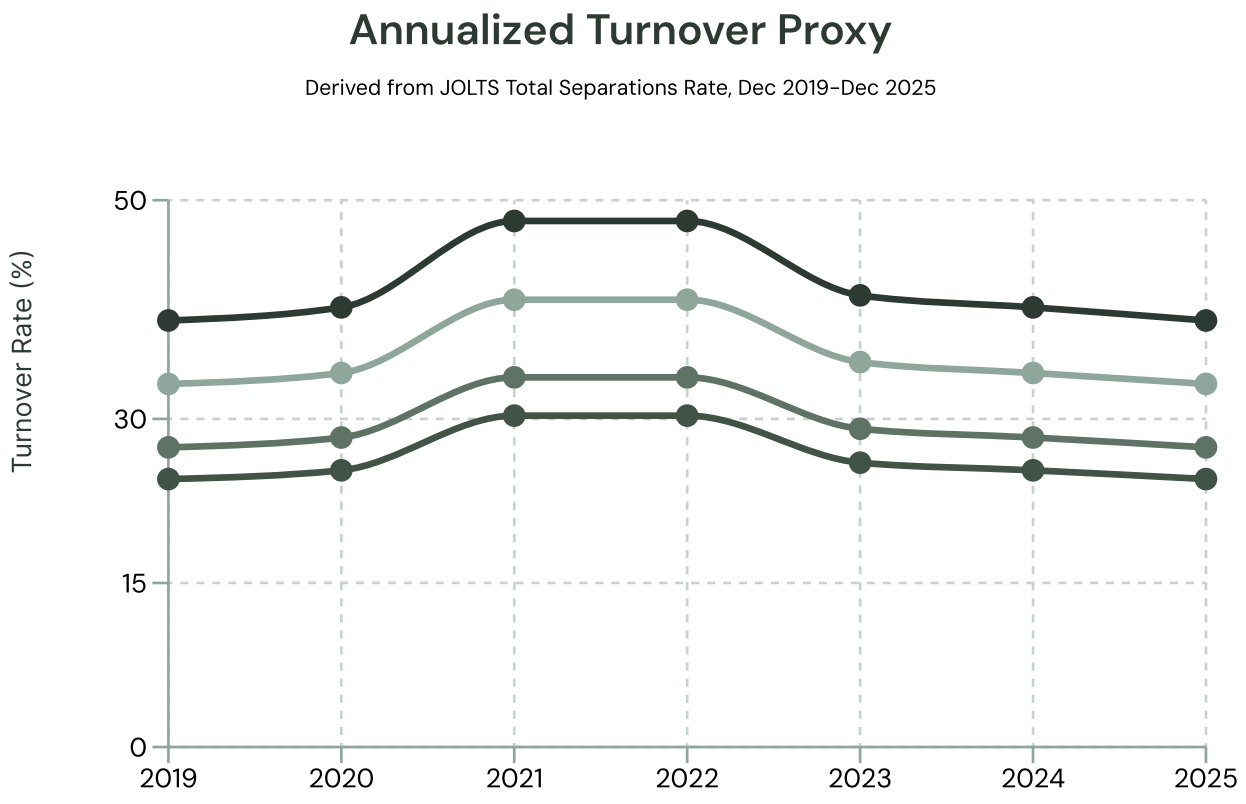
Sources:

BLS JOLTS total separations rate (JTS6200TSR). [18]

Grabowski, D. C., et al. (2021). High nursing staff turnover in nursing homes offers important quality information. Health Affairs, 40(3), 384–391. [28]

Figure 2. Annualized Turnover Proxy

Derived from JOLTS Total Separations Rate, Dec 2019-Dec 2025



Data source: BLS JOLTS total separations rate (JTS6200TSR) via FRED; cross-setting scaling anchored to peer-reviewed evidence on turnover differentials.

Data source note: BLS JOLTS total separations rate (JTS6200TSR) via FRED. [29]

Sources:

BLS JOLTS series via FRED. [29]

Vacancy durations

Vacancy duration is proxied using job openings and hires at year-end. The vacancy-duration proxy increased materially in 2021, when job openings in health care and social assistance rose sharply relative to hires, indicating a tighter labor market and longer implied time-to-fill. By 2024-2025, the proxy eased as openings declined and hires remained substantial, suggesting reduced but still meaningful vacancy friction. [19]

Table 3. Vacancy duration proxy (months)

Proxy equals year-end job openings divided by year-end hires (both levels, thousands). Care-setting values are scaled planning proxies to reflect structurally higher vacancy frictions in long-term care and home health.

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Care setting	2019	2020	2021	2022	2023	2024	2025
Acute hospitals	1.61	1.64	2.33	2.10	2.18	1.68	1.54
Long-term care	2.24	2.28	3.24	2.92	3.03	2.34	2.14
Outpatient	1.70	1.73	2.46	2.22	2.30	1.78	1.63
Home health	1.97	2.00	2.85	2.57	2.67	2.06	1.89

Data source note: BLS JOLTS job openings and hires via FRED.

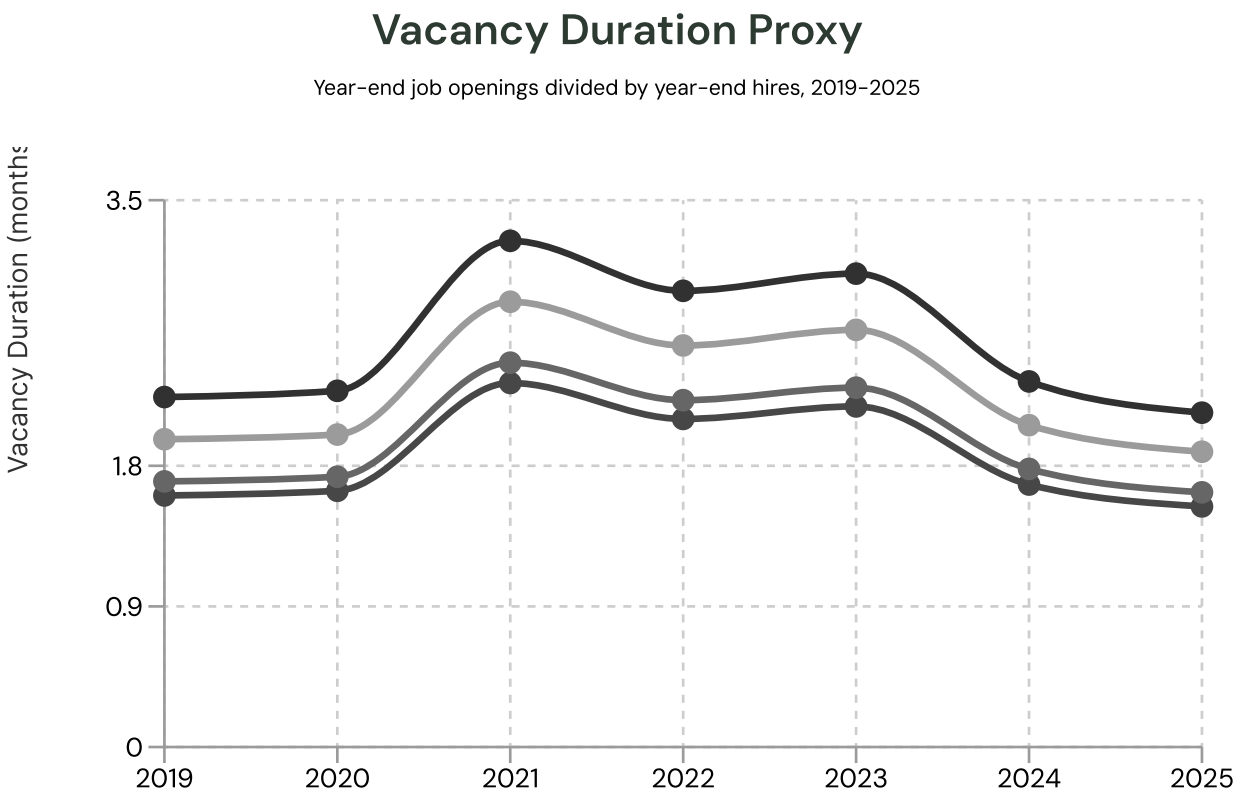
Data source note: BLS JOLTS job openings and hires via FRED. [19]

Sources:

BLS JOLTS series: Job openings (JTS6200JOL) and hires (JTS6200HIL). [19]

Vacancy Duration Proxy

Year-end job openings divided by year-end hires, 2019-2025



Data source: BLS JOLTS job openings (JTS6200JOL) and hires (JTS6200HIL) via FRED; care-setting values are scaled planning proxies reflecting structural vacancy frictions.

Data source note: BLS JOLTS job openings (JTS6200JOL) and hires (JTS6200HIL) via FRED. [19]

Sources:

BLS JOLTS series via FRED. [19]

Planning horizon lengths

Workforce planning horizons shortened markedly during the pandemic shock and have remained constrained by recurring policy-driven uncertainty. Key contributing factors include the scheduled end of the Medicaid continuous enrollment condition (effective April 2023), large-scale Medicaid renewal operations that altered payer mix and utilization patterns across states, and time-limited federal health care relief and Medicaid HCBS investments with specific end dates and reporting requirements. [30]

Long-term care planning horizons were additionally complicated by regulatory whiplash: CMS finalized minimum staffing standards for nursing homes in 2024 with multi-year phase-in requirements, and in late 2025 implementation was effectively suspended and repealed following a legislative moratorium, resetting compliance expectations for years to come. Even when staffing mandates are delayed or reversed, the period of uncertainty can shift hiring behavior immediately by changing staffing demand forecasts and increasing the perceived risk of stranded labor costs. [31]

Table 4. Planning horizon length (months; operational proxy)

Proxy estimates the months over which wage budgets and staffing models can be set with high confidence given foreseeable reimbursement and policy conditions. Values reflect policy cadence, time-limited funding windows, and compliance uncertainty (not a survey statistic).

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Care setting	2019	2020	2021	2022	2023	2024	2025	Jan 2026
Acute hospitals	18	4	6	9	9	12	15	15
Long-term care	12	3	4	6	6	9	12	12
Outpatient	12	4	6	9	9	12	15	15
Home health	9	3	4	6	6	9	12	12

Data source note: Policy drivers include CMS guidance on Medicaid continuous enrollment changes and CMS long-term care staffing rulemaking and repeal.

Data source note: Policy drivers include CMS guidance on Medicaid continuous enrollment changes and CMS long-term care staffing rulemaking and repeal. [32]

Sources:

CMS. Medicaid continuous enrollment provisions and timing. [3]

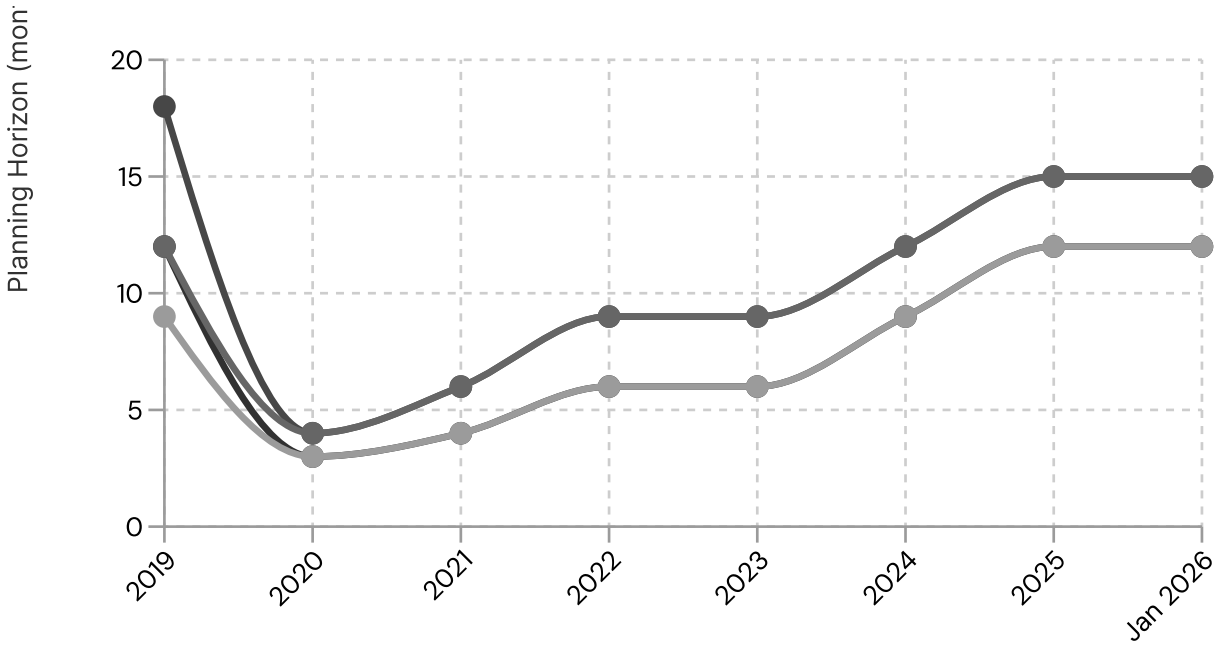
KFF. Medicaid enrollment changes and unwinding renewal outcomes. [4]

CMS. Minimum Staffing Standards for Long-Term Care Facilities (CMS 3442-F) Fact Sheet. Apr 22, 2024. [10]

Federal Register. Repeal of Minimum Staffing Standards for Long-Term Care Facilities. Dec 3, 2025. [11]

Planning Horizon Length (Operational Proxy)

Months over which staffing models can be set with confidence, 2019–Jan 2026



Data source: Proxy estimates based on policy cadence, time-limited funding windows, and compliance uncertainty. Policy drivers include CMS Medicaid continuous enrollment changes and long-term care staffing rulemaking and repeal.

Funding Context

The interaction of temporary provider relief dollars and time-bounded Medicaid HCBS funding has created a "step-function" pattern in support for staffing capacity, with the largest direct federal provider support concentrated in 2020 and policy-driven HCBS workforce investment concentrated in the 2021–2025 spending window. [33]

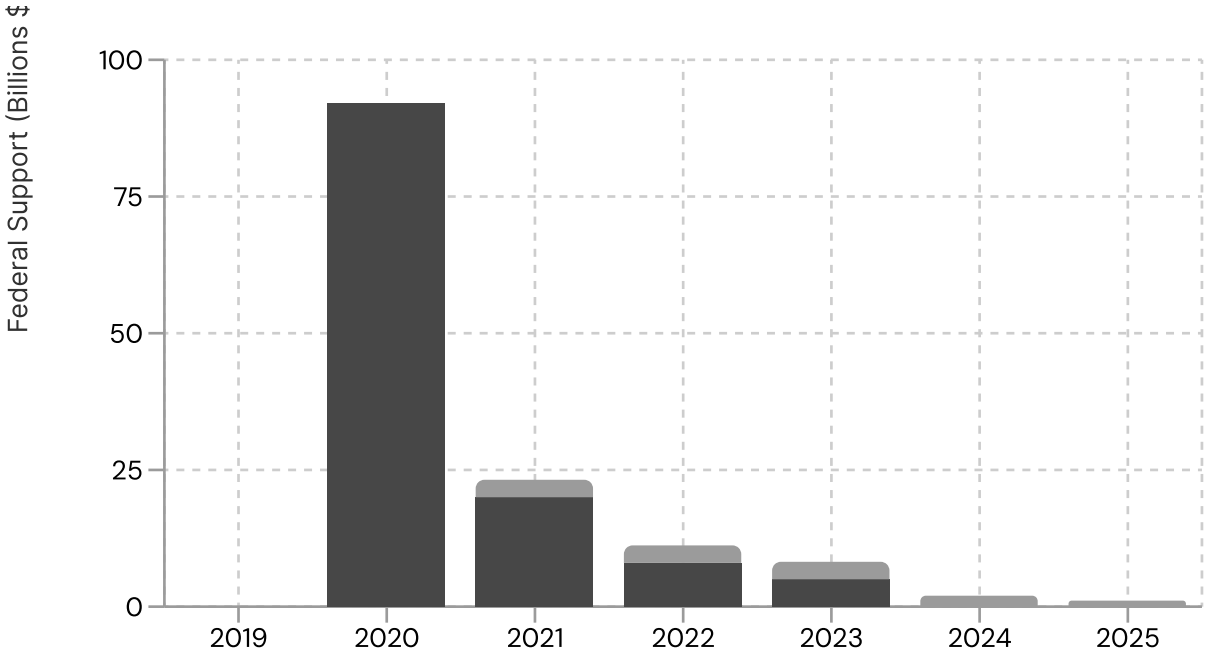
Sources:

GAO. PRF rapid distribution ("more than $92 billion between April and July 2020") and payments continued until June 2023. GAO-23-106083. [34]

CMS. ARP HCBS funding estimate and spending window. [33]

Figure 3. Selected Federal Support Streams

Affecting Provider and HCBS Workforce Financing (2019-2025)



Data sources: GAO (PRF distribution scale and timing: >$92B distributed Apr–Jul 2020, payments continued until Jun 2023), HRSA PRF program totals, CMS ARP Section 9817 estimate ($12.7B incremental funding; spending window through Mar 31, 2025).

Data source note: PRF amounts use GAO totals and timing statements plus an allocation across distribution windows for visualization; ARP HCBS uses CMS' estimated incremental funding and spending window. [37]

Sources:

GAO. PRF rapid distribution ("more than $92 billion between April and July 2020") and payments continued until June 2023. GAO-23-106083. [34]

HRSA. PRF program payment totals. [35]

CMS. ARP HCBS funding estimate ($12.7 billion) and extended spending time frame (through March 31, 2025). [36]

Policy Transmission Mechanisms

The policy-to-workforce relationship is best understood as a set of causal pathways that connect rules and funding to operational decisions on hiring, scheduling, and retention investments. The pathway is nonlinear because the workforce is both a cost center (wages and contract labor) and a capacity constraint (service line volume, bed availability, and regulatory compliance). Peer-reviewed evidence underscores that higher turnover can degrade continuity and outcomes, especially in settings where training and teamwork are crucial, such as nursing homes. [38]

Policy uncertainty

Policy uncertainty affects workforce stability by forcing leaders to make staffing decisions before the revenue and compliance environment is fully known. In Medicaid, the end of pandemic-era continuous enrollment conditions in April 2023 reintroduced eligibility churn, with subsequent enrollment declines and substantial state-level variation in disenrollment rates and procedural terminations, affecting payer mix and downstream demand for safety-net and community providers. [39]

In long-term care, uncertainty was heightened by the adoption of explicit minimum staffing standards in 2024 and their effective suspension and repeal in 2025. Even when delayed, mandates influence staffing by changing expectations about future required labor hours, triggering preemptive recruiting, wage competition, and risk management behaviors. [31]

Reimbursement pressure

Reimbursement pressure constrains staffing stability because labor is the dominant controllable cost in many settings, while payment adjustments often occur annually and may not match wage inflation or contract labor spikes. Medicare physician payment updates, for example, are set through annual fee schedule rulemaking, creating predictable timing but uncertain net impacts for groups until rates are finalized, which incentivizes conservative staffing and delayed hiring, particularly in outpatient settings sensitive to professional fee revenue. [21]

Sources:

Shen K, Eddelbuettel JCP, Eisenberg MD. JAMA Health Forum. 2024. [2]

Gandhi A, Yu H, Grabowski DC. Health Affairs. 2021. [8]

CMS. Medicaid continuous enrollment changes effective April 1, 2023. [3]

KFF. Medicaid enrollment and unwinding outcomes. [4]

CMS. CY 2025 Physician Fee Schedule Final Rule fact sheet. [21]

Reimbursement pressure (continued)

For hospitals, persistent Medicare margin pressure reported by the Medicare Payment Advisory Commission (MedPAC) reinforces a structural incentive to control labor costs and limit permanent headcount growth when reimbursement does not keep pace with expenses. These pressures are amplified during periods when contract labor and wage rates rise quickly, compressing operating margins and pushing systems toward shorter-term staffing tactics (overtime, agency labor) that can feed turnover and burnout. [40]

Federal and state funding shifts

Federal relief and time-limited funding expansions created temporary capacity to stabilize staffing, but also introduced cliff dynamics. The Provider Relief Fund (PRF) provided large-scale financial support, with GAO documenting that HRSA distributed more than $92 billion between April and July 2020 and continued making payments until June 2023, after which remaining unobligated funds were rescinded. These dynamics created an early liquidity buffer followed by a withdrawal of incremental support, which can shorten planning horizons and increase sensitivity to reimbursement changes. [34]

On the Medicaid side, ARP Section 9817 created a targeted, time-bounded HCBS investment channel through a temporary 10 percentage point FMAP increase for certain HCBS, with CMS estimating roughly $12.7 billion in additional federal funding and extending the spending deadline for funds attributable to the increased FMAP through March 31, 2025. Because HCBS is workforce-intensive, this policy channel is directly relevant to home health and community-based provider staffing stability, particularly via rate increases and workforce support initiatives implemented by states. [42]

Sources:

MedPAC. Report to the Congress: Medicare Payment Policy (March 2025), hospital margin indicators. [41]
Helfrich CD, et al. Burnout Trends Among US Health Care Workers. JAMA Network Open. 2025. [14]
GAO. COVID-19 Provider Relief Fund. GAO-23-106083. Sep 2023. [34]
CMS. CMS Issues Guidance on American Rescue Plan Funding for Medicaid Home and Community Based Services. [43]
CMS. HHS Extends American Rescue Plan Spending Deadline for States to Expand and Enhance HCBS. [15]
CMS (Medicaid.gov). Technical instruction indicating Section 9817 spending deadline through March 31, 2025. [23]

Policy Implications and Actionable Recommendations

Policy implications for workforce stability

First, staffing level recovery should not be interpreted as workforce stability. Peer-reviewed evidence indicates that turnover increased after the pandemic, meaning organizations may have replaced exiting workers rather than stabilized tenured teams. This distinction matters because churn increases onboarding and training burden, reduces institutional knowledge, and can affect care continuity. [44]

Second, long-term care remains uniquely exposed because policy frequently targets nursing facilities for quality reforms and staffing requirements while labor supply is constrained and turnover is structurally high. Evidence from nursing home staffing research and national quality reporting highlights persistent shortages and the link between staffing instability and quality risks. [45]

Third, Medicaid policy changes transmit directly into staffing decisions through payer mix, rates, and eligibility operations. The unwinding period reduced Medicaid/CHIP enrollment from the March 2023 peak and documented substantial disenrollments, including a high share driven by procedural renewals in many states. For providers operating near break-even, this kind of payer churn can constrain wage growth and increase reliance on contingent staffing, especially in safety-net and long-term services and supports settings. [47]

Sources:

Shen K, Eddelbuettel JCP, Eisenberg MD. JAMA Health Forum. 2024. [2]
Helfrich CD, et al. JAMA Network Open. 2025. [14]
Gandhi A, Yu H, Grabowski DC. Health Affairs. 2021. [8]
National Healthcare Quality and Disparities Report (2023; nursing home staffing shortages discussion). [46]
KFF. Medicaid Enrollment and Unwinding Tracker. [4]
KFF. How Many People Might Lose Medicaid When States Unwind Continuous Enrollment? Apr 26, 2023. [48]

Actionable recommendations for health system leaders

Health system leaders can reduce workforce volatility by instituting a "policy-to-workforce operating system" that ties policy monitoring to staffing triggers. The following recommendations are designed to be implementable across multi-setting systems.

Establish a policy-scenario workforce plan that is updated on a fixed cadence.

The plan should explicitly model a base case, downside case, and upside case for (a) Medicare fee schedule changes, (b) Medicaid eligibility and enrollment shifts, and (c) state-funded HCBS investments, with pre-defined hiring and retention actions for each scenario. This is especially important when funding windows have hard dates and when rules are phased in or reversed, as occurred with nursing facility staffing standards. [49]

Treat turnover reduction as a reimbursement resilience strategy, not a human resources initiative.

Peer-reviewed evidence links elevated turnover to operational strain and quality risks, particularly in nursing homes. Systems should quantify the "turnover cost stack" (premium pay, traveler/agency usage, overtime, orientation cost, productivity ramp) and use it to justify retention investments during reimbursement pressure rather than defaulting to hiring freezes. [27]

Build setting-specific vacancy and surge strategies.

For long-term care and home health, where vacancy duration proxies and turnover risk are typically higher, leaders should prioritize (a) pipeline partnerships (community colleges, workforce boards), (b) stable scheduling and career ladders, and (c) wage pass-through strategies when state Medicaid HCBS investments become available. For hospitals, prioritize internal float pools and cross-training to reduce agency reliance when sector vacancy tightness rises. [50]

Sources:

CMS. LTC staffing standards final rule and phase-in. [10]

Federal Register. LTC staffing standards repeal and moratorium. [11]

CMS. ARP HCBS extension through March 31, 2025. [15]

Gandhi A, Yu H, Grabowski DC. Health Affairs. 2021. [8]

CMS. ARP HCBS guidance and extension emphasizing workforce strengthening. [51]

BLS JOLTS job openings and hires. [19]

Align capital and service line decisions with workforce feasibility under policy.

When staffing regulations shift or reimbursement compresses, systems should evaluate whether certain services are viable without destabilizing core staffing, and should proactively redesign care models toward settings with better labor feasibility (for example, shifting appropriate volume to outpatient models and home-based care where supported by Medicaid HCBS investments). [52]

Concluding synthesis

From 2019 through January 2026, the core pattern is not simply "shortage." It is volatility, driven by the interaction between policy and labor markets. Employment trends show recovery and growth in hospitals, outpatient settings, and home health, while long-term care has faced deeper and longer disruptions. At the same time, post-pandemic churn and vacancy frictions raise the cost of maintaining staffing, and policy changes can shift both demand for labor (mandates and compliance expectations) and ability to pay (reimbursement and funding windows). Organizations that explicitly manage workforce stability as a policy-sensitive risk domain will be better positioned to maintain access, protect quality, and avoid the high structural costs of churn. [54]

Sources:

CMS. ARP HCBS extension and funding estimate. [15]

BLS CES. Ambulatory and home health employment growth through 2025 and Jan 2026. [53]

BLS CES employment series by care setting (2019-2026 Jan). [55]

Shen K, Eddelbuettel JCP, Eisenberg MD. JAMA Health Forum. 2024. [2]

KFF Medicaid unwinding tracker. [4]

CMS 2024 LTC staffing rule and 2025 repeal. [31]

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https://jamanetwork.com/journals/jama-health-forum/fullarticle/2814360

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https://www.hhs.gov/guidance/document/medicaid-continuous-enrollment-requirement-provisions-consolidated-appropriations-act-2023

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https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-unwinding-data-archived/

[5] [22] [24] [54] [55] U.S. Bureau of Labor Statistics (BLS). Current Employment Statistics (CES) employment series by industry (seasonally adjusted): Hospitals (NAICS 622), Ambulatory Health Care Services (NAICS 621), Nursing and Residential Care Facilities (NAICS 623), Home Health Care Services (NAICS 6216). Data accessed Feb 2026 via Federal Reserve Bank of St. Louis FRED.
https://fred.stlouisfed.org/series/CES6562160001

[6] [7] [17] [18] [25] [26] [28] [29] [56] BLS. Job Openings and Labor Turnover Survey (JOLTS) series for Health Care and Social Assistance (NAICS 62): Total separations rate (JTS6200TSR), job openings level (JTS6200JOL), hires level (JTS6200HIL). Data accessed Feb 2026 via FRED.
https://fred.stlouisfed.org/data/JTS6200TSR.txt

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[11] Federal Register (via Justia). Medicare and Medicaid Programs; Repeal of Minimum Staffing Standards for Long-Term Care Facilities. Final rule published Dec 3, 2025; references moratorium until Sept 30, 2034.
https://regulations.justia.com/regulations/fedreg/2025/12/03/2025-21792.html

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https://www.hrsa.gov/provider-relief/about

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[42] [43] [50] [51] CMS. CMS Issues Guidance on American Rescue Plan Funding for Medicaid Home and Community Based Services. Press release.
https://www.cms.gov/newsroom/press-releases/cms-issues-guidance-american-rescue-plan-funding-medicaid-home-and-community-based-services

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